The Shaping of Decision-making in Governance in the New Zealand Public Healthcare Services

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A Thesis submitted in partial fulfillment of the requirements for the degree of Doctor of Health Science

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Cogita Cogitata

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

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W. Lee Mathias Date

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Abstract

The study explores what shapes decision-making in governance in the New Zealand public healthcare services. It contributes to the understanding of the impact of the beliefs, perceptions and roles of the decision-makers and the tensions in public healthcare services in New Zealand. The focus was on ascertaining the characteristics of the people as individuals and as members of groups, their skills, preparation and the experience required to make governance decisions in healthcare services in New Zealand. The research analysed data from interviews with individuals in senior positions in public healthcare services in New Zealand, focus groups made up from those individuals and observations of formal District Health Board (DHB) meetings. The context for the study is the New Zealand public healthcare services within the DHB model.

This study focuses on the organisational and operational aspects of governance from the socio-anthropological viewpoint of Pierre Bourdieu. Bourdieu's methodology was chosen as it highlights the interaction of power and the management of tension between individuals and groups in different, but abutting, *fields of practice*. Using Bourdieu's methodology the researcher has placed healthcare services in an *economy of political power* where the *capital* individuals and groups bring to an environment is demonstrated through their power and influence within a particular *field of practice.* In this study the *field of practice* is governance in New Zealand public healthcare services.

The method involved purposive sampling of participants from three DHBs. The participants included appointed and elected members, chairmen, chief executives and senior clinicians from medical and nursing cohorts.

The participants identified 22 abstracts which determined the shape of their decision-making. Through analysis and reflection these 22 determinants were organised into groups reflecting the generic principles of governance identified in the literature. The study concludes that decision-making in governance is shaped by the concepts of professional maturity, quality and safety, power and tension and fiduciary duty within the context of structure and time. The scope of governance is connected across healthcare organisations by the tension of power manifested through the *capital* individuals and groups bring to the interaction or *field of practice*.

The study also found that there are two aspects to decision-making in governance which allow transferability of the concepts of governance across healthcare service organisations. Firstly, governance is decision-making in good faith with independence of mind and with the appropriate skills, diligence and care on behalf of others. Secondly, the structures of governance operationalised in audit, laws, guidelines, codes and principles support the decision-making on behalf of others. Consequently, the rules of decision-making in governance in healthcare services are the same whether the decision is being made in a clinical or corporate environment. They are enacted differently because of the different contexts.

The study brings together the determinants in their concept groups into a framework in the context of structure and time. Use of the framework will enable those with governance responsibilities to shape their governance decision-making from an informed and common base which recognises the tensions in the *field* of healthcare services governance.

Chapter 1

Introduction

The health sector in New Zealand is complex. In New Zealand, publicly funded healthcare services are subject to political and commercial intrusion for reasons not related to health outcome, which will be elaborated upon in Chapter 4. Those intrusions create a tension between public healthcare services. Some services are free and accessible and others not. Some services are considered a public good and others are provided on private good principles, for example, general practitioner services which are largely provided by the private sector using private sector business principles but are largely publicly funded. There is a diversity of health professionals and allied health personnel providing care and support services to and for unique individuals requiring care and treatment from a range of services. Therefore decision-making is often in an environment of ambiguity, contingent on the context and the attributes of individual decision-makers. Although guided by health profession standards and the boundaries of legislation, at present decision-making in governance in New Zealand healthcare services is not determined by a commonly understood principled base but by the values and ideals of individuals and health professions.

Change and differences in the understanding of what governance is also contribute to the ambiguous environment. The New Zealand public health sector has been reviewed and restructured four times since 1989. These have been major organisational structural changes based on the political ideologies of the incumbent governments of the day and in the context of major changes to the underpinning principles of how New Zealand is governed. With each change came a new group of people and new legal and organisational structures based on different policies.

The research question – the shaping of decision-making in governance in New Zealand public healthcare services

This research has explored and analysed the data given by participants who are key people within District Health Boards. They described what influenced their decision-making in governance in New Zealand's public healthcare services. The influence of the experience

and persona of individuals and groups within the context in which they work was explored. Experience, personal and group characteristics are recognised as influencing or shaping decision-making in governance (Leblanc & Gillies, 2005). Exploring decision-making in governance in healthcare services also identified the durability required of a healthcare services governance model in relation to political change and its pertinence to all healthcare services stakeholders. This study explores whether there is a common thread or link between a DHB and its clinicians in their decision-making within governance positions.

Position of the researcher

I am a nurse. I have been a nurse for 40 years. Until recently I was the managing director of a private company offering maternity facilities services contracted to DHBs and a founding director of a start-up laboratory- human pathology- company. I have been a professional company director since 1993 and I am an accredited Fellow of the New Zealand Institute of Directors. I maintain a small management consulting business which includes several DHBs as clients. The focus of my management consulting business is organisational review, strategy, planning, change and governance. My experience as a company director has led to my questioning what shapes the decisions people make in healthcare services governance and allows exploration of decision-making in such governance from a position of experience.

In my practice I bring to the board table an unusual collection of skills and experience. Unusual in that I have a broad business and clinical experience coupled with the management and teaching of every health profession. Some of the strategic and operational decisions made each day have onerous moral and ethical implications for clinical outcomes; others simply ensure solvency and the endurance of the business.

As a researcher I was seeking to develop a package of ideas and concepts that could help explore the plethora of relationships and tensions between individuals and groups who make decisions within the health sector and could accommodate the dynamic nature of those relationships. The relationships respond to the context in which they are formed, simultaneously altering the character of the individual and the structure of the group in which they are participating (Rayman-Bacchus, 2003). Both the relationships and the context are dynamic, thereby making decision-making itself complex.

Background and justification for the study

Humans are emotional beings whose decisions are affected by the limitations of their own knowledge, by boundaries to their thinking and by the relationships with others within the context of the decision-making experience (Simon, 1982a, 1982b). In practice, as a nurse, I often witnessed, and pondered upon, the behaviour individuals demonstrated as patients which was different from their behaviour as non-patient members of the public; as mothers, fathers, men in business, women as community leaders. As patients, human behaviour is limited by specific characteristics and acceptable behaviours which are attributed to the role of patient. 'Patiency' is a concept understood by health professionals as being implicitly related to the roles people play when receiving care and treatment from health professionals and in clinical environments (Roy, 1980).

The context of the hospital (or other healthcare service) environment leads people, both patients, and personnel, to respond to decision-making in a different manner than if they were in more familiar surroundings, where they were confident of their ability and knowledge and less bounded by the unfamiliarity of both the physical environment and the intellectual context of their illness. In my experience, this lack of familiarity causes the patient to hand over decision-making to the knowledgeable health professional and, for the most part, clinical decision-making, supported by the structures of governance, has remained with the health professional.

Around the board table, and similar to my experience as a nurse, I experienced the varying behaviour of board members placed in a context in which they were unfamiliar, making decisions based on the limitations of their own knowledge or under the guidance and/or direction of others. It was not evident to me whether the tensions, especially between directors and clinicians, were created by the lack of understanding I observed or some other broader influence. This quandary provided impetus for this study.

Whether at a board table or in a clinical discussion, I question what makes people approach decision-making in governance of healthcare services the way they do. To begin to understand the position people making governance decisions in New Zealand healthcare services find themselves in, there needs to be an understanding of the historical context to establish how precedents have been established and their impact on decision-making.

Historical Context

The political context in which decisions are made influences decision-making in healthcare services. Styles of government in New Zealand since 1989 have ranged from the neo-liberalism, which grew out of the 1980s into the 1990s, to the centralized control of the ideologies of traditional Marxism from 2000 (Crotty, 1998). As the principles underpinning governments changed so did the style and structure of healthcare organisations. Management of healthcare services has evolved from a system based on centralized funding and decentralized service provision by discreet independent companies to a system devolved to districts but with the centralised right of veto of organisational board decisions emphasized by the shareholding Minister of Health (Minister).

In order to facilitate governance decision-making in healthcare services boards, managers and clinicians have placed governance in the context in which decisions are made, e.g. corporate or clinical governance. Governance in healthcare services has therefore been separated into discrete concepts.

A definition of governance without contextualization was elusive to the researcher.

“The term governance refers to the processes of decision-making within an institution.”

“A set of principles informs governance arrangements…... the most fundamental is accountability…. accountability depends on transparency in taking of decisions…..three further principles: effectiveness, efficiency and the establishment of expertise”

(Oxford University, 2006 s. 11,13,16)

The Oxford definition, while specifically relating to institutions, illustrates the concept of underpinning principles which is explored in this study. Contextualization of governance is one justification for this study because governance definitions appear to be contingent on the context in which decisions are made.

Corporate governance

Governance, or more specifically how to make governance effective, has become the concern of directors with case law and statutory bodies such as the Securities Commission

(2004) as catalysts for initiating change in regulated governance practice. Corporate governance is the topic of the decade for management and business journals but it is a latecomer as a subject of academic enquiry (Leblanc, 2003). While case analysis established precedent for change from the legal perspective, business and management literature, until recently, was largely focused on applied business magazines offering opinion rather than research with academic rigor. Writers outside of popular business journals were limited to a few (Cadbury, 1992; CCH, 2004; Charkham, 1994; Farrar, 2005; Garratt, 2003b; M. King, 2003; Monks & Minow, 2001) and most other research was quantitative and often related to business financial performance (Leblanc, 2003). The basis of decision-making in corporate governance in healthcare services styles the delivery of services and is therefore important to explore in this study.

Clinical governance

Clinical governance, on the other hand, has featured widely in the clinical and quality health literature since its inception in the United Kingdom in 1993 (Department of Health (UK), 1998). There has been much debate about what it is and is not and the result has been an over-representation of quality issues of governance to the detriment of other governance principles (Campbell, 2001). Much clinical governance literature fails to recognise transparency, accountability and duty as characteristics with equal importance to issues of probity (Campbell, 2001; Harrison & Lim, 2000). New Zealand healthcare services have been heavily influenced by the requirements for audit. Scarce resources and the focus on accreditation cycles have often outweighed the development of services to meet both need and professional development in healthcare service organisations. Decision-making in clinical activity is of primary importance to the study as it is the essence of governance in healthcare services. Healthcare services exist to provide clinical and public healthcare.

Therefore, while decision-making in governance in healthcare settings has been influenced by the context in which it occurs, the emphasis is arbitrarily assigned by the people involved. The emphasis on results for corporate governance and audit and compliance for clinical governance has obscured the influence of other governance principles such as fiduciary duty, accountability and transparency, and the impact they have on decision-making.

Structure of the thesis

Culture and the economy of power – Pierre Bourdieu's methodology

The theories of Pierre Bourdieu, discussed in Chapter 2, offer a philosophical framework to explain the complexities of decision-making in healthcare services governance within a critical framework. Through this framework explanations of the complexities of healthcare can be interpreted and contextualized. The explanation and discussion of the methodology of Bourdieu is placed early in the thesis to locate the subject of decision-making in healthcare governance within Bourdieu's *political economy of symbolic power*. This study uses Bourdieu's concepts of power as *capital* in interpreting the tensions in the *field of practice* from the data. The reader is exposed to the language of Bourdieu early as it is linked with the literature and facilitates the understanding in the chapters that follow.

New Zealand healthcare services in context

Chapter 3 discusses the recent history of the healthcare services in New Zealand, enabling the understanding of the role of history and experience on decision-making in governance in the healthcare services environment. Discussion about the history enhances the appreciation of the impact of evolving healthcare services over time and the influence on decision-making in governance of ideological changes within successive governments.

The discussion on the impact of the political context on healthcare services focuses on the background to the DHB organisational structure and an analysis of the structures which support decision-making in governance in New Zealand's public healthcare service. The focus on organisational structure not only places governance in context but also identifies the boundaries and frameworks within which decision-making takes place.

Decision-making and governance

Chapter 4 examines the historical perspective and research of others on decision-making in governance including corporate and clinical governance. Gaps are identified in the understanding of how and why decisions are made the way they are, which demonstrated the need for this research. Questions raised and support given from the literature provides the justification for this research. In discussing the research on decision-making, the

contextualization of governance, and how that contextualization obscures the basic duty of faith, is made visible.

Method and data collection

Chapter 5 describes Bourdieu's research method which provides the framework for data collection and analysis. The chapter describes the data collection process and the timeline. Bourdieu's research method consists of three sections; describing the *field of practices,* creating a *social topology* and *structuring the field* all of which are used to guide the analysis of the data.

Data analysis

The data analysis and discussion is presented over three chapters, 6, 7 and 8 and is underpinned by Bourdieu's theories. The first, Chapter 6, describes the *field of practice* that is the *cultural field of power* in which healthcare services governance is located. The second, Chapter 7, involves the construction of a *social topology* which examines the power relations within the institutional and organisational complexity of New Zealand's public healthcare services. And thirdly, Chapter 8 analyses the influences of healthcare services structure on decision-making in governance. That is, *structuring the field* in which healthcare services governance happens.

Discussion and conclusions

The final Chapter, 9, discusses the conclusions of the study which identify what shapes decision-making in governance in New Zealand's public healthcare services and promotes a framework for governance in those services. The study concludes that participants believe that governance decisions are shaped by 22 determinants. As part of the research process reflexivity grouped those 22 determinants into concept groups of professional maturity, quality and safety, power and tension and attaining a balance between the duty of utility and the duty of care within the context of structure and time. The concept groups are a reflection of the generic principles of governance identified in the literature and applied to the data using the reflexive process. The scope of decision-making in governance is supported by political, economic and organisational structures and located in time. The framework brings together the dimensions of decision-making in governance into a tool

which aims to facilitate the understanding of the influences on governance decisions in healthcare services.

The implications and recommendations are discussed in the final Chapter 9. Having outlined the overall structure of the thesis and explained the rationale for the research question and for the structure, the thesis will now move to Chapter 2, where, as outlined earlier, the philosophical underpinnings, or methodological basis for this study will be presented. The focus will be on the theories of Pierre Bourdieu.

Chapter 2

Pierre Bourdieu – culture and the economy of power

Introduction

This chapter focuses on placing decision-making in healthcare services within a critical framework using the influences of Pierre Bourdieu's methodology within the *political economy of symbolic power*. The chapter extends traditional economism to include an economic valuation of all goods, material and symbolic, and their influence on the environments in which interaction occurs. The chapter concludes with the justification for this choice in exploring the question of shaping decision-making in governance in the New Zealand public healthcare services.

Choosing Bourdieu

Bourdieu (1977a) brings a strong sociological base influenced by experience in education and anthropology, along with a belief that involves individuals as agents who understand and control their own actions (Webb, Schirato, & Danaher, 2002). Bourdieu (1977a) was influenced by Karl Marx, 1818-1883, especially through building on the use of the economic metaphor in using *capital*, defined as the product of labour, to explain how *power* is gained and used (Marx, 1962, 1998, c.1933-1935). In criticising Marx's ideas on the primacy of the economy, Bourdieu expanded the limitations of *capital* as an economic measure into metaphor by introducing the frameworks of *social*, *cultural* and *symbolic capital* (Bourdieu, 1971, 1977a, 1985, 1986, 1990b, 1992). He expanded economism to include economic valuation of all scarce goods, material, non-material and symbolic goods which are desirable within society (Bourdieu, 1990b) and the balancing of the different types of power that results.

From a sociological perspective the rich heritage left by Emile Durkheim (Crotty, 1998; Durkheim, 1984; Giddens, 1971) in relation to the role of symbolic interactionism provided a basis for Bourdieu to build on the concept of *symbolic power*. And from Max Weber, Bourdieu developed the idea of social order, eventually into the *theory of fields* which will be discussed towards the end of this chapter.

The exciting characteristic about Bourdieu's work is that he was influenced by and took ideas from many disciplines. Some were his contemporaries like Maurice Merleau-Ponty and Edmund Husserl who influenced Bourdieu's understanding of phenomenology and Michel Foucault who, as well as the *economy of power*, provided ideas and concepts on discourse (Bourdieu & Wacquant, 1992b).

Bourdieu's methodology accommodates individuals, groups of people, their responses to each other, and the dynamic environments in which they work and which influences their governance decision-making. Bourdieu allows for the identification of the collective cultural characteristics, *doxa*, which influence those decisions (Bourdieu, 1990b). Bourdieu's framework was chosen because the methodology does not limit the interpretation of *culture* to those characteristics of ethnicity, religion and race but broadens the concept to include the values, beliefs, perceptions and attitudes of any social grouping. Bourdieu's framework brings together *culture*, structure as the *field*, and power through the concept of *capital*. Bourdieu offers a framework with practical application to a complex enquiry which balances theory and practice. Research is sited in real situations with the aim of real outcomes and application (Bourdieu, 1990b).

The role of *practice*, as practical sense – *sens practique*, and the situation of *practice* in social dynamics, is central to Bourdieu's work (1990). Bourdieu used the concepts of *habitus* and *field* interacting with *capital* as power, to explain the tensions between individuals and groups with their environment. Bourdieu uses these key concepts in a dialectical and interrelated process to explain a situation and the practical activities in a *field*. Structures within the *habitus* and *field* are predisposed to function in providing organisation to *practice* (Bourdieu, Chamboredon, & Passeron, 1991) which allows people to anticipate the actions and/or decisions of others. Structure, process and context make *practice* (Bourdieu, 1985, 1990b).

The eclectic breadth of Bourdieu's methodology provides a suitable vehicle to explore the complex area of healthcare services governance. As researcher I was seeking a framework which allowed exploration of the different perspectives within the social context in which governance decisions are made. In this chapter concepts in Bourdieu's methodology will be defined identifying the relevance to the study.

Through using Bourdieu's framework there is the opportunity to reveal the different struggles for position and power within the individuals and groups being studied and their influences on decision-making.

The Context of a Critical Framework

Early applications of critical theory were Marxist in style as researchers such as Friere (1972a), Habermas (1987) and Honneth (2004) sought to overcome the structure versus agency problematic. Power is an intrinsic feature of human agency (Carspecken, 1999) and the struggles for position, and influence, based on power are as evident in the healthcare services as any other institution or organisation (A. Dixon, 1996; Harrison & Lim, 2003). Power has been manifested in the healthcare system through historical hierarchical structures of healthcare service, particularly, but by no means exclusively, the medical professional culture. Critical theory recognises the social forces of domination and is considered a way to instigate change especially through understanding power and tensions in political life (Rush, 2004). Bourdieu (1999) posits the continuing relevance of critical theory in that there is an underlying aim for change and emancipation from domination and oppression in society through attaining balance using *capital* as power.

The critical approach to research is also characterised by reflection (Habermas, Rorty, & Kolakowski, 1996; Honneth, 2004) and described by Webb, Schirato & Danaher (2002) as reflecting on how forces such as culture and social position shape our interpretation of the world and the location of the cause of collective marginalisation of social groups in ideology. The critical approach seeks to move interpretation beyond self –understandings and illumination (Carr & Kemmis, 1982) to emancipation and achieving change to historically established processes. As Carr & Kemmis state (1982, p. 138) "...critical social science seeks to locate the cause of the collective misunderstandings of social groups in ideology.". This study examines the context of governance in healthcare services and seeks to make visible the issues influencing the foundations of collective understanding and therefore the shaping of peoples decision-making in governance, both as individuals and in groups.

Reflection, as applied to practice is relevant in this study in that the research seeks to establish what forces shape peoples' decisions in governance, as well as exploring how, and

on what basis, they undertake decision-making. Ryle (1949), as cited in Schön (1992), describes the action of knowing as one action and not thinking what to do as a separate action from doing. Schön (1992, p. 56) refers to "reflection in action" in which in professional life there is a tacit knowing happening as the professional decision is made. Schön identifies reflection on one's activities as a key aspect of professional practice in establishing proficiency in professional decision-making and which will be applied to professional decision-making in this study. Bourdieu (1992b) goes further in recognising the impact of social distinctions, that is, the values of individuals, on the practice of social science itself. In that regard Bourdieu (1984) rejects scientific positivism in recognising that value-free science is not possible (Bourdieu & Wacquant, 1992b). Therefore Bourdieu encourages the researcher to not only recognise the impact of their own values but also the impact of the power in those values on the scientific process itself. He names that *reflexivity*, and in assuring probity in science, proposed that there is a "moral obligation to provide unfettered examination" (Swartz, 1997, p. 271).

Schön (1992, p. 56) also alludes to the "common sense" nature of knowing how things are done in a similar manner to Bourdieu's *sens practique*, practical sense applied to a *field of practice*. In the *field* of health practice an example of *sens practique* might be the sharing of reflection, through team meetings, "grand rounds" and "handovers" aimed at ensuring there is a balance of power during professional decision-making within healthcare service teams (Horder, 1992) thus ensuring that one particular set of professional opinions does not dominate healthcare practice.

Domination and oppression are the constructs of interactions in which power is used to achieve either positive or negative results. Bourdieu's ideas fit within critical theory in that, for Bourdieu, all interactions between individuals or groups are characterised by the use of power (1990, 1977a). Bourdieu (1986, 1990) utilises the idea of power as *capital* having value in influencing interactions and relationships. Therefore through using Bourdieu's *theory of practice* (1977a) in this research it will be possible to make visible the impact of different types of power on both the relationships within healthcare services and the decision-making which occurs in the governance of those services.

Theory of Practice

Bourdieu's *theory of practice* (1977a) involves critique, reflection and relationships between the individual and society and the use of power as *capital*, to influence those relationships. He emphasised the role of *practice* in social dynamics. For this study a flexible and dynamic framework was required to facilitate the responses of individuals within the changing and complex healthcare services environment to be considered in the context of governance. Bourdieu's work is not bound by the limitations of either sociology or psychology (Webb *et al.*, 2002) as he continuously sought to offer a different way to explain our societies and the interactions of individuals responding to and being affected by our changing place in groups and in different environments. Examples lie in Bourdieu's early work with the Kabyle people of Algeria in which he describes non-economic societies (Bourdieu, 1977a) from a generic social science perspective. Bourdieu also attempted to eliminate or reduce the influence of oppositions; for example subjective/objective, micro/macro antimonies which he suggests bound our way of thinking about situations. He did this through the development of conceptual innovations of *habitus*, *field* (Bourdieu, 1971, 1993a) and *capital* (Bourdieu, 1986).

Bourdieu locates practice in an *economy of power* using the term *capital* to explain the value of power and its influence. Bourdieu's use of the economic metaphor provides a logical fit with the researcher's professional experiences and the particular way of considering individuals and their place in society based on previous learning and practice in governance and business. As Bourdieu states when discussing modes of domination, "practices never cease to comply with an economic logic." (Bourdieu, 1990b, p. 122).

As shown in figure 1 Bourdieu's concepts are active; the interplay between them is key to utilizing the methodology.

Figure 1. Political Economy of Power

The concepts of habitus, field and capital are integral to Bourdieu's theory and each will now be discussed in more detail.

Habitus

Bourdieu (1990) used the term *habitus* to describe dynamic dispositions of the interiorised self within a *field* of forces (*field*) where the struggle for position in a particular environment takes place. The *habitus* is shaped by a number of characteristics which Bourdieu (1990) uses to explain the dynamics between the *habitus* and *field*. These dispositions are durable and transposable, acquired through experience, and varied in how they are demonstrated in different contexts and at different times. The dispositions are transposable in that they can be transposed to different circumstances and durable in that they remain with the individual or group always but are subject to different applications in different circumstances which may alter after experience. The dispositions are *structured structures*, a collection of principles, aspirations and perceptions on which decisions and responses are based without assuming any outcome (Bourdieu, 1977b). These structures become *structuring structures* as individuals and groups respond through using their experience in different contexts and the responding to different tensions placed on them. *Structuring structures* allow some anticipation, an element of getting to a response in an economical way by using prior experience embedded in the *habitus*. And while similar to Schön's (1992) *tacit knowing*, described previously, no two responses will be the same because each is based on a unique experience. People or groups respond to idiosyncratically different environments, because of the *capital* others bring to situations as different types of *power* in different *fields*, and the *habitus* evolves accordingly.

Habitus can be individual, that is, as a result of an individual's place and experiences within society. Or it can be group, that is, the dispositions a group gathers as its power as *capital* interplays with the individuals, their roles in the group and the group's interaction with its environment. The concept of *habitus* provides a framework which accommodates

the complex and applied experiences of decision-making individuals and groups found in New Zealand healthcare services.

"The *habitus*, which is constituted in *practice,* is always oriented to practical functions." (Bourdieu, 1990b, p. 52). The logical and practical application of the theory fits well with decision-making which is a real activity; it is located in real situations. This study is about real situations with real implications and it does not assume that what people do in their daily lives is taken for granted. Bourdieu (1990) strived to put a theory around social *practice* to explain why people respond to circumstances and environments in the way they do.

The *habitus* is made up of schemes of perception, thought and action (Bourdieu, 1989b), formed from the individual's cultural unconsciousness. As people and groups grow, their *habitus* is formed by the forces from the environment and from the experiential responses to the power of those forces within the *fields*. For example nurses apply "intuition" to their problem-solving based on applying knowledge of and experience in observing patients and debriefing with their colleagues. And board members give direction based on advice and their experience in the success or failure of decisions in creating value for the organisation. The outcomes are described by Bourdieu (1989) as *dispositions* which become habituated in the individual or group. *Dispositions* may be conscious or people may not recognise that their practices, including their decision-making, are not spontaneous but are rooted in their *habitus*. "History….is the foundation of the *habitus*" (Jenkins, 1992, p. 80). The *habitus* is created from both the historical place from which people arrive from experience, and where they are located by others based on all their collective experiences and through what is recognised as the place of the individual in that *field*. The *habitus* and *field* are symbiotic; they can only exist in relation to each other.

Field

For Bourdieu (1990b; 1992b) the *field*s are the arenas where all interactional and relational behaviours occur. The concept of *field* is loose in that *field*s do not have fixed boundaries and there may be overlap and invasion into a related *field*. *Field*s are "tightly coupled" (Swartz, 1997, p. 124) as a relational configuration in which the activities of one *field* impact on abutting *field*s. This creates a dynamic situation in which the boundaries and

makeup of abutting *field*s may change as a result of the activities within an adjacent *field*. Healthcare services are made up of a collection of complex specialties at primary, secondary and tertiary levels. Each service abuts against or integrates with other services, for example decision-making in governance in maternity services impacts on the abutting service of specialist neonatal care, and even intersectorial services such as social services.

Bourdieu (1993c) describes *field*s as having three key structural properties. The first is that *field*s are the environments in which the struggle for control over scarce resources takes place. Secondly, within *field*s there are dominant and subordinate positions which are based on the *capital* resources of each party. This may be *social, cultural* or *symbolic capital*. The third structural property is that specific *field*s demand from actors forms of behaviour which are *field* specific. That is, in relation to their decision-making, people execute roles dependent on the space and time of the unique environment (Bourdieu, 1989b). For example, people as patients often exhibit different behaviours than when they are in their more accustomed everyday roles and their consequent decision-making reflects the unfamiliar status of 'patient'.

*Field*s are therefore characterized by the unequal distribution of *capital*, including the resources, and therefore *power*, which people or groups have. Unequal distribution of *capital* is evidenced in such clearly observable features as different levels of qualification and experience. It is also evidenced in more subtle areas such as the perceived power of different social groups observable through class distinct accents or use of sophisticated technical professional language. The result is tension within the *field of forces* as players attempt to get balance in the distribution of *power* within that particular environment, for example at a board table. *Field* characteristics also include the struggle that parties with less *capital*, for example non-professional support staff such as cleaners, have to attain a share from those in positions of power and authority whose cultural characteristics are *misrecognised* as being legitimate, for example doctors and nurses. Bourdieu believes that the ultimate aim in society is to have balance within and between *field*s in order to achieve progress in common purposes.

The *field* is contingent on the *habitus* and the *capital* within the *field* and the power which is yielded from that *capital*. Resulting from the interplay is *practice*, the practical outcome of a situation.

Capital and the concept of economism

The third key concept through which Bourdieu (1986) explains his theory is the concept of *capital* which seeks to explain value beyond the material and into the intrinsic. The logic that orders the struggles for authority and position in the *field* of forces results in power and interplay, is the logic of *capital* (1990b, p. 112). For example, when people bring skills, experience and qualifications which have value to a situation, their authority will be recognised by others and they may often influence decisions for their greatest benefit. Bourdieu proceeds to say that, "Economism is ethnocentric" (1990, p.112) demonstrating that economism is considered from the perspective of the *habitus* in a specific *field* and under specific circumstances. Economism, the inclusion of economic valuation of all types of *capital*, reduces the *social, cultural* and *symbolic* "economies" or *power* to objective realities. This allows measurable value to be placed on non-market goods i.e. those that are not generally valued in monetary terms such as prestige or educational qualifications, but which nevertheless can be exchanged for opportunities and positions of value such as employment or political appointments.

Bourdieu did not confine his use of *capital* to monetary economic affairs, as did Marx. He applied it to all manner of actual and symbolic actions and statuses which have value. The recognition that there is value in an intangible concept, its objectification, places that concept inherently in an economic context. However, this is not emphasized by Bourdieu or those who critique his work such as Swartz (1997) who restrict *capital* value to *cultural, social, political* and *symbolic* objectifications. For example Bourdieu does not include human or intellectual *capital*, the value that experience in a particular organisation brings to a position which will be elaborated on in *social capital*. For Bourdieu *capital* acts as a 'social relation within a system of exchange' (Harker, Mahar, & Wilkes, 1990, p. 1).

The relationship of habitus, field and capital

At the heart of the functioning and structure of the *habitus* is power and its legitimation within the *field* (Bourdieu, 2005; Swartz, 1997). *Habitus* has an unconscious calculation to maximise the position of the individual or the group within the *field*. That is, self-interest is a characteristic of *habitus*. Using the economic metaphor, the *habitus* maximises the *capital* invested in that *field*.

The conversion of *capital* to *power* is enabled by the unique *field* within which it is operating. Bourdieu (1989a, p. 375) describes the resources which individuals use to ensure their position in a social situation as *capital* when the resources function as a "social relation of power". Therefore, *capital* is *power* only when it is applied in social interplay in a particular *field* and people, through their *habitus,* draw on their *capital* to influence the balance within the *field*. Application of *capital* ,which can be facilitatory or inhibitory as described by Jones (2000), can relieve tensions in the *field* through, for example, players in dominant positions using their skill and experience to solve problems such as a chairperson facilitating a decision of a board.

Webb *et al.* (2002, p. xii) provide a succinct definition for Bourdieu's metaphor: "for the *field of power* operates as a configuration of *capital* (*economic, cultural* and *symbolic*) that shapes social relations and *practices* within these *field*s."

The Field of Power

Bourdieu proposes three overlapping theories which interpenetrate orientating the reader to power.

- Theory of symbolic interest, which extends the notion of economic interest to non-economic goods.

- Theory of power as *capital* in which Bourdieu extends the idea of *capital* to all forms of power; he conceptualizes *capital* as a "social relation of power" (Bourdieu, 1989a, p. 375).

- Theory of symbolic violence and *capital* in which power is used in a symbolic way such as the denying of resources or the limitation of rights or opportunities (Bourdieu, 1977a).

Each theory will be discussed through the explanation of the use of *capital* and how it is used in this study.

Symbolic Capital

Capital for Bourdieu includes material things which may have symbolic value (such as a European motor car), as well as intangibles which may have significant symbolic *capital* such as prestige – belonging to a certain group within social stratification or authority from an honorific title. A requisite for symbolic *capital* to have value as power is that it must be recognised by others as having value. Values, especially of symbolic goods, are arbitrarily placed and can differ considerably even between people who participate in common *field*s for other purposes. Swartz (1997, p.81) identifies that capital is "interconvertible" but that interconvertability varies between *capitals*. For example, in countries where education is easily attained the *social capital* which traditionally came from family and tradition is easily converted to *cultural capital* inherent in qualifications.

Another characteristic is that "symbolic *capital* accrues from the successful use of other *capital*s" (Bourdieu, 1990, p.122). So, while *symbolic capital* can be accumulated in the same way as the other forms of *capital* it can only exist when other *capital* has been accumulated by the individual or group *habitus*. For example, that other *capital* may be *economic* in the form of monetary or real assets, *social* in the form of family networks, *political* in the form of position or status, or *cultural* in the form of social background, qualification and career.

Social Capital

Social capital is the *capital* of "social connections, honourability and respectability" (Bourdieu, 1984, p. 122). *Social capital* can be converted to maximise other advantages such as social position. It should be noted that Bourdieu defines *social capital* within the social context of France, which lacks the utilitarian approach to social structure, the social networks and acquaintances that identifies us as New Zealanders.

While Bourdieu was not the only writer to use the economic metaphor of *capital* he differs from many in that his emphasis is placed on the power that all kinds of *capital* give the individual, the group or community (Swartz, 1997). The recognition of *capital* in all its forms, especially social *capital* (Adler & Kwon, 2002; Edelman, Brensen, Newell, Scarborough, & Swan, 2004; Nahapiet & Ghoshal, 1998) is necessary in the research reported in this thesis, particularly in the analysis of data from the governance groups as *capital* is synonymous with power (Bourdieu, 1986, 1989b). *Capital* as a concept has been developed by others (Adler & Kwon, 2002; Edelman *et al*., 2004; Nahapiet & Ghoshal, 1998; Webb *et al*., 2002) and is now well used in every day business management practice where there is free talk about the value of human *capital*, brand power and the economic value placed on not only goods but also "goodwill".

Position, experience and intellect give the power to influence the decision-making of others. Significant *social capital* is derived from class or membership of various groups such as doctors and nurses. Recognition and valuing of the social attributes others bring to the decision would make that decision one which better reflects the position of all stakeholders. This *social capital*, brought by a group to a decision, is jointly owned by that group and it is this "fabric of social relations" (Adler & Kwon, 2002, p. 17), which is mobilized to facilitate and enhance action.

Social and *cultural capital* are closely related. Social *capital* is complemented by *cultural capital* which includes formal structures.

Cultural Capital

Cultural capital is one of Bourdieu's conceptual trademarks which focuses on "the power dimension of cultural resources in market societies" (Swartz, 1997, p. 287). *Cultural capital* is a form of power as *capital* where there is cultural value and significance placed on a wide variety of what appear to be non-material goods. Bourdieu's (1986) ideal is to attain balance between *economic* and *cultural capital*. Such goods include attainment such as educational qualification or ownership, such as of land, but can also include verbal facility especially accents and general cultural awareness.

Health professions have *cultural capital* based on the value attributed to both their qualifications and the *symbolic capital* within the social stratification of the health sector. Historically, in the health sector, various levels of cultural inequality have persisted without challenge. For example the *capital* (in the form of academic qualifications) held by the medical fraternity is perceived as having greater value than that held by nursing staff even though the "degree" value is similar and the context of their practice is different. That *cultural capital* makes visible doctors demand for resources – physical and cultural, which supported by the institutions, hospitals and universities and to an extent other health professionals, maintains the inequality. An excellent example is the resource allocated to continuing medical education within employment agreements which is not allocated to the same degree, to continuing education for any other health professional group. Tensions arise when there is imbalance in the *field* and especially when others see their value, in terms of qualification and experience, not being recognised to the same extent.

Similarly, governance at the board level maintains unequal social relations within the organisations demonstrated by the tension resulting from the interplay between the *symbolic capital* of the board members that is their authoritative position as board members and the *cultural capital* of the employees demonstrated by their educational qualifications and experience. Understanding the impact of the power of *cultural capital* on decision-making by board members is important in understanding governance in healthcare services and the ambitions of individuals.

More recently Bourdieu changed the terminology from *cultural* to *informational capital* (Bourdieu & Wacquant, 1992b, p. 119) to differentiate the term from the common use of the term relating to the high culture of the arts and to better recognise the full generality of the concept. *Informational capital* exists in three forms:

- embodied, as in that collection of beliefs and practices which is inculcated when part of a particular culture;
- objectified as in that collection of practices which are recognised as the norm in a particular society or

- institutionalised as being the collection of practices which are accepted as being the way things are done within a particular environment (*field*).

In this thesis, categories of *cultural capital* will be interpreted through analysis of data and their impact on the shaping of decision-making in governance considered.

Society's relationships are kept active as people strive to manage tensions through using the *capital* they possess as power to influence the tensions in the *field* and to achieve decisions. As Grenfell and James (1998, p. 18) say in their discussion of Bourdieu and education, "scarcity of social resource is the lubricant of social systems". Examples may include the use of one's position or contacts to ensure that a question is answered or a position gained, such as membership of a DHB. In practice, understanding the *capital* people – *habitus* – bring to the development of a working relationship - *field*- allows individuals in the group to anticipate the actions of others through common organizing principles and the transfer of tacit knowledge (Nahapiet & Ghoshal, 1998) and trust (Putnam, 1993) providing efficiency in decision-making including that of DHBs.

The key elements within the *theory of practice* and *the field of power* are supported by practical functions through which Bourdieu explains the action within *fields.*

The supporting concepts

The concepts of habitus, field and *capital* have characteristics which account for particular behaviours and processes. The practical functions of *habitus* are *reproduction, misrecognition and social trajectory.* Explaining the *culture* within a group is *doxa. Field strategies* enable imbalances in *power* to regain equilibrium. These supporting concepts are used in the data chapters in relation to particular participant behaviours which influence decision-making and are discussed now.

Reproduction

Reproduction is the unconscious transferring of behaviours from one generation to the next without questioning their relevance and especially including the sanction of inequalities in particular *fields.* History and experience generate dispositions which are compatible with the familiar objective conditions which have durably supported the *habitus*. These

dispositions, therefore, offer a level of comfort to the group as they are generated from such conditions which are "pre-adapted" by those dispositions (Bourdieu, 1984, p. 370). Reproduced behaviours unconsciously maximise self-interest to gain advantageous positions in society through ensuring that their dispositions are recognised as having greater *capital* and are therefore the acceptable way to behave. Bourdieu (1984) names these reproduced behaviours *reproduction.* For example, establishing boards in the British model has the expectation of behaviours which assume that the value of what is done from the chairman leading the board perspective is greater than that done from the Maori tribunal perspective as described by Smith (1999).

The practical effect of *reproduction* is that there is continuity of social behaviour allowing players to anticipate interplay in their environments. Intense forms of *reproduction* can impede change but *habitus* has a role in mediating to ensure change (Harker *et al*., 1990). The healthcare services environment is characterised by power plays and the investment of *social, cultural* and *symbolic capital* by different groups, in the maintenance of power within *field*s *of practice*, e.g. the tensions which arise between healthcare professionals and managers, or DHBs themselves as confirmed by Boyce (2001). The resulting behaviours are reproduced between generations and are, at times, resistant to change. This aspect of Bourdieu's work provides the opportunity to understand reproduced behaviour, *misrecognised* by players in the *field* as the cultural or social norm, and that such behaviour can be defined and its influence on decision-making understood.

Misrecognition

People come to accept normality, a level of comfort, in the characteristics which are possessed both as individuals and as members of particular groups (Webb *et al*., 2002). The individual characteristics vary in different *field*s as within the *habitus* those attributes are highlighted which are most likely to maximize the individual's position in a particular circumstance; that is, the attributes which have most value, *capital* and therefore, power. The familiarity with those dispositions obscures the individuals' recognition that those dispositions have been produced as the result of experiences different than those of others. It is a *misrecognition* of power relations similar to Marxian theory in which people falsely recognise symbolic structures to dominate social relationships (Swartz, 1997) e.g.

distinctions based on educational qualifications. However, the recognition of dispositions, by others as having value is arbitrary (Bourdieu, 1990b; Bourdieu & Passeron, 1977b). For example the position and status of board members are recognised as having higher value than those of employees. However, related classes, such as doctors, nurses and allied health staff, and even the general public, also recognise those dispositions as legitimate. Therefore "*misrecognition*" of the value of *capital* by those dominated legitimizes practice (Bourdieu, 1990, p.118). The relationship between *habitus*, the *cultural capital* and how that *capital* has been produced is linked with *misrecognition* through the reinforcement of practice as legitimate and therefore as accepted behaviour.

The reflexive nature of Bourdieu's framework (Bourdieu & Wacquant, 1992b) allows the researcher to explore the *misrecognition* by accommodating the perspectives and assumptions of all participants in the research, and ensuring that their responses are included in the data. The understanding of *misrecognition* may be influenced by the maturity of participants, that is, the multiple *literacies* they call on in considering arguments (Bourdieu, 1977a). For example, doctors with specialist qualifications coupled with experience in specialist practice over years and involving many episodes of care and many patients have expertise derived from multiple sources.

Social trajectory

The *economy of power* is dynamic recognising that individuals and groups build on the base of *cultural habitus*. One aspect of the *cultural economy of power* is *social trajectory*, which is the direction an individual takes as they seek to establish their place in a particular *field* along with the adoption of behaviours and practices which reflect the individual's expectation of a particular role in that *field* (Bourdieu & Wacquant, 1992b). In turn, the individual *habitus* will modify to demonstrate new behaviours making them legitimate both for the individual and within that *field*. In practice some people have the *capital*, the 'wherewithal', to find a place in a particular environment, while others modify their behaviour in order to survive the *power* within the *field* they find themselves in. Bourdieu also recognizes that individuals play games in relationships in order to remain in them. This is described as *illusio*, the self-deception necessary to keep players involved in the game (Dreyfus & Rabinow, 1983). In healthcare services some professionals promote caring as

an altruistic characteristic of what they do to legitimize their continued employment in the *field*.

The impact of self-interest on decision-making in governance in public healthcare services is explored in this study as people are guided by self-interest as they seek to maximise their position within a *field* for their long-term benefit (Bourdieu, 2005).

Doxa

Doxa is a characteristic of *field* involving tacit understandings of how things happen and should be expected to happen within that *field*, including the behaviours which are considered both important and necessary to gain a place in that *field* (Bourdieu, 1993a). *Doxa* is characterised by "undisputed, pre-reflexive, naïve native compliance with the fundamental presuppositions of the *field*" (Bourdieu, 1990b, p. 68). Presuppositions include the pattern of power relations which are reproduced by the *doxa* of the *field* itself. *Doxa* also allows participants to start a relationship or interaction with large amounts of knowledge rather than from a position of naivety on each occasion. Bourdieu's idea of *doxa* is not dissimilar to the concept of "collective representations" espoused by Durkheim (1984, in Swartz (1997)), in which the people in the group share a set of basic understandings with implied consensus in respect to those understandings. The difference for Bourdieu however, is that there is no assumption of consensus as *doxa* which is specific to a *field* (Swartz, 1997) e.g. a team of clinicians within a specific service or the process of a DHB meeting, rather than a collection of tacit core values and discourses which is reality within a generic *field.*

The characteristics of *doxa* are arbitrarily assigned by those with the *capital*, the power, to manipulate the *doxa* to their advantage (Webb *et al*., 2002). Recognition of the tacit understandings in healthcare service environments will facilitate analysis. However, in situations where the researcher is or has been part of the *field* of healthcare services objective consideration of the *doxa* of the *field* was recognised as part of *reflexivity*. The researcher was able to understand participants' situations because experience was used to inform the data collection and analysis but, objectively, not used as a basis for analysis.

Field strategies

Bourdieu (1993c) suggests that strategies are used for manipulating and managing irregularities in the balance of power within *field*s. Key strategies, which are relevant to this study include:

i) conservation

ii) subversion

iii) succession.

Conservation strategies are used to maintain "the monopoly of legitimate violence" (Bourdieu, 1993c, p. 73) and focus on maintaining the structure of the *capital* "within the limits of that *field*". Legitimate authority only has relevance when in a specific *field* and those with the *capital* work to ensure that their privileged position will be preserved through the maintaining the status quo, the orthodox, and subverting the power exhibited by others as they struggle for equality. For example, some members of the public find access to healthcare service decisions through complex organisational structures difficult and they feel helpless in competing against the bureaucracy.

Subversion strategies are used by those who have lesser power in the *field*. These are the strategies of heresy which strive for a critical break with the *doxa* of the specific *field* (Swartz, 1997). This may be in response to a crisis and may stimulate those of the orthodox persuasion out of their zone of comfort. Examples include when aggrieved parties will not engage in meetings to solve problems affecting all groups or when traditionally conservative groups behave extraordinarily such as nurses taking strike action.

Succession, ensuring the continuation of the characteristics of the *field* of power is recognised as legitimate through the appointment of "likeminded" people or those with skills compatible with those required to maintain the monopoly of the specific authority in the *field*. Appointed DHB members are often drawn from groups who support government policy rather than those who may necessarily have specific skills to complement a board.

This study sought to identify whether such strategies are part of shaping decision-making and what the strategies are which people use to exercise their influence in decision-making. The analysis of the data collected for this study required a methodology which would facilitate interpretation of the *field*s, the environments in which decision-making occurs and the characteristics of and tensions within those *field*s and their interaction with neighbouring *field*s. Within this study the *field* is governance, within public healthcare services in New Zealand. As a specific *field* governance abuts all clinical and support services within the organisations, including the *field*s of the professions and those external to the organisations such as the Ministry of Health and organisations which manage compliance with standards and safety within the healthcare sector.

Political Economy of Symbolic power

The *economy of symbolic power* describes the best use of scarce resources through the use of *social* and *cultural capital*. It is *political* in that the power source requires activation through recognition of the *symbolic power*. A DHB is an example of a *political economy of symbolic power* in that symbolic and political interests bring *capital* to the *field* of interplay between board members. That *capital* is power in that *field* and it is used to maximise the self-interest of individuals and the collective board including *symbolic violence,* or used to balance the tensions within the board's *field of forces*.

"Symbolic power has to be based on the possession of symbolic *capital*" (Bourdieu, 1989b, p. 23). *Symbolic capital* is only such until it is recognisable as *economic, social* or *cultural capital*. Until then it is an intangible asset but based on authority gained previously through demonstration in *practice* (Bourdieu, 1989b). It is a personally institutionalised credit and once recognised by others it is able to be rallied to impose power over others. It is an authority to act, legitimized by the recognition of others. However, as Swartz (1997, p.89) states, recognition is arbitrary and therefore legitimization creates *misrecognition*. To be efficacious it must be founded in reality; *symbolic power* is the power to describe, to envision for others things that are already there (Bourdieu, 1989b) and in that respect is parallel to leadership.

Understanding *capital* as power and the value placed in *symbolic power* is key to Bourdieu's raison d'etre: "power is not a separate domain of study but stands at the heart of

all social life" (Swartz, 1997, p. 6). That is, the use of power, positively or negatively, is embedded in social interaction.

The structures of the *field*s *of power* need to be distinguished, that is, how *capital* is activated to influence the *field*, along with the *habitus* with its inherent *capital* base, the agents (individuals) bring to the interactive *field*. The *habitus*, the packages of attributes which makes us unique or "categories of social classification" (Bourdieu, 1984, p. 477) represent underlying social distinctions which are constructed by the players. Individual histories, experience, qualification, intellect, culture and social status distinguish one from others, and it is others who construct that package of attributes around each individual. These *structures* are dynamic and, as such, are *structuring structures* where the underlying social distinctions influence the development of the decision-making *structures* (Bourdieu, 1993a). For example, distinctions include the structured lore and mores gathered as members of a culture.

Bourdieu transcends the subjective/objective antinomy through reorganising the relations between the symbolic and material dimensions of life. Therefore it is this subjective/ objective antinomy which has constrained the understanding of how relationships impact on humans, as individuals and groups. For example recognising that situations do not need to be right or wrong, good or bad or black and white allows the consideration of a situation for what it is. Decision-makers are bounded in their thinking and, while not explicit, this is Bourdieu's way of providing a framework for the explanation of complexity which is used in this study.

Symbolic violence

Reproduction in the form of *social* and *symbolic capital*, when used by some to change the behaviour of others, may be exercised as *symbolic violence*.

Bourdieu extends Marx's ideology, the power of domination through legitimizing actions, to include the use of *cultural capital* as power to dominate through legitimizing assumptions taken for granted. *Symbolic violence* is "the capacity to impose the means for comprehending and adapting to the social world by representing economic and political power in disguised taken for granted forms" (Swartz, 1997, p. 89). *Symbolic violence* is

demonstrated through the denying of resources and opportunity, by one group ensuring that their way, which reinforces their power, is the dominant way activities in society are carried out e.g. in relation to this study nurses are denied the resources for continuing education and as a result feel undervalued. Other examples could include the denying of resources so that a task can not be completed satisfactorily, or making healthcare services inaccessible to some cultures then suggesting that people from those cultures won't attend. In research *symbolic violence*, the use of *misrecognised* power to influence the responses of others, may distort the data captured in group work. Therefore recognition of *symbolic violence* in data collection was considered in this study.

Symbolic violence is often subtle and unassuming, with those being denied power unaware that the power may be theirs to have. The *symbolic violence* exhibited between doctors and nurses, and within the hierarchical structures of medicine and nursing as professions, remains (Hall, 2004; Morand, 2005) and this aspect of the context of healthcare services is germane to the study of what shapes decisions in governance.

Practice

Bourdieu's theories and the concepts of *habitus*, *field* and *capital* that he used to conceptualise those theories were to explain reality as he sees it. As indicated in figure 1 (page 18), for Bourdieu reality is in *practice* and to be legitimate and to have worth all knowledge should be explained in a practical sense to have worth (Bourdieu & Wacquant, 1992b; Webb *et al*., 2002). Another key understanding of Bourdieu's (1990, 1999) is that practical knowledge can only be obtained by *practice* and can only be expressed in *practice* in real situations. This suggests that his theory is of no use on its own and must be applied to a practical situation to be of any sense. Is it possible from this theoretical viewpoint, that corporate governors without the benefit of clinical experience will never understand clinical governance issues because as board members they simply do not have experience of the clinical environment? Similarly, do directors need to be accountants to understand financial prudence or lawyers to comprehend the legal boundaries to practice? In the researcher's governance experience the experience required is complex and difficult to understand without having had experience. This study explores what shapes the *practice* of decision-making in governance in New Zealand public healthcare services.

Bourdieu's process of research

The choice of Bourdieu's framework facilitates open investigation into the subject without preconceived restrictions on enquiry through reflection. Bourdieu proposes a general research method (Bourdieu *et al*., 1991).

First, there is an objective stage of research, looking at the social space within which the research relates to the particular *field of practices.* In this case the social space is the New Zealand public healthcare services and its relationship to the broader *field of power* of governance which is discussed in Chapter 3. The literature pertaining to decision-making in governance is the subject of Chapter 4. The objective stage allows for an investigation into the stratification of the *capital* base (Bourdieu, 1985) that is, the attributes that are necessary to shape decisions in healthcare services.

Second, the research should identify the structure of objective relations, a "social topology"– the relationships between the individuals or groups who hold opposing positions as they compete for their position to be recognised as the more legitimate. Bourdieu affirms the "primacy of relations" (Bourdieu & Wacquant, 1992b, p. 15): the power in the relationships between parties which will dominate the tensions in the field. To identify the impact of power in the relationships of players in a particular *field* those undertaking research are encouraged to "search for the forms of *economic* and *cultural capital* that are specific to the *field* under investigation" (Swartz, 1997, pp. 142,). The study will identify the dimensions of governance which reflect the *symbolic, social, cultural, political and economic capital,* and the power imbalances which arise in governance in New Zealand's public healthcare services.

Last, the research must analyze the class *habitus* brought to the respective positions by the individual agents involved in the study and the *social trajectory* they are taking as they struggle for their place in the *field*(s) being studied and as determined by the structure of the *field(s)* (Bourdieu, 1990b; Jenkins, 1992). In this study this includes the role of the professions and the ambitions of individual participants.

Immunity from the ethnocentrism of the observer is a key characteristic of Bourdieu's (1977a) approach, which stems from his sociological background. Bourdieu continually

reminds the researcher of “participant objectification” (Jenkins, 1992, p.177) and suggests that if it is not possible to “think as one’s subjects” then one should “imagine oneself doing what they do in the visible word of practice” or “extrapolate from how one’s own social world is produced” (Jenkins, 1992, p. 178). Therefore the ability to build on past thoughts, to develop new ways of explaining the environment within which practice takes place in response to context, the *field*, is relevant to healthcare services in analysing continuous technological, political, social and economic change.

However, Bourdieu’s method also requires the ability to be *reflexive*, applying conscious attention to one’s own position, one’s own *habitus* and set of dispositions and their demonstration in different circumstances (Bourdieu, 2004). This provides the vehicle for the researcher to be flexible and responsive to data as it is presented during the research process. In this study all participants were familiar with the experience and qualifications of the researcher.

Conclusion, justification for the choice of methodology

The complexities of the healthcare services are often characterised as plays for power and authority (Bigelow, Arndt, & Stone, 1997; H. T. O. Davies & Harrison, 2003). Through Bourdieu’s critical approach and the framework of the *political economy of power* the complexities of the healthcare services are able to be uncovered.

Bourdieu’s methodology offers an empirical approach grounded in everyday life, which, because it is inclusive of all interaction in all *field*s, suits the analysis of complex environments such as governance in healthcare services. Similarly, the subject of “shaping decision-making” requires the flexibility that the methodology of Bourdieu allows, including being *reflexive*. Bourdieu challenges the researcher to look for connections between people and their environments. ‘The existence of connections is not a natural given, or even a social given…it is the product of endless effort…’ (Bourdieu, 1986).

Bourdieu offers aspects of environmental theory which are embedded in healthcare (Nightingale, 1860) in that the *field* is an environment in which balance is the ideal state. Bourdieu’s use of the economic metaphor is well-chosen in the analysis of data from a sector which has a focus on scarce resources – funding, people and clinical capacity.

Within the critical methodology as described by Thomas (1993) and the expectation of action, it was envisaged that this study would provide the healthcare service sector with a new governance framework which reflects both common understanding and practice of decision-making in governance within the context of public healthcare services in New Zealand. The following chapter will explore the recent history of the public healthcare services in New Zealand in relation to decision-making in governance and the context in which it occurs.

Chapter 3

New Zealand healthcare services in context

Introduction

This chapter places the shaping of decision-making in governance in the context of New Zealand public healthcare services as they were from 2000- 2007. It provides support from the literature to explain why and how the context influences and shapes decision-making in the governance of New Zealand's healthcare services. In so doing positive and negative attributes will be considered. Gaps are identified in the understanding of the influences on decision-making, with particular focus on those influences attributed to the structure of the institution of healthcare services.

The foundations of the public entity structure, discussed from a theoretical perspective, explain how institutions are organized in particular ways in response to the econo-sociopolitical demands of a particular period. Generic influences on the New Zealand healthcare services include universal coverage for healthcare within the context of the welfare state, as well as the rights and obligations of New Zealanders within the existing political frameworks. These foundations and influences will be identified and analysed.

Decision-making in governance is underpinned by the health policy of the day. This is analysed within the context of the funding model and the influence of reformation on healthcare service delivery and professional practice. Further analysis of the governance framework in the context of the legislation identifies organisational structure and the influence of central government as influencing all governance decisions. Other attributes of reformation policies which style the context for decision-making are identified including leadership, managerialism and the corporate model, and rationing. The structure of the current DHB system and its characteristics are described and analysed, the genesis of those characteristics is explained and the achievements and failures discussed with support from the literature. This includes the effect on professional decision-making at all levels within the system, the importance of buy-in from key stakeholders and the influence of the globalization of the health services market.

Context

In comparison to the affluent third quarter of the 20th century in New Zealand described by Shirley (1999), Davis and Ashton (2000) suggest that the healthcare services now operate with limited resource availability. New Zealand is now facing choices about who should make decisions, how much should be spent and what priorities should be made (Mersi, 2007; Tenbensel, 2007). Choices made based on funding decisions are further influenced by the Mixed Member Proportional Representation (MMP) voting system in which minor party policy may impact on or compromise pure healthcare service models and the personalities and ideologies of the day.

Little disagreement is expressed concerning the determinants of health as demonstrated in successive governments' policies, and statements on healthcare strategy (A. King, 2000a, 2000c; National Health Committee, 1998; Shipley, 1995). Therefore, rather than the health strategy of political parties affecting the process of decision-making in governance in New Zealand public healthcare services, the impact comes from the parameters created by wider party policy, demonstrated in the structure and funding made available to resource healthcare services.

Economic globalism, the availability of health professionals, the technological advances in medical treatment and information technology have created tension between healthcare services' ability to provide and the needs identified by planners and providers. Colloquially, the system is simply referred to as "health" and in describing the context of this study a suitable definition of the central terms was required i.e. both health and healthcare services.

Health and Healthcare services

Decision-making in healthcare service governance is influenced by the understanding individual decision-makers have of health and healthcare services. Understanding common definitions gives policy makers, board members, managers and clinicians a common base from which they can define specific roles, scopes of practice and recognition of the optimum environment for a healthy state to be attained. This definition is presented early in the thesis to provide clarity of how the term health is used in this study and to anchor the term "healthcare service" in the context of the thesis.

In creating this definition the researcher has drawn concepts from many sources and experiences as a nurse, manager and director.

"Health is a state which allows an individual and his/her community to live harmoniously within their environments."

The roots of this definition of health lie in one proposed by Nightingale (1860), who provided the basis for scientific enquiry for nursing. In Nightingale's definition there is an emphasis on the physical environments in which health may occur and recognition of the impact of the econo-sociopolitical state of those environments. For the researcher, a definition of health should reflect the holistic nature of life, recognising the stakeholder and environmental tensions including potential complexities within the healthcare services environment.

Similarly, the design of a healthcare system reflects the influences of politics, economics, law, social policy of the day as well as healthcare system theoretical models (Boston, 1991; Shortell & Kaluzny, 1994). Public healthcare services in New Zealand are predominantly, but not exclusively funded and provided by DHBs. Private providers of publicly funded services include general medical practice services, women's health services and primary maternity services. Therefore, in this thesis the terminology *public healthcare services* will be used to distinguish the organisations accessible to the New Zealand public which fund and provide care and treatment. These are distinct from DHBs *per se* which, although they fund and provide services, they are not exclusive in the provision of public healthcare services. This also distinguishes healthcare services from the myriad of other services which use the word health to describe the sector in which they work e.g. dietary supplements. It is public healthcare services and the decisions made in the governance of those organisations which is the focus of this study.

Theoretical Underpinnings of Public Healthcare Services

An understanding of the impact of political ideology on our healthcare system can be gained by reviewing theoretical explanations of how those ideologies underpin the policy and structure of the health care system. Boston (1991) identifies public choice theory, agency theory and transactional cost analysis as theories which underpin public sector

policy based on political ideologies, parts of which can be identified in recent New Zealand healthcare services models. Added to these is stakeholder theory as first described by Freeman (1984), because of its relevance to governance in corporations and the inclusion of non-shareholder interests such as patients and communities receiving care from healthcare service organisations. The community building model described by Kenny (2002) is included as it facilitates explanation of the DHB model.

Elements of all or some of these theories appear in recent and current healthcare systems. Underpinning theories offer an explanation of power imbalances in healthcare systems by explaining how the tensions within the *fields of practice* are created and the influence of power imbalances on decision-making.

Public choice theory

The central tenet of public choice theory is that all human behaviour is dominated by self-interest (Boston, 1991). The domination of self-interest over other interests is identified by others, for example Bazerman (2005) from a psychological perspective and Bourdieu (1986) in his theory that individuals maximize the use of their *capital* in the form of *power*. Boston's emphasis in public choice theory is on the extent to which politicians are guided by self-interest and not the common good of others. In relation to this study, this assumption could be relevant because such self-interest may impact on decision-making. In public choice theory the concepts of public spirit and public interest are minimised as this may allow the influence on decision-making of sectional interests (Boston, 1991). These characteristics were evident in the policies of both the Labour government of the 1980s and the first National government of the 1990s, with lesser application to the policies of the National led coalition from 1997 (Ashton, 2001; Cumming, 2000). All these recent policies are in contrast to the intended characteristics of DHBs which are discussed below.

Key characteristics of public choice theory relevant to this study include limiting the discretionary power of politicians and the role of the State; promoting individual preference and choice in decision-making and an assumption that individuals, including those involved in policy and planning decision-making and in collective situations, are rational actors. However, the assumption that people are rational utility maximisers has been challenged historically (Becker, 1976; Boston, 1991) and continues to be challenged by those

investigating clinical programmes. An example of such a challenge is that made by Barnes, Moss-Morris and Kaufusi (2004) in their comparison of cultural differences in diabetes. Therefore decision-makers in healthcare services governance should not rely on the rational behaviour of patients or communities when developing policy or when planning services.

Agency theory

Agency theory also assumes rational utility maximisation. The central tenet is that "social and political life can be understood as a series of contracts", (Boston, 1991, p. 4) in which the government, the principal, enters into agreements with others, the agents. This reflects the classical work of Jensen and Meckling (1983, p. 308) in which "contractual relationships are the essence of the firm". Based on these ideas were the radical changes of the New Zealand Labour government in the 1980s. Because government owned enterprises demonstrated lower productivity than those in the private sector, they should be valued and contracted within a similar manner as those in the private sector (Cameron & Duignan, 1984). Thus agents of the government, providing public healthcare services, for example Crown Health Enterprises (CHEs) from 1993-96 and then Hospital & Health Services (HHS) from 1997-99, would be in contractual relationships which would reflect the drive to efficiency. Much of the principal: agent relationship and the formal contracting for outputs characterised by CHEs & HHSs have been retained in DHBs through the Statements of Intent and Crown funding agreements. However, the key difference between CHEs & HHSs and DHBs is that the former were Crown-owned companies subject to the Companies Act (1993) and therefore independent of the Ministry of Health in governance issues (see Appendix 7 for an explanation of governance and reporting relationships). DHBs are classed as Crown agents under the Crown Entities Act (2004), resulting in a closer principal: agent relationship with the Minister of Health as shareholder on behalf of the public. Crown Agents are required to give *effect* to government policy in contracts to Autonomous Crown Entities (ACE) which must only have *regard* to government policy (Crown Entities Act, 2004 Part 1 s.7 (1) (a)).

In New Zealand's healthcare services tension is created through many of the agents having split relationships, including those of DHB members who have duty to the minister and to their boards (Cassie, 2005). More specifically, Gauld (2002b) and Ashton (2006; 2005)

found that in the DHB system contract allocation decisions are influenced by multiple accountability relationships including parochial biases and special interest electorates and conflicts of interest. Mayes *et al.* (2007) identify the divided loyalties as being a risk to the required collective decision-making of boards. Gauld (2005) recognises the inadequacies of the DHB elected membership in relation to multiple agency relationships but there is not a discussion on the impact of multiple agency relationships and collective decision-making in relation to fiduciary duty owed to the organisations, specifically in relation to DHBs. This study explores these issues.

Similar split agent tension occurs when a doctor is agent for both the patient, formalised through informed consent processes, and the organisation by which he or she is employed. And a further example is the health professional who is also the manager. In Coates' (2005) opinion the health professionals' primary allegiance is to the patient and not the organisation as demonstrated in Cullen v. The Preliminary Proceedings Committee ("McGechan, J in Cullen v Preliminary Proceedings Committee AP 225/92," 1994) in which the doctor's duty to the individual patient was deemed to have greater importance than those duties of the doctor, as manager, to the organisation.

Further tension is created for DHBs by the strong central control exerted by the Minister, supported in legislation ("Crown Entities Act," 2004 s.103; Ministry of Health) and the contrasting belief by some board members that they were elected to make decisions on behalf of their communities as identified by Cumming *et al.* (2003). Although the Crown Entities Act (2004 s.3) provides clarity in specifying accountability to the Minister and, as above, there is no accountability to the electorate. The electoral process, however, gives board members the *perception* that they represent their communities.

Following a comprehensive review of the state sector including government/agent relationships (Wintringham, Bollard, Foukes *et al.*, 2001) the Crown Entities Act (2004) was specifically designed to clarify the accountability relationships between the government, ministers and board members (P. Smith, 2005). However, while the legislation is clear that DHBs as Crown agents (State Services Commission, 2000c) are accountable to the Minister of Health ("New Zealand Public Health and Disability Act," 2000Part 3, s.37), elected board members, in particular, have identified a split in agent relationships. Ashton

et al., in their comprehensive study of DHBs (2005), found relationships to the Minister, to the board and to the elected member's electorate. It can be concluded that, at the very least, there is a *perception* of split agent relationships in decision-making and whether those involved have been capable of the impartiality and independence in decision-making in governance is explored in this study.

Transactional cost analysis

The third theory Boston (1991) discusses is transactional cost analysis which also assumes self-interest but recognizes authority relationships. Its central characteristics include uncertainty when the providers are unable to control what happens in the market, for example fluctuations in births. Another source of uncertainty is small numbers bargaining, resulting in frustration for providers who may choose not to enter or exit a market, leaving the funder with limited choice, for example acute brain injury services. These types of situations have the impact of encouraging the development of specific assets, particularly intellectual assets found only in certain healthcare sector specialties and fragmentation of service provision as identified by Wintringham *et al.* (2001). DHBs, therefore, are faced with funding decisions which are influenced not only by cost but also by availability of services, entry and exit costs and the limited view some specialists bring to decision-making, described by Bazerman & Chugh (2005) as 'bounded rationality'.

Stakeholder Theory

Stakeholder theory has many mutations and for the purposes of this study deontic stakeholder theory as defined by Heath & Norman (2004) will be used. That definition describes how an organisation relates to society, specifically to those people, organisations and entities with legitimate interests and rights. In that respect the concepts of stakeholder theory are not unlike the obligations of fiduciaries albeit minus the acceptance of a trust. Fiduciary duty will be discussed in Chapter 4. Freeman (1984) identifies stakeholders as falling into four categories, those from the organisation such as shareholders, employees and the board; those from the community; regulatory organisations and the media. In addition, Buchholz (2004) has recently argued a case to include the natural environment as a stakeholder, reflecting a more holistic approach to decision-making in governance which

includes the impact of decisions on the environment such as in population and environmental public health.

While there is a popular movement to include stakeholder opinion in decision-making and to argue that establishing stakeholder relationships is good for business, often they are considered value-free. Anatonacopoulou and Méric (2005) argue that the concept of social good, especially when there is no obligation or legitimate right, too often outweighs the ideology of control, disempowering governance decision-making. This can be compared with the pressure placed on DHBs by special interest groups who perceive their own needs to be paramount displacing the priority for services of others.

In New Zealand's healthcare services the public as stakeholders are considered through both the electoral and legislated consultation processes within the regulatory environment. Section 40 of the New Zealand Public Health & Disability Act (2000) (NZPHD Act, 2000) requires DHBs to consult on proposed changes to a district's annual plan and sections 34, 35, and 36 require the establishment of statutory committees for community and public health, disability issues and hospitals' performance. Therefore, consideration of the values and power brought to healthcare organisations by stakeholders is felt through the Minister, DHB board and statutory committee membership, 'interested' parties including employees and professions, and the media.

Community building model

The community building model proposed by Kenny, Brown & Turner (2002) focuses on the devolution of accountabilities, responsibilities and risk to the community. Although designed for the not for profit third sector this model can be used to explain the intent of the NZPHD Act (2000). In the DHB model this includes the engagement of the public as discussed above and devolvement of the decision-making on resource allocation, including the rationing function. In explaining the model Power (1997) suggests that Western society has a preoccupation with instrumental rationality, that is, the idea that decision-making has become a technical exercise that is to be developed scientifically. This is coupled with a technocratic consciousness, the undermining of the community's capacity to take a critical view of society as it is bound by technocentrism as identified in the "Review of the Centre" papers (Prebble, 2002; Wintringham *et al*., 2001). The result is the frustrating of ordinary

people to contribute to healthcare systems because the healthcare services community has reduced tasks to complex, technical procedures (Kenny *et al*., 2002). This was a criticism of the Crown Health Enterprise model of the early 1990s because the public felt they had little control or influence on healthcare services. Following from this concern the primary intent of the NZPHD Act (2000) was to establish processes which included the opinions of the general public in decision-making in governance in New Zealand's public healthcare services and to engage the public in the decisions about how resources are spent, especially in moving the focus of services to the primary sector.

It is government's prerogative to take the opportunity through reform to change public service structures to reflect their ideology.

Reformation

Reformation of New Zealand's healthcare services was based on an economic imperative demanding efficient and effective spending and economic affordability. Authors with different political perspectives proposed "reformation" of the New Zealand healthcare services from the late 1980s and into the early 1990s (Clark, 1989; Gibbs, Fraser, & Scott, 1988; Upton, 1991).

In the pre-1989 context the healthcare services were faced with growing demand for services, which were poorly defined and not costed in dollars, and there was a demonstrable "slack" in the finances of the system (Gibbs *et al.*, 1988). Healthcare service governance structures have progressively developed from the local body elected hospital boards of that time and the separation of public health services (Gibbs *et al*., 1988), through to a period, during the 1990s, of corporate governance characterized by the commercial approach usually applied to business and managerialism (Ashton, 1998; Barnett, Perkins, & Powell, 2001).

During the 1990s decision-making in governance was influenced by commerciality and personal director accountability of the Companies Act (1993). There was an emphasis on improved quality and responsiveness to identified service need. The model of the late 1990s was based on the experience of managerialism and output focus of the previous three years (Prebble, 2002). In contrast, within the DHB model functions must be performed

consistently with ‘spirit of service to the public’ and reflect the desire to include the community in healthcare resource decisions specifically to ‘restore public faith in a quality and comprehensive public health system’ and through democratically elected boards to ‘restore the system’s moral authority’ (A. King, 1999b; A. King, 2000c). However, central government would determine funding allocations, policy and accountability frameworks (A. King, 2000b). The Minister of the time recognised the rigour inherent in the accountability and monitoring of the Companies Act (1993), the familiarity of directors with the Act and its backing by case law (A. King, 2000b) but sought to develop separate legislation to ensure that the government would have a mechanism to act in response to poor performance of DHBs.

A detailed table is provided in appendix 7, table 1, which demonstrates the multifaceted nature of the impact of structure influenced by political policy and the complexity of healthcare services per se. The funding model is identified as being dominant in its influence on decision-making in governance. The Health and Hospital Services and DHB models are germane to this study of shaping decision-making in governance within New Zealand’s public healthcare services.

The impact of change in funding model

The impact of context, in this case the structure of governance and healthcare service organisations, on the decision-making in healthcare services is described by Barnett *et al.* (2001), Gauld (2000) and, in relation to corporations, Rayman-Bacchus (2003). These authors indicate that governance structure brought about by institutional or organisational policy can impact on the success or not of organisational outcomes.

From 1996-99 the key purpose of the centralised funder, Health Funding Authority (HFA) was to limit transfer costs through contestability, national service specifications, prices and contracts for many services directly paid to service providers. In contrast the multiple purchaser DHB model focuses on district service specifications, contracts and prices. Ashton (2006) identified inequities of service provision occurring and Tenbensel (2002) questioned whether the DHBs have the capacity to be making funding decisions. The combined purchaser-provider function, coupled with government policy, has encouraged use of DHB provision of services first. Therefore, those differences on which decision-

making may be dependent include the distribution of funds based on market and economic principles of cost benefit and cost effectiveness. In the later DHB period this has changed to provision based on need first and in relation to the needs of others requiring care. This has resulted in many people not receiving care based on their need not being high enough as reported by the National Health Committee (2004a) i.e. rationing. The principle of universality is compromised. A further flow-on effect of the policy is to provide acute services at the expense of elective services, resulting in inefficiency as evidenced in DHB quarterly reports (*Fourth quarterly report: 2005/06 District Health Boards' Crown Funding Agreement*, 2007)

Ashton *et al*. (2006, p. 34) identify that a fundamental problem in tax-funded healthcare systems is the "constant reassertion of upwards accountability towards the body that is responsible for raising the money". Alternatives such as third party insurance and health maintenance organisations appear to generate the same concerns (Shortell, Gillies, Anderson, Erickson, & Mitchell, 1996). Therefore the dilemma is in finding a funding structure in which the public can have confidence and which assures provider accountability. No matter what the choice in structure, however, funding will have an impact on decision-making in governance and this is elaborated upon on page 57.

Structural change, however, does not equate with reformation of healthcare service delivery which requires a change in how people think and not just how they are organised.

Reformation of healthcare delivery

Schwartz (2002, p. 1424) states, "most attempts at change have been primarily structural in nature. Restructuring requires little expenditure of political, economic or emotional resources and only occurs where needed……results are usually dismal ….never truly attempt corporate transformation". It is concluded that restructuring detracts from the real issue of reforming healthcare service delivery and both decision-making and strategic thinking are compromised by the priority and demands of structural change. Schwartz (2000, p. 1424) goes on to say, "Changing titles and adding or changing bureaucratic layers will add to corporate cynicism and dysfunction". Carnall (1999) Perkins (2004a, 2004b) and Hayes (2002) agree, stating that transformational change is about function and relationships and not structure. Therefore effective reformation changes people and how

they make decisions and perform their roles and, rather than driving change through structure, policy should develop structures which support that decision-making. Therefore, while recognising improvements in some professional care delivery especially in the primary sector, information services and communications healthcare service delivery has not benefited very much from changes in healthcare systems. It is the role of clinicians to drive fundamental redesign of the *care* process.

Reform and the effects on professions

The role of clinicians in both governance and management was marginalized by the new managerialism which characterised the changes of the 1990s (Ashton, 1998; Barnett *et al*., 2001) disenfranchising some professional groups (Sage *et al*., 2001). This changed the balance of power in the healthcare services *field* of governance. Changes to organisational structure and the influence of health policy in New Zealand have created tensions between boards, managers and clinicians that impede progress towards an environment in which an optimum healthcare service may be attained. Aldrich & Mooney (2001) found that the key tension for health professionals caused by the reform process focuses on who and how the agenda for reformation is made. New Zealand's agenda for health sector reform was largely set by political parties (Clark, 1989; A. King, 2000c; Shipley, 1995; Upton, 1991). More recently this has been within the State Services Commission review framework of associated legislation, especially the advent of the Crown Entities Act (2004) (Prebble, 2002; Wintringham *et al.*, 2001) and advice from the State Services Commission (State Services Commission, 2000a, 2000b, 2000c). Representation from the broad public service unions was included (Wintringham *et al.*, 2001) but not that from specific professional groups, especially the health professions. While it is recognised that the Crown Entities Act (2004) reforms were blanket reforms to address the relationship between the State and Crown Entities, the impact flowing on to the health and disabilities legislation was not recognised in those reports. The conclusion was that healthcare professions were alienated from the planning process for healthcare services reform which created tension between the professions, management and DHBs.

The marginalisation of health professionals was directly related to the strong cultural and symbolic *capital* now evident within management demonstrated in managers' authority

over many health professionals (Sage *et al*., 2001). This had the effect of challenging the traditional power bases occupied by the clinicians and resulted in an imbalance in power in healthcare service organisations. Tension within the *field* of *cultural power* also uncovered a paucity of capability, both knowledge and power, within the traditional health professional discourses and their inability to respond to change in a positive and timely manner (Tenbensel, 2002). There was reluctance on the part of some clinicians to embrace change and medical professional power clashed with the formal authority of managers (H. T. O. Davies & Harrison, 2003; Harrison & Lim, 2003; Nash, Malcolm, Wright, & Barnett, 2003). While the new management had leadership through formal authority, many individuals lacked practical experience in healthcare services. Decision-making, therefore, was influenced by the need to retain authority and power rather than good leadership and was not always in relation to the cost benefit or efficiency of the service being provided.

Leadership

The 'logic' of managerialism has little recognition of the passion which health professionals put into care giving. The value of health professional practice has been without recognition and therefore lacking authority within their own working environments (A. Dixon, 1996; Sage *et al*., 2001). While the impact of leadership on connectedness and feeling valued has been discussed by Perkins (2004b) and Mathews (1999) it does not appear to have been valued in terms of decision-making in the management and/or clinical environments. Similarly, the attributes of caring and vocation are identified by many health professionals as essential to their practice (Benner, 1984) and their leadership needs to recognise those attributes in order to maximise the benefits of health professional skills.

The DHB structure was also proposed to ensure community leadership through participation and responsibility. However, Mays *et al.* (2007, p. 17) reported that most board members indicated they had "little scope for strategic leadership" and that it "would have been disingenuous to have raised expectations in the community that it could make a major difference to the priorities and actions of the DHB". I concur that these later comments indicate that boards may not have the experience and skills necessary to make strategic governance decisions and further supports the need for this study.

The influence of policy

The ideology underpinning current healthcare services policy has a foundation of social democracy which is demonstrated by central control by government, prominent public participation and ownership of services, along with a thriving private sector (Giddens, 1999). The renaissance of social democracy in healthcare services was clearly enunciated in the Labour party manifesto prior to the 1999 election (A. King, 1999a). The New Zealand Health policy (2000, 2005) has the following characteristics and aims:

> Health policy development and the provision of healthcare services will enjoy the engagement and collaboration of the public who will have every opportunity to participate in healthcare service decisions. This is reflected, for example, in the requirement for seven elected DHB members (NZPHD Act, 2000 Part 3, s.29, cl.1). The purpose is to build intellectual capability in the community as discussed by Tenbensel (2002), however a consequence is the divestment of rationing risk from central government to the people and the risk is that few members of the public wish to be involved in the decisions about healthcare services.

> The policy (A. King, 1999a, p. 5) includes the "restoration of a non-commercial system", including the limiting of competition and avoidance of routine contestability of funding for hospital services. That shift is designed to secure long term funding arrangements with preferred provider organisations which have a history of providing quality services, which in turn encourages investment in the sector. However, this aspect of the policy makes entry to complex services difficult for new providers because of the expected time gap between the availability of contracts and the cost of entry for all but the basic primary services. The result is that the DHBs have to contract with either poor service providers or those who maximise their price because they are the only available provider.

> The original memoranda suggested that the distribution of contracts between public and private services would be managed in "an even handed manner' (A. King, 2000b cl.19). However, from 2006, ministerial policy directed DHBs to be the provider of first choice, all other things being equal[1]. This has resulted in few new private providers entering the

[1] Personal communication from ADHB officer

market as the result of decision-making by DHBs to enhance integration of services and their desire to reduce the costs of contestable contracting.

DHB funding has been provided, based on the population-based funding formula (PBFF) plus further funding for the implementation of the Primary Healthcare Strategy (2000). The commitment to change services to focus on primary care is illustrated by the huge funding increase in Vote Health since 2000 [Vote Health 2000 $5.78 billion, Vote Health 2005 $10.2 billion, Vote Health 2007 $14 billion (budget) source Health Expenditure Trends, Ministry of Health]. So funding should not be an issue. However, the "need first" policy has disadvantaged some New Zealanders. Need is a subjective measure to many people and this has created a tension with the traditional universality of the New Zealand healthcare system.

The policy of community participation, to promote public engagement with health services, is reinforced through the establishment of statutory committees, the Community and Primary Health Committee, Disability Support Advisory Committee and the Hospital Advisory Committee, whose membership is from the board and co opted members from the community to provide expert or special interest opinion enabled under s. 34 & 35 (NZPHD Act, 2000). Decision-making in governance therefore has the opportunity to be influenced at several levels within DHBs although Tenbensel (2007) identified an inconsistent approach to the implementation of the statutory committees and Ashton *et al*. (2005) found that special interest groups had the opportunity to capture the committees. This inconsistency and vulnerability of the decision-making in governance within committees contributes to the need for this study.

Transparency of decision-making is a further underpinning principle of the Labour Party policy (2005) and is formalised in the NZPHD Act in schedule 3, clause 31. All formal meetings of DHBs, including those of the statutory committees, are open to the public as a way to achieve formal transparency in decision-making. However, evidence suggests that few public attend meetings and only one person is recorded as attending regularly in the Auckland area (Ashton, Mays, & Devlin, 2005). Transparency as a characteristic of governance will be elaborated on in Chapter 4 but it appears that board meetings open to

the public are not meeting the government's aim of a transparent decision-making process in healthcare services.

In summary, through the democratisation process the government's aim was not only to improve population health but also to regain confidence in the public health system (Gauld, 2005; A. King, 1999a). The DHB system is explicitly designed to engage with the public but tension has arisen because of the strong central control as identified by the Health Reforms 2001 Research Project (Cumming *et al*., 2003) and the considerable ability of the Minister of Health to intervene (Ashton, Tenbensel *et al*., 2005). The effect has been that most board members, as reported by Mays *et al*. (2007, p. 31), believed the focus of their decision-making was given by the government and they were "to minimise deficits and implement government priorities". By its specific direction, this suggests that decision-making in public healthcare services is bounded by government direction, and this study will further examine the influence of boundaries in shaping decision-making in governance.

Governance framework

Decision-making in governance is bounded by the legislation and by convention which set the rules of the action, the rules of the game. The statutory duties of company directors generally are codified in the Companies Act (1993). Director behaviour is also framed generally by a range of supporting and monitoring legislation including the Public Finance Act (1989), the Financial Reporting Act (1993). DHBs as Crown Entities are also subject to the Crown Entities Act (2004) and Statements of Intent or equivalent and relevant reports, the Securities Act (1978), along with the supporting legislation of the Health and Disabilities Commissioner Act (1996) and the HPCA Act (2003). The Crown Entities Act (2004) has precedence over the New Zealand Health and Disabilities Act (2000) so the duties of board members will be considered in that context.

The duties of the Crown Entities Board are defined by whether the duties are owed collectively as a board or individually as a member and to whom they are owed ("Crown Entities Act," 2004 s.49). There is no distinction between elected and appointed members. Elected members do not have any duties in law to the electorate, meaning that although the electorate nominated them for appointment to a DHB the members have no legal responsibilities or duties to the electorate. All board members have a duty to disclose any

interests relating to the DHB prior to appointment, and after election in the case of elected members ("Crown Entities Act," 2004 s.31).

Collective duties for Crown Entity Board members (Part 2, s.49) include:

- The Entity must act consistently with objectives, functions, current statement of intent and output agreement (if any). Note that for DHBs the Crown Funding agreement is considered as the output agreement.

- The Entity must perform its functions efficiently and effectively and in a manner consistent with the *spirit of service to the public*.

- The Entity must act in a financially responsible manner, which in practice should mean solvency, but many DHBs have ongoing deficit budgeting and solvency issues (*Fourth quarterly report: 2005/06 District Health Boards' Crown Funding Agreement*, 2007).

DHBs as Crown Entities are therefore charged with planning and providing healthcare services efficiently and effectively in the context of prudently managing their assets and ensuring the entity's long term future. As Crown agencies, DHBs may be directed by the Minister to implement government policy ("Crown Entities Act," 2004 s.103) which challenges the intent of autonomy of DHBs in decision-making as expressed in policy (King, 2000), especially those related to specific services. For example Waitemata DHB made a specific decision not to provide biological infertility services for its population but this decision was overturned by the Minister, as reported by Ashton *et al*. (2005). The Crown Entities Act (2004) does not address the situation where in order to meet the output agreement with the Crown the entity must compromise its effectiveness or long term financial viability. For DHBs there is a conflict as they are required to provide services based on need as per government policy (A. King, 1999a; Labour Party, 2005) but that strategy may not be the most efficient or the most effective. This is so because while the Health Needs Assessments focus on a strategic view of the community (Coster, 2000) acute demand takes precedent, compromising service efficiency. Public acute services providers must continue to provide services. This is a conflict which impacts on decision-making for DHBs as they strive to balance strategic plans with acute demand.

Further discussion on the duties of DHBs is in Chapter 4 within the discussion on duty.

Ashton (2003) and Cumming *et al*.(2003) found that DHB members had difficulty in understanding the definition of duties defined in the Public Health and Disabilities Act (2000) and Crown Entities Act (2004). Whether this is through the inadequate basic knowledge of individual members or because of a deficit in their induction and education as members is not clear from their research. The impact of this ambiguity on the decision-making of DHBs is explored in this study, not only to establish a commonly understood environment for DHBs but also to give confidence to the New Zealand public of the quality of decision-making in healthcare services governance. Restoring public confidence in healthcare services was one aim of the 2000 health reforms (Mays *et al*., 2007).

Organisational structure and the impact on decision-making

The organisational structures and their environments, the *field*, change in response to shifts in *social, intellectual,* and *cultural capital*. Systems should enhance decision-making in contrast to the existing formal hierarchical reporting structures (Drucker, 1999). However, vertically defined and compartmentalised levels within management structures impede decision-making and, as suggested by Sage *et al*. (2001), frustrate the point of care decision-making of experienced health professionals. The notion is supported by Davies and Harrison (2003) that doctors are angry at the limiting of professional decision-making which is reduced for example by the structure of best practice guidelines and clinical pathways. This limits their sphere of influence in decision-making to direct clinical decisions and away from those affecting the organisation as a whole.

A characteristic of organisational structure is whether decisions are centralized or decentralized. The decentralization of decision-making is supported by Porter-O'Grady, Hawkins, & Parker (1997) with the suggestion that control and the authority to make decisions should be spread across the healthcare services system. "Decentralising the structure of an organisation does nothing if the decisions are not decentralised to the point of service. Unilateral control at any place in the system is just as destructive as it is at the top of the system" (Porter-O'Grady *et al*., 1997). It is the spread of accountability, in contrast to control, in professional decision-making across the system which appears to be

the challenge as Porter-O'Grady *et al*. (1997) are some of only a few authors who have identified the challenge.

Similarly, denoting levels of management, in terms of seniority and reporting authority e.g. some DHBs grade positions as level 1 (CEO), level 2 (General Manager) and so on, emphasizes hierarchy which conflicts with the notion that the management role is one of creating an environment for operational decisions to happen with ease as indicated by Drucker (1999). Therefore healthcare service environments require the management focus to be where clinical decision-making occurs and not on power and control of resources. This is supported by Porter-O'Grady, Hawkins & Parker's (1997) premise that whole systems shared governance operates outward from the point of service, but they offer a complex organisational structure. The relocation of power, within the organisation, to the point of care will only happen when there is a focus on outcomes and results, and accountability for those results. Support for the point of care to be the focus of healthcare services governance decision-making was explored in this study.

The impact of managerialism and the corporate model

Public sector reform has been influenced by managerialism and the new public management (Bamford & Porter-O'Grady, 2000). These are concepts taken from corporate management functions and applied to public sector administration. An emphasis is placed on efficient management rather than policy implementation. Traditional hospital management methods based on health professional leadership did not provide the logical and pragmatic decision-making related to resource use and monitoring (Shortell, 1989) within the wider neo-liberal political context in New Zealand previously discussed. Managerialism and the commercial model created the much needed systems for defining what New Zealand healthcare services do, when they do it and by whom they are performed (Barnett *et al*., 2001; Cumming *et al*., 2003; Davis & Ashton, 2000; Porter-O'Grady *et al.*, 1997) and the benefits have been recognised by successive governments (Creech, 1999; A. King, 2000b). However, the promotion of a managerialist approach, during the 1990s, resulted in strong, almost overpowering, management and associated leadership which challenged the traditional leadership roles of health professionals (Sage *et al*., 2001) and, as previously stated, many felt disenfranchised.

Managerialism has been recognised as being a necessary and positive part of the development of the New Zealand public healthcare services (Prebble, 2002). Through managerialism there was a clear attempt to measure and quantify the outputs of the health service; the result was a service which for the first time could be budgeted for and costed in dollars at the clinical activity level. This also created a service which could be responsive to changes in the healthcare services market (Barnett *et al.*, 2001; Shortell, 1989) and dealt with the lack of accountability and fiscal responsibility (Gibbs *et al*., 1988).

Aspects of the corporate model have been retained in the DHB model especially the more formal basis for contracting and the extension of contract monitoring (Ashton, 2006; Cumming *et al*., 2003). While financial reporting systems remain in place and have been reinforced by the reporting and financial obligations in the Crown Entities Act (2004) Part 4, s137-149, Cumming *et al*. (2003) identified that the discipline of working within budget both financially and in meeting all planned outputs, has largely lapsed and this is confirmed by the governments own reports (*Fourth quarterly report: 2005/06 District Health Boards' Crown Funding Agreement*, 2007; Mays & Cumming, 2007). It can therefore be concluded that managerialism instigated financial and performance accountability within New Zealand's healthcare services and within the structural disciplines of the Companies Act (1993). However, the DHB membership and the governance decision-making within it has not been able to maintain those disciplines introduced during the 1990s. While this may be the result of insufficient funding available to provide services it may also be the immunization provided to boards in the Crown Entities Act (2004) provisions (s. 20, 21, 22). This provides further impetus for this study concerned with what shapes decision-making in governance.

Funding

Funding the 21 DHBs directly was designed to allow communities to allocate funding based on local decisions. (A. King, 2000b). The funding for each district is based on the population and demographic mix residing in the district, the average national cost of health services used by each demographic group, and the level of unmet need adjusted for rurality and the high needs ethnic groups. The genesis of the funding formula lies in the attempt to correct the inequities of historical funding allocation to regions (Creech, 1999; Shipley,

1995) and was not limited to specific funding or purchasing structures such as fee for service or bulk funding. It is called the population-based funding formula or PBFF.

Previously established in this discussion is the substantial increase in funding since 2000. DHBs decision-making should not, therefore, be constrained by the amount of funding. Ashton (2006), however, found that some boards had identified that the amount of funding available directly impacted on their decision-making, especially those which provide tertiary services. PBFF also fails to recognise the mobility of New Zealanders especially those with complex health needs relocating to the DHBs which offer more complex services, the complexity of those patients receiving high level care and the cost of that service provision (Ashton, 2006). While inter-district flow mechanisms go some way to correct these imbalances, tensions between the tertiary providers and their feeder DHBs remain (Ashton, Mays *et al*., 2005). The tensions include the availability of specialist services to "out of district patients" and the payments for those services. Therefore, tension between DHBs in relation to funding for some services impacts on their decision-making in relation to the provision or rationing of those services.

The conclusion is that decision-making by DHBs will be influenced by the availability of funding for their populations and the systems in place to recompense them for extraordinary services required and/or provided. The influence of funding on decision-making was explored in this study.

Rationing

Rationing within clinical services, the decisions made to provide healthcare services from scarce resource, has become formalized through guidelines and procedures for acceptance to specialist programmes for care and treatment. For example those guidelines published for the management of cardiovascular disease (Buetow & Coster, 2001) and renal replacement therapy (Feek, 1999). DHBs prioritize healthcare services for their communities based on the Ministry of Health framework as advised by the National Health Committee (Health Funding Authority, 2000; National Health Committee, 2004a, 2004b) and a toolkit for DHBs – The Best Use of Available Resources: An Approach to Prioritisation (Logan, 2004). The DHBs choose which services should be provided for their communities based on a health needs assessment (NZPHD Act, 2000, Part 3, s.38) and a

series of formal strategy documents published by the Minister of Health (A. King, 2000c) which provide comprehensive frameworks for implementing government policy.

However, when service need outweighs funding, rationing exists. Rationing is a complex process requiring capacity and skill from analysts and ethicists. Tenbensel (2002a) suggests that the dilution of this capacity across 21 DHBs is of major concern. Cumming *et al*. (2003) concur, having identified that the lack of board governance expertise in rationing is complicated by lack of capability and capacity and Ashton (2006) identifies the inefficient distribution of funds compounding rationing. The conclusion is that boards are reliant on their executives to provide the level of expertise needed to make difficult choices and that executive skill in rationing is scarce, resulting in the risk of inconsistent rationing decisions across DHBs.

Further, there are tensions between a DHB's ability to fund and political direction as identified by Ashton *et al*. (2005) over what services should be provided at the expense of others, for example biological infertility. There is little discussion on whether these tensions between the central government and DHBs have an impact on the decision-making in governance and exploration is necessary to establish what influences the rationing process has on DHB healthcare service decisions.

Conclusion and Integration

The provision of healthcare services is complex. The DHB model offers opportunities and impediments to decision-making in governance. Decision-making in governance is driven by context, political ideology, economic imperative and the changing variables which impact on the New Zealand healthcare services environment. These variables include demographic, epidemiological, sociopolitical and economic tensions.

Knowledge of the theoretical models underpinning healthcare services facilitates understanding of the drivers of policy and the boundaries of decision-making. New public management (Scott, 2001) structures and policies of the 1990s provided recognizable frameworks within which decisions could be made. The discussion in this chapter has suggested that the ideological base of policy influences strategy and directives creating tensions between central government and the DHBs. Institutional and organisational

structure, which should facilitate decision-making, frustrates decision-making through centralised policy, processes and funding, especially the control of capital.

The DHB model is multifaceted, complex and sometimes opaque (Mays *et al*., 2007). The legislated changes have resulted in *perceived* multiple accountabilities, lack of personal accountability and potential for conflicts of interest. The model has placed service provision risk with the community through DHBs. The risk of service fragmentation is increased and the capacity of DHBs to respond is thinly spread. The tensions between DHBs, clinicians, patients and their communities remain and the impact of limiting DHB authority on decision-making has been identified as influencing decision-making.

This chapter has described and analysed the environment, framework and *field* (Bourdieu, 1985, 1990b) in which decision-making in governance in healthcare services in New Zealand happens. Understanding the context allows identification of tensions which impact on that decision-making. The review of the literature on decision-making and governance will further identify the gaps in knowledge of the subject and lead to questioning the shaping of decision-making in the New Zealand public healthcare services.

Chapter 4

Decision-making and Governance

Introduction

This chapter explores the genesis of good governance and is a review of the literature on decision-making and governance. It leads through to the study of the shaping of decision-making in governance in New Zealand public healthcare services. In the context of research practice in New Zealand healthcare services, the researcher is seeking to establish what shapes the decisions of those people who have been given and accepted authority to make governance decisions; the process, the principles on which decisions are based, the environment in which decisions are made and why it is that decisions are made in those ways. The subject of governance is multifaceted and, in this study, lies within the complexity of the healthcare sector discussed in the previous chapter. Assuming that context, this exploration of the attributes of governance was undertaken to lead to a better understanding of the genesis of the key principles, their development over time and their application in corporate and clinical decision-making in 21st century healthcare services.

The focus for this thesis is on decision-making in the organisational and operational aspects of governance. This perspective does not devalue other perspectives from which governance can be considered. Reference to the law is to place decision-making in governance within the legal framework and the relevant legislation will be identified and discussed. Boundaries to decision-making are discussed using examples of ethical and moral behaviour of directors and board members and within society in general.

The duties of those who govern have developed throughout history, reflecting the context of the times, particularly the political and economic environments. The common law duties of care, skill, diligence and good faith have been codified in common law ("Companies Act," 1993; Trustees Act," 1956; Trustees Amendment Act," 2005) and are recognised as underpinning the legislated framework for decisions made in the corporate context and situations where trust is accepted on behalf of others. The contribution to governance from the case law and law literature in general is recognized, especially the underlying first principles of duty to which there is a moral duty of all decision-makers in governance to

adhere to. However, the tension explored in this study is between governance of the organisation and governance in clinical practice, which is not determined by the common law principles embedded in legislation for example the Companies Act (1993).

There has been little published theory on the subject of director characteristics which shape decision-making in governance (Leblanc & Gillies, 2005). There are few qualitative studies (Leblanc, 2003) which focused on how decision-making by boards occurs. A comprehensive literature review by Zahra & Pearce (1989) identified that the quantitative research being undertaken was not identifying reasons for gaps in board performance based on the decision-making of boards. Those who have ventured to explain the process of decision-making by boards have largely limited their data to personal experience, discreet observation while working with boards or anecdotal recounts from board members (Bosch, 1995; Garratt, 2003b; Tricker, 1984). Others have published with the authority of commissions of enquiry or similar official investigations while establishing codes of practice (Cadbury, 1992; Hample, 1998; M. King, 2003). Several authors have sought to explain through research how governance happens (Leblanc & Gillies, 2005; Mintzberg, 1996; Muth & Donaldson, 1998) but only a few specifically consider the subject of decision-making in governance (Cutting & Kouzmin, 2000; Scherrer, 2003).

Following an introduction to decision-making the discussion will be expanded under the following headings: personal experience and the habituation of insight, the individual and the group, the impact of culture, collective decision-making, and board process. The section on governance will include the contexts of institution and community, and the governance principles of duty, including fiduciary duty, transparency, accountability and probity. The literature pertaining to corporate governance and clinical governance will be analysed separately, reflecting the popular understanding of these as two separate concepts.

Decision-making

Decision-making is complex. It encompasses human development through environmental and experiential learning, emotion and formal education (Bourdieu, 1971, 1990b, 1993a; A.R. Damasio & Bechara, 2005) and values (Seedhouse, 2005). The history of decision-making is long, rich and diverse. Buchanan (2006) has summarised the development of human decision-making from historical decisions which were guided by interpretations of

things like entrails, smoke or dreams, to Caesar's crossing of the Rubicon or even Hamlet's most famous dilemma, 'to be or not to be'. More recently published is 'Blink' (2006) putting forward Gladwell's notion that instantaneous decisions, intuitive decisions, the result of man's adaptation to his environment, are sometimes better than those based on lengthy rational analysis. Decision-making therefore is drawn from an eclectic collection of ideas ranging from formalised processes developed from history and experience to the informality of intuition or the personal boundaries individuals establish from their experiences in life.

A key influence on decision making in the corporate sector has been Simon (1982a, 1982b, 1987) who describes how human decision-making was limited by the boundaries individuals themselves place on it. Simon describes "bounded rationality" as that ability to make decisions that are limited by the individual's own understanding and awareness of the world. Simon's ideas are similar to those of Damasio (2005), debunking the rational man concept described by Descartes in 1637, "I think therefore I am". Damasio (1994) states that Descartes' error was to separate the body and the mind; specifically "the separation of the most refined operations of the mind from the structure and operation of a biological organism" (1994, p. 250). Damasio proposes that we are, and then we think and that the way we think is dependent on what has gone in our lives before "since thinking is indeed caused by the structures and operations of being" (1994, p. 248). Damasio (2005) is quite specific, proposing that in the absence of emotion it is impossible to make any decisions at all. Therefore, taking this perspective into account, decision-making, including decision-making in governance, is guided by the values and mores learnt as part of individual and group interaction with the environment.

Personal experience and the habituation of insight

Similarly to Damasio's thesis discussed above, Hanson (2004) has questioned whether it is possible to make a decision without bias created by personal experience and circumstance. Hanson (2004), in comparing the ideas of philosophers Ronald Dworkin and Bernard Lonergan, identifies the impact of experience on decision-making especially related to Lonergan's "Theory of Knowing" (1972). Lonergan's theory emphasizes experience coming before insight and that it is experience that provides the data that allows for the possibility of insight and eventually objective decision-making. As previously discussed,

Bourdieu also identifies the impact of experiences becoming habituated in the individual. Bourdieu (1990b) calls this the individual's *habitus*. Bourdieu (1990b, p. 53) states "The foundation of the *habitus* is the collective history inscribed in objective conditions and that *habitus* inscribed in individuals". The conclusion is that it is the personal experiences in growing and developing those dispositions which become part of the unique psyche of individuals, which gives them insight in decision-making.

Buchanan & O'Connell (2006), writing in relation to leadership and decision-making, focus on the inability of the individual to replicate the experiences, thought patterns and personality traits that inform individual decision-making. Buchanan and O'Connell (2006) identify experience, structure and emotion as underpinning individual decision-making and forming the very basis for how humans think. The impact of emotion, developed from years of experience as individuals in the world, developing one's *habitus* as described by Bourdieu (1990), is also recognised in the psychology literature by Magai (1995), Lewis (2000), Dai, (2004), Stein, Leventhal & Trabasso, (1990) and especially Damasio (1994, 2005) as a neuropsychologist. However, the unanswered question is 'what makes individual decision-maker's behaviour idiosyncratic in certain circumstances and environments such as boards?'

The individual in the group

The role and actions of the individual in groups has been well investigated in the psychology, sociology and leadership literature (Baert, 1998; Bourdieu, 1985, 1993c; Bowditch & Buono, 2005; Cooper, 2003; Graham, 1997; Hesselbein, 2004; Janis, 1983; Kanter, 2005; Ket de Vries, 1994; Lewin, 1947; McDaniel, 1997; Sadler, 2003) and case law has a specific focus on the intent and tactics of individuals as directors or quasi-directors. However, the governance literature focuses on the success of organisations, rather than individual behaviour (Sonnefeld, 2004; Tricker, 1984; Zahra & Pearce, 1989). Only recently has the individual director as a member of the board been given research priority (Gonzalez, Modernall, & Paris, 2006; Leblanc, 2003; Pech & Durden, 2004). Gillies and Leblanc (2005) highlight the role of directors as people with distinctive characters and roles to play which differ according to the characters and personalities of their fellow directors. Pech *et al*. (2004) identify that, aside from observations and anecdotal evidence which have led to business success, relatively little is known about the decision-making processes

which have led to business compromise and failure. In a similar manner to bounded rationality described by Simon (1982a), Pech *et al*. (2004) identify the arbitrary filtering of information, discarding the undesirable information, the enlarging – out of proportion – of desirable information and the limiting traditional behaviour of senior management as behaviours which are demonstrated when directors are influenced by the group. They suggest that this results in collusion between board members to create a culture that initiates and sustains these cognitive filtering and sieving processes. The impact of the place of the individual in the group was explored with the participants in this study and is discussed in Chapters 6 & 7.

The impact of culture

The impact of culture in the context of decision-making and the relationship with others is considered by Bourdieu (1985) as *doxa* and specifically in relation to boards of directors by Gillies (1997), Leblanc and Gillies (2005) and Sonnefeld (2004) who identify the impact of culture, the *social and cultural power,* of individual members of specific groups and the influence of the culture of the leadership style of the chairman. The conclusion is that environments which are not familiar or which challenge the individual's understanding of the world, their *doxa*, can influence the individual's behaviour. Simon (1982a, 1982b) described individuals as prone to the erroneous framing of decisions and went on to identify excessive optimism as decisions were contemplated without full information or the ability to synthesize the information available. Individual decision-making is at risk when directors are placed in an unfamiliar context where they are either required to make decisions based on the limitations of their own knowledge or the guidance and/or manipulative skill of others. However, while the legal duties of good faith, skill, care and diligence mitigate that risk, being able to anticipate the behaviour of others makes people feel comfortable in their actions. To what level culture or the unfamiliarity with the culture of others, impacts on the individual's decision-making within the context of healthcare was explored in this study using the framework of Bourdieu and *cultural power*. The individual's role in groups also extends to collectivity.

Collective decision-making

Simon (2002) identifies that humans have a powerful urge to identify with groups. History has provided tribes and gangs, religious groups and those brought together by family and nationality. Group bonding can have highly desirous consequences in organisational decision-making (Simon, 2002) and Bazerman & Chugh (2005; 2006) suggest that this allows humans to achieve together that which they would have no hope of achieving on their own. That is, individuals are able to use the *cultural power* of the group. However, collective decision-making can be influenced in a number of ways as follows.

Herding

Gonzalez (2002) found evidence to suggest that individuals participate in "herding" behaviour in order to be perceived as part of the group and to protect reputations. Gonzales (2002) developed a theoretical model which demonstrated that in a board composed of a CEO and two external directors, director B tended to copy director A's decisions. Gonzales and others confirmed this behaviour in a further experiment (2006). They suggested that the context of governance itself, the board and the hierarchy within it, has an influence on the decision-making behaviour of individuals in contrast to "good faith" behaviour. Leblanc (2005) suggests that the relationships between board members, and the roles they play in that environment, influence the decisions made by a board. However, while the purpose of a board is to get collective decisions made, the power of influence, especially on the independence of directors is at risk in a herding environment. This will be further discussed under independence on page 78.

Groupthink

An alternative view is that group behaviour can have negative consequences when the desire to be like other individuals in the group limits individuals' ability to think rationally (Janis, 1972). Janis (1972) coined the term "groupthink" to explain the behaviour of a highly cohesive group indulging in self-censorship to achieve unanimity. This self mindedness, *misrecognition*, overrides the group's ability to look at alternative courses of action objectively and realistically. The cultural expectation of the group, the *doxa,* is characterised by unanimity overriding struggles for individual power positioning. In this

type of situation it is the group which is struggling for position within another environment and they will mobilize *social capital* to facilitate decision-making in order to maximise the position of the group.

Bazerman and Chugh (2005) concur in highlighting that groups focus much more on shared information than sharing information that is uniquely held by participants. This reduces the advantage that a group has over the information available to one individual only. The impact of the relationships within the group that makes up the board on their collective decision-making has also been identified as worthy of investigation (Leblanc, 2003). Leblanc (2005, p. 203) highlights the concept of shared information as a risk to successful board outcomes –"One of the greatest deterrents to effective board operations is groupthink…", the restraint of decisions by the collective opinion of the group.

The concept of bounded ethicality refers to the limits placed on the individual's ethical decision-making when influenced by the group or when the challenges to ethical decision-making are gradual and over time (Cain, Lowenstein, & Moore, 2005). For example Fairfax (2002) identified that the Enron auditors, Arthur Anderson, had been party to minor and gradual ethical misdemeanors as the gradual movement of the boundaries of the ethical standards had not been recognised over time.

It is established that collective decision-making can be influenced by the behaviour of the group both as a collective and as individuals. What is not clear, however, is what shapes the decision-making of the group as a collective.

Collective decision-making in DHBs

The requirement for collective decision-making behaviour is acknowledged in the legislation governing the actions of DHBs (NZPHD Act, 2000, Part 3, 26 (2). Board's collective duties include: acting in a manner consistent with the functions of the DHB, and with the DHB's district strategic plan, statement of intent and any directions or requirements given under section 32 – 'Minister may give directions', or section 33 – 'Minister may require provision of services'. "There is no parallel set of *collective duties* in company law" (Palairet, 2005, p. 26). In contrast, while the ability of a resolution of a majority of shareholders to supersede a board resolution and the accountability to

shareholders is recognised as a process of governance (Tricker, 1984), they cannot intervene at will in the business of the company except as provided for by the constitution of the company. The implications are that board decisions may be superseded by direction of the Minister. While the reason must be given (NZPHD Act, 2000, Part 3, s. 32, 33) it can be based on political considerations. On the reported occasions where the Minister has intervened in a DHB decision on the prioritisation of services, for example biological infertility at Waitemata DHB as reported by Ashton *et al*. (2005), there has not been comment about the impact on the integrity of the Board. Notwithstanding the legislation relating to collective duties (NZPHD Act, 2000, Part 3, 26 (2)) cited above, the collective accountabilities of the DHB are perceived by the electorate to be challenged by the minister's intervention as suggested by Ashton *et al*. (2005). The implications on future decision-making, especially concerning prioritisation, are not evident and these issues are explored with the participants in this study and discussed in Chapter 7.

In contrast to the Companies Act (1993) the collective responsibilities of DHBs do not extend to passing the solvency test. At the shareholder's discretion, DHBs are only required to be financially prudent and responsible and, as Crown Entities, "act as a going concern" ("Crown Entities Act," 2004). Similarly, DHB members are not personally liable (except for some unavoidable Occupational Safety and Health or Resource Management regulations) for liabilities of the entity ("Crown Entities Act," 2004s. 120) in contrast, with company directors who have personal liability specifically if a company trades while insolvent (Companies Act, 1993). The difference is that the collective discipline of financial prudence and personal accountability which is accepted by directors under the Companies Act (2003) creates the tension required to meet a company's obligations. That same tension is not created for DHBs, many of which have deficit budgets approved by the Minister and some of which do not meet those budgets (*Fourth quarterly report: 2005/06 District Health Boards' Crown Funding Agreement*, 2007).

Board process, director behaviour classified

Board process and director behaviour has been researched by Leblanc (2003) who observed boards as closed systems and identified that individual director behaviour is a fundamental component of boardroom processes. Five functional and five dysfunctional behavioural types and the characteristics, skills and aptitudes, which those behavioural types possess,

were identified. The contrasting behavioural types are conductor-chairs/caretaker-chairs, change agents/ controllers, consensus builders/ conformists, counselors /cheerleaders and challengers/critics. The suggestion is that functional types have a more positive impact on board behaviour and the dysfunctional have a negative or, at the very least, a maintenance function in board performance. Leblanc and Gillies (2005) also identified three factors which determine the effectiveness of directors and relate to the board as a corporate. These factors include independence of mind, which also is a theme common to King (2002b) and Garratt (2005), competencies (which will be further discussed under director preparedness) and behavioural characteristics as identified above. The director classification begins to explain behaviour in the boardroom and the outcome of decisions. However, Leblanc and Gillies (2005) did not look beneath the observed boardroom behaviour or consider why some people fit into one classification and not others except in relation to their roles, competencies and interrelationships *as members of a particular group* – the board. That is, what shapes the decisions of individuals as board members is not considered.

Also, the analysis of the development of the characteristics of those groups and individuals is not in relation to those who participate in decision-making in governance in healthcare services. This is important because if the factors can be identified that shape decisions in the healthcare service governance environment, then those attributes can be sought out, encouraged and enhanced to shape successful governance.

Governance

The term governance has its origins in ancient Greek – kubernetes- the steersman and the word director has its roots in the Latin – dirigere, to guide.

Governance enables the administrative organisation to set its policies and objectives, to achieve them and to monitor them. Leblanc and Gillies (2005, p.157) describe board process as “the way in which boards make decisions, the directors and their behavioral characteristics, plus the manner in which they interact among themselves”. This is attained through the governance process comprising accountability to shareholders, supervising of managerial action, and setting strategic direction (Tricker, 1984). Directors have a duty to give over-sight, to be familiar and have current information about the organisation so that they can make those decisions on a sound base (Fairfax, 2002).

As previously identified, the common law duties of care, skill, diligence and good faith are recognised as the underpinning legal framework within which corporate governance occurs. However, these duties do not form the basis for all governance decision-making. For example, those governance decisions made in clinical practice which are based on the fiduciary duty accepted between health professional and patient and the duties of care, skill and diligence but which are framed by historical oaths and, more recently, legislation specifically related to professional practice, for example the HPC A Act (2003) which will be discussed on page 96. In exploring the shaping of decision-making in healthcare services, underpinning concepts which have relevance in all healthcare services contexts in which decision-making in governance occurs were sought.

Governance Principles

Three values (some describe them as principles which is the terminology used in this thesis) are identified by Tricker (1984), Sonneveld (2002), Garratt (2003b), Leblanc (2003) and Wieland (2005) and are concepts similar to Proclus (1963) and Cutting and Kouzmin (2000) to describe governance. The three values of governance are transparency, accountability and probity. To those, others such as Farrar (1998), would add duty including fiduciary duty both as principles and as legislated requirements. The principles, listed above, inform the governance arrangements and provide mechanisms whereby those who have been given the responsibility and authority to pursue those agreed policies and objectives are held accountable. Decision-making in governance is therefore decision-making of behalf of others once a trust has been exchanged.

Filatotchev (2007) places governance in the context of the community recognising that the effectiveness of particular governance practices cannot be considered in isolation from the frameworks within which decisions are made for a particular organisation. A similar approach is offered by the Institutes of Directors in New Zealand (2007) and by the Policies and Guidelines of the Securities Commission of New Zealand (New Zealand Securities Commission, 2004) which uses values and principles instead of rules. This is intended to allow companies the freedom to develop governance styles which reflect the nature of their business and to provide a guideline that was both able to be applied in any context and, at the same time would not restrict the growth of business and organisational effectiveness

(2005). The conclusion is that a set of underlying principles customised for each organisation will best meet the needs of decision-making in governance rather than the restrictions of a rules-based approach.

However, the preference for principles-based guidelines has resulted in some DHB members requiring more specific levels of definition of their roles as identified by Cumming *et al*. (2003). They have also identified a need for better definition of the framework in which they work (Mays *et al*., 2007). The influence of poor role definition and rules on shaping of decisions in governance was explored with the participants in this study.

The law offers a framework in which governance occurs through defining the duties of directors.

Duty

The common law duties of directors - care, skill, diligence and good faith in the interests of the company emanated from the court of chancery, established to enable decisions based on equity and which governed fiduciary relations prior to the Judicature Acts in the United Kingdom. The most prominent 19th century judgment relating to the genesis of fiduciary duty was Re Cardiff Savings Bank ("Marquis of Bute," 1892 2, Ch 100). The Marquis, who had had little or no contact with the Bank in the thirty years since inheriting at the age of three months, was found to be not liable for the reckless lending of the Bank's officers. The judge found that the Marquis knew nothing of the affairs of the Bank and further, that he had no duty to keep himself informed. However, his fellow directors were found in breach of their duty as they had opportunity to be diligent and therefore duty to be informed while in the position of director. The opinion in this case stimulated debate on duty, the meaning of the duties of care and loyalty, and the duty to have the skill, knowledge and experience to undertake the role of director. These duties were codified in (UK) law in 1925 ("Romer J. in Re City Equitable [1925] Ch 407) ") and in New Zealand law first in 1950 and most recently in the Companies Act (1993).

The general law subdivides the fiduciary duties of loyalty and good faith from the non-fiduciary duties of care, skill and diligence (Farrar, 2005). Loyalty and good faith are

embedded in the trust which people give to another to act on their behalf while in a particular position.

Fiduciary Duty

The word fiduciary has its roots in the Latin *fides* - trust. Fiduciary duty describes the relationship of trust that directors and officers have with the organisation as an entity and which health professionals have to their patients and communities. This includes the duties of care and loyalty, the obligations of which are broad and flexible (Hinnant, 1988). The use of the term fiduciary duty has generally been descriptive of the rules and principles pertaining to individual entities which have developed over time. Finn (1977, p. 1) states: "it (fiduciary duty) is not definitive of a single class of relationships to which fixed rules and principles apply " and goes on to state that it is "because a particular set of rules apply to an individual that he is a fiduciary for its (the entity's) purposes" (p. 2). Fiduciary duty, then, is only in the context of the authority which has been given to and accepted by an individual. Therefore, directors accept their position as fiduciaries for a company as an autonomous entity and not as fiduciaries for all or particular shareholders. This is to ensure that the interests of the company take precedence over any other interests directors may have. The position exists for the benefit of others in that context only (Finn, 1977; Hinnant, 1988). Therefore fiduciary duty is a moral duty in contrast with the non-fiduciary duties codified in law discussed below. Authority to be a fiduciary for a company or DHB is under the terms of appointment and acceptance to the board. However, as discussed on page 228, DHB members have a specific responsibility to the Minister (NZPHD Act, s.37) which, along with perceived allegiances to community interests, obfuscates the obligation of fiduciary duty to the entity.

More recently there has been discussion of breadth of fiduciary duty being extended to include parties beyond the entity and its shareholders (Hinnant, 1988), such as employees, and other stakeholders such as statutory committees of DHBs. The stakeholder group might include those affected by the decisions made by the entity such as suppliers and consumers (Hinnant, 1988; Stein *et al*., 1990) and in the broader context when a company is seen as doing more than maximising the shareholder interests (Wieland, 2005). Finn (1977) argues that this type of duty is not fiduciary as those other parties have not been given and do not

have the authority to act in the interests of the organisation. As previously identified, Cumming *et al*. (2003) found that some DHB members needed the parameters of their role defined especially in relation to their perceived responsibilities to others. Crown Entity boards do not have the power to act outside of the purpose of performing statutory functions (Palairet, 2005). Therefore, there is no authority to go beyond that context although there may be other reasons for perceiving that as a board member, one has a responsibility to others.

Similarly, health professionals have a fiduciary duty to patients for whom they are caring and treating. Patients give authority to health professionals to act on their behalf through informed consent and, in New Zealand hospital services, on signing the general admission form. Conflicts of interest relating to fiduciary duty are identified in relation to doctors researching patients they are treating (Cartwright, 1988), patient vulnerability (Tolich, 2005), sexual relationships ("Director of Proceedings v K 03/116 D," 2004) and resource expenditure (McKneally, Dickens, Meslin, & Singer, 1997). However, the conundrum that occurs when the fiduciary duty resting in the corporate governance of the organisation i.e. to the DHB, is in conflict with the fiduciary duty embedded in the professional relationship (Michalick, 1999) (that is, to the patient or community), is not highlighted in the literature. Restricting governance decision-making to a particular context could resolve the conundrum. However the preponderance of self-interest to prevail as suggested by Bazerman & Chugh (2005) challenges the suggestion that two contexts, corporate and clinical, can be easily distinguished for directors who are also health professionals receiving benefit from the same organisation. The conflict which arises between duty to the organisation and duty to the patient will be discussed on page 92.

While fiduciary duty obligates the director to act loyally and in good faith and in the best interests of the organisation the duty of care requires the director to “exercise a certain degree of care, diligence and skill” (Lalanne, 2005, p. 36). In common law the three non-fiduciary duties are separate.

Duties of diligence and skill

Historically, the courts offer more specificity, arguing that the expectation of directors is care, skill and diligence of a director in that particular position as director ("Marquis of

Bute," 1892). That is, “directors” in contrast to “reasonable persons” are expected to be familiar with, and understand, the role of director in the particular company for which they have accepted a fiduciary role. Members of DHBs are only expected to take “reasonable care, skill and diligence” ("Crown Entities Act," 2004, s.56). It is also acceptable for directors who have an adequate level of knowledge and skill to call on the knowledge and skill of others to assist in decision-making when a deficit in knowledge and skill is identified, a fundamental principle in governance.

The diminution of the threshold of director to *reasonable person* in section 56 of the Crown Entities Act (2004) was in order “to provide consistent framework” and “clarify accountability relationships between Crown Entities, their board members and their responsible ministers…” ("Crown Entities Act," 2004). Thus the Act was not only to provide a set of generic rules for Crown Entities but expressly clarifies the difference between director and board member accountabilities to respective ministers.

In contrast with the codification of directors’ duties are the duties required of health professionals which are reproduced in behaviour passed from one generation to the next, underpinned by the oaths and pledges health professionals take on becoming professional. Examples are the Nightingale Pledge (Dock & Stewart, 1938) and the Hippocratic Oath (Edelstein, 1943), which nurses and doctors take respectively. These declarations require that there be no discrimination in the provision of the professional skill to persons in need, that no harm is done and that care is not withheld for any reason.

In recent times rationing has impacted on duty surrounding clinical decisions for individual patients and health professionals have sought guidelines authorized or confirmed by other legislation or case law (Feek, 1999). The concept of care is specifically reflected in the NZPHD Act (2000) s.90, in that, unlike other Crown Entities ("Crown Entities Act," 2004 s.121), DHB members and personnel must have acted in good faith by doing the right thing *and* with reasonable care through being properly qualified and current in practice and having the skills to balance resources with patient need. However, as discussed on page 58, those skills are not always present in DHB members and “reasonable” care may be open to personal interpretation. The recognised conflict faced by DHB members and clinicians

between decisions in the best interest of the patient versus the best interests of the organisation created an impetus for this study.

Section 27 of the NZPHD Act (2000) requires members to act in good faith, with *reasonable* care, diligence and skill with honesty and integrity in accordance with any code of conduct that applies to Crown Entities. Section 27 (NZPHD Act, 2000) lies within the framework of the Crown Entities Act (2004). The five individual duties of Crown Entity board members reflect the common law duties of directors. However, the duties are owed to both the entity and the Minister, as shareholder, which is in contrast to the Companies Act (2003) where the duties are owed, through the fiduciary relationship, to the company, with the recognition that shareholders have a majority right to veto. Multiple accountabilities have been identified as problematic in the previous chapter.

Under the Crown Entities Act (2004) board members as individuals must:

- Not contravene, or cause the contravention of, or agree to the entity contravening, this Act or the entity's Act (s.53)
- Act with honesty and integrity (s.54)
- Act in good faith and not pursue his or her own interests at the expense of the entity's interests (s.55)
- Exercise care, diligence and skill that a reasonable person would exercise in the same circumstances, taking into account (without limitation) (s.56) –

    (a) the nature of the statutory entity

    (b) the nature of the action

    (c) the position of the member and the nature of the responsibilities undertaken by him or her

- Not disclose or make use of, act on information that they would not otherwise be party to (s. 57) except in the following circumstances:

    (d) in performance of the entity's functions

    (e) as required or permitted by law or

    (f) when authorized to do so by the board or Minister and that the disclosure will not or be unlikely to prejudice the entity

(g) in complying with the requirements for members to disclose interests

On analysis the duties are similar to the directors' duties in the Companies Act (2003), part 8, ss.131-138. It was the intention to maintain the essence of the Companies Act (1993) to drive board discipline (A. King, 2000b). However, the second part of s.55 (Crown Entities Act, 2004) contrasts with the requirement of company directors to act in the best interests of the company ("Companies Act," 1993 s.131). Signifying a lower threshold of responsibility which accommodates ordinary people without the necessary skills of governance, DHB members are not required to act in the best interests of the entity but only that their own interests will not be placed before those of the board. While this allows board members to act responsibly as a collective in their duties to the board the clause allows members individual interests to continue, to be identified and managed. However, board members with interests, such as health professionals whose practices benefit from the decisions of the Board, have been appointed and this has been identified as the main source of conflicts of interest on DHBs (Barnett & Clayden, 2007). This has resulted in major disruptions to the activities of some boards; for example the potential of a substantial contract being awarded to a board member's company in Hawkes Bay DHB (Wilson, Clarke, & Wigley, 2008) and the Auckland Regional DHB's awarding of an eight-year contract for laboratory services to a former board member ("DML v ARDHBs and Labtests," CIV 2006-404-4724).

The fourth duty is also similar to the Companies Act (2003), however the concern is that the diligence and skill that *reasonable* people bring to the board table through the electoral process has been identified by Cumming *et al*. (2003) as not always meeting the expected standard of board members *in that position*. Those offering themselves for election need no special skill or experience and, while extreme cases of skill deficit could be managed at the appointment stage, this has not been tested. This study explores what shapes decision-making in governance and therefore the underpinning skills, experience and qualification board members require.

Transparency

Principles embedded in the concepts of duty discussed above are described by Boggust, Deighan, Cullen & Halligan (2002); openness – the means by which the government or the

organisation is managed on behalf of the public and for the public good, in as transparent a manner as possible. This is reflected in the transparent nature of public organisations, especially those in countries such as New Zealand, where public information is readily and legally accessible as enabled by the relevant legislation requiring transparency, for example the Financial Reporting Act ("Financial Reporting Act," 1993). The concept of transparency, however, is not reflected in the more common understandings of corporate governance as used in everyday business. Competition and commercial sensitivity shape the openness of boards in the market place.

The intent of government was to remove the *perceived* secrecy in decision-making of the company structure of Hospitals and Health Services (A. King, 2000b). Transparency in DHBs is operationalised through the requirement to hold board meetings open to the public (NZPHD Act, 2000, Sch.3, s.31), the Financial Reporting Act (1993) and the reporting requirements of the NZPHD Act (2000) including progress in relation to the District Annual and Strategic plans and output data (NZPHD Act, s.38, 39). The impact of the requirement for public meetings challenges DHB members' confidence in expressing situations with clarity and honesty although most boards report that few members of the public choose to attend meetings. Ashton (2006) reported that some individual DHB members, while being able to articulate their roles, still found exercising governance in a transparent manner a challenge, so boards had established strategies to ensure that debate was undertaken in other fora prior to opening to the public (Cumming *et al*., 2003). The impact of transparency, especially the inclusion of the community and the public nature of decision-making process of DHBs, on decision-making was explored with the participants in this study and is discussed in Chapter 8.

Transparency is a characteristic of trustworthiness and accountability and is important as it allows the public to have confidence in the healthcare services being provided, one of the intentions of the DHB model in response to the perceived secrecy surrounding previous models of Crown Health Enterprises and Hospital and Health Services.

Accountability

Accountability is the manner in which the organisation's officers are deemed to be responsible for their actions on behalf of and for which they are responsible to the public

Boggust *et al*. (2002). Secondly, there is no accountability without relevant and timely information and this does not happen unless directors are in a position to ask the right questions and the board understands what it is doing (Bosch, 1995). The Crown Entities Act (2004) s.61 details the circumstances when a board member may rely on the advice of others in a similar manner to part 8, s.138 of the Companies Act (1993). This includes the advice of competent employees, advisors or experts or other members or committees with statutory authority. However, members must ensure that, when taking advice, that they do so in good faith, that they make proper inquiry if the need for inquiry is indicated by the circumstances; and that they have no knowledge that the reliance is unwarranted. Therefore members should have the skill and experience to assess and be accountable for the advice they take.

The corresponding clauses in the Companies Act (1993) s.138 rely on board members understanding their obligations of good faith and having the knowledge and skills to use the information provided and to satisfy themselves that the advice they are receiving is reliable. Therefore the experience, skill and qualification of board members in being accountable become an important attribute in shaping decisions.

Independence and independent thinking

The need for independent directors is one area that has been highlighted by the literature, especially this century, following collusion amongst directors in large company collapses e.g. Enron. Van Den Berghe and Baeldon (2005) describe the ability to think independently as the prerequisite for independent directors. Leblanc and Gillies (2005, p. 158) identify the need for "independence of mind" and Garratt (2003b, p. 83) demands that all directors have a 'duty of critical review and independent thought". The extrapolation of these ideas is that the confidence of the independent thinker enables the processes of probity to retain their integrity as the independent thinker keeps check on the collective decision-making of the board.

Ashton *et al*. (2005) found that some of the democratically elected DHB members had difficulty in attaining independence, as many are elected by specific interest groups and had strong allegiances and responsibilities to represent those electorates. Elected members are vulnerable to political pressure from their electorates (Cumming *et al*., 2003; Dew & Davis,

2005; Gauld, 2005). Comparably, majority shareholders can appoint directors to ensure that their interests take priority. However, Leblanc and Gillies (2005) would contest that those appointments are not necessarily appropriate in putting the interests of the organisation first. The basis of the duty to act in good faith is the ability to be independent, no matter what the basis of appointment, coupled with having the skills and competency to operationalise that independence of mind. Leblanc and Gillies (2005) propose that director selection needs to be based on competency, behaviour, strategy and recruitment – the antithesis of the democratic elected board structure that is the DHB structure. The conclusion that New Zealand's desire for democracy in healthcare services risks with the appointment of elected members unable to think independently was explored with the participants in this study and is discussed in Chapter 8.

Probity

Probity is the means by which the organisation legally and managerially discharges its duties in an ethical manner (Boggust *et al*., 2002). For the corporate sector probity has been traditionally demonstrated through monitoring and audit mechanisms focusing on the financial health of the organisation (Cadbury, 1992). The events resulting in the collapse of major corporate entities in the early part of the century stimulated a closer investigation of how corporations were assuring probity (Cadbury, 1992; A. Davies, 2006; Fairfax, 2002). In New Zealand cases, directors have been penalized for not being sufficiently diligent (New Zealand Securities Commission, 2007cl. 154) and some corporate failures have been explained away by blaming management decision-making processes that have destroyed the integrity of the organisational learning experience or by blaming corrupt and dysfunctional behaviour of the companies' managerial elite (Pech & Durden, 2004).

Governance must be based on a foundation of "executive integrity" (Charkham, 2005, p. 23) and boards have a responsibility to ensure, *to the extent of their skills set*, executive integrity through application of leadership, technical and social skills which shape governance decision-making. However, in the United States, to assure probity, the focus moved to financial reporting and regulation ("Sarbanes-Oxley Act," 2002) which has been claimed to constrain business activity through excessive risk management (Fairfax, 2002). But in other countries including New Zealand that focus was on safety and quality in organisational activity (Farrar, 2005).

Legislation that endeavours to protect the public from fraud (Companies Act, 1993; Finance Act 1994; Financial Reporting Act, 1993; NZPHD Act, 2000, s. 27(2), s.41; Public Finance Act, 1989) and provide requirements for solvency is recognised as an integral part of the governance framework. The legislative framework is supported by professional best practice standards, particularly the New Zealand equivalents to the international accounting reporting standards.

In healthcare services clinical activity probity has largely focused on the introduction of quality and safety programmes and their audit (Benson, Boyd, & Walshe, 2006; Maddock, Kralick, & Smith, 2006; Sheps, 2006; Stanton, 2006) and a reliance on those programmes to assure probity.

A further challenge in assuring probity is to get corporate decision-makers to recognise their own limitations of understanding the governance reality. This challenge is claimed by Dixon & Dogan (2003) two of the few writers who focus on the ontological and epistemological perspectives of governance. They further question the ability of directors to treat all truth claims skeptically (so important in the specialist areas of healthcare services), and the ability to not resort to self-deception just to avoid unpleasant corporate governance truths (J. Dixon & Dogan, 2003). In a similar explanation to that given by Dixon & Dogan (2003) the researcher suggests that probity in clinical governance also explores the decision-making process in clinical reality and from the perspective of maintaining professional *social* and *cultural capital*. Probity in clinical governance is multifaceted and will be elaborated on later in the chapter.

Probity is complex. It has characteristics which range from the underpinning ethical and moral stance of the organisation, uprightness and honesty and the power of those in control, to the processes which ensure quality and safety including the qualification of practitioners and systems applied in business and clinical environments. The complexity will be discussed under the following headings; *political and social power*, stewardship and trust, the professional preparation of directors and health professionals and governance across the organisation.

Political and Social Power

Corporate decision-making is a political process. Pfeffer (1992) posits that the dynamics of power are what is called politics and it is just as evident at board levels as it is at the highest levels of national politics. The exercise of *political power* will always be evident where there are autonomous groups with common interests. However, there is evidence that groups and individuals are influenced by external alliances coupled with the promotion of the concept of stewardship, as a common good, as the primary responsibility of a board (Muth & Donaldson, 1998). Notwithstanding the influence of stewardship, there may be a risk that the politics of self-interest, as discussed in public choice and agency theory, or common interest challenges probity of an organisation. This is recognised by Charkham (1994, p.40) as a reality.

> 'No one who talks to any of the protagonists in the worlds of commerce, politics, unions or, even, in its own way, academe, has the slightest doubt that beneath the elegant logic and complex arguments, the basic dynamics are those of power. Everyone speaks their own book."

The board's role includes the exercise of power, not only in eliciting compliance, but also ensuring that decisions get made and actioned, extending across all aspects of the board's operations. The exercise of power is about the way decisions are reached, not so much the decisions themselves (Deverson 1997) and for Bourdieu (1990) using *capital* as power to influence the interplay with the *field* of governance.

The phenomenal growth in *social power* and influence demands of corporations the need to be fair [to all stakeholders] and moral in their decision-making (Rossouw, 2005). In healthcare services the demands of *social power* are reflected in the inclusion of patients and their communities in decision-making, demonstrated through elected boards and statutory committees. The public are also required to be consulted on strategic planning - the intention being to hear the community voice (NZPHD Act, 2000, s.3(c)). In relation to employees, a number of authors discuss the role of professional power in clinical governance (Alvanzo, Cohen, & Nettleman, 2003; Ashmos, Huonker, & McDaniel, 1998; Balding, 2005; Sage *et al.*, 2001; Schwartz & Tumblin, 2002; Shortell, 2004).While the *social* and *cultural capital* held by professions and professionals is recognised as both aiding and limiting quality assurance programmes, these authors do not specifically relate it

to probity, the ethics and honesty underpinning clinical decisions, within healthcare service organisations. Therefore, the influence of quality assurance programmes on decision-making in governance is an important area explored with participants.

Stewardship and Trust

O'Neill (2002) identifies trust as valuable *social capital*, and therefore power and she links the mutual trust around the board table with stewardship, an integral attribute of the board. However, O'Neill also suggests that we have a culture of suspicion brought about by a relentless need for people, especially professionals, to demonstrate accountability which, in her view, damages trust rather than supports it. The Minister has to trust DHBs to make decisions which ensure the provision of healthcare services and assure the public of the quality of those services. In DHB governance Crombie[2] proposes that board members and executives need to have trust in health professionals to use resources appropriately and efficiently. Perkins (2004b) extends the context to those making governance decisions needing to demonstrate trust through the creation of an environment conducive to best, as well as innovative, practice. Boards, who have the stewardship of public healthcare services, need to have trust of and in clinicians because, as O'Neill (2002) states, processes cannot be put in place to guarantee everything.

The trust in directors, managers and employees to undertake their role as stewards of the public healthcare services resources is paradoxically opposed to the "sacred duty of trust' (Halligan, 2006), the fiduciary duty in which health professionals accept to always make decisions in their patients' best interest. The literature, however, does not provide a link between trust around the board table and trust at the bedside and the researcher suggests that, in this study, it may be found that such a link improves decision-making in governance in all settings.

Professional preparation of directors

Probity requires individuals to be aware of and educated in the moral and ethical bases of their professional decision-making. Much *social* and *cultural capital*, power, is gained

[2] Crombie, D. 2003 in a lecture to Doctor of Health Science entrants, Auckland University of Technology

through education (Bourdieu, 1993a; Bourdieu & Passeron, 1977b). As discussed on page 79, board directors are required, in common law, to exercise an appropriate degree of skill ("Companies Act," 1993 s.37), which is both subjective and contextual reflecting the nature of the company and the nature of the decision. Cutting and Kouzmin (2000) identify director skill, developed through ongoing education, as a necessary part of any board quality assurance programme. Leblanc and Gillies (2005), and Garratt (2003) identify the lack of director education as a major consequence generated by the corporate failures of the early 2000s. Coupled with regular board and director appraisal within best practice programmes, director education may give stakeholders confidence in the future.

Hilmer (1993) considers the effect of director experience and the skills people bring to a board within the organisational structure. Cutting and Kouzmin (2000) also call for an ongoing learning experience for executive decision makers which Garratt (2005) has expanded into the “learning board” that is, the board is accountable to shareholders for developing the skills of its directors. The learning board focuses on the four key tasks of the board: formulating policy and foresight, strategic thinking, supervising management and being accountable. Garratt is therefore suggesting that the induction and education requirement should provide depth to the understanding of the role of director.

DHBs have a particular responsibility in ensuring that their members are inducted and receive on-going education (NZPHD Act, 2000, Sch 3, s.5(1)), however, that does not account for those members who are appointed from the electoral process without the intellectual ability to meet the level of decision-making, and therefore accountability, required for DHB decisions.

Not only are there traditional education programmes specifically for those becoming directors - NZ Institute of Directors, for example - but also the development of formal accreditation programmes which are in direct response to the perceived lack of skill attributed to those directors of failed companies both after the 1987 sharemarket crash (Bosch, 1995) and the more recent failures of the early 21st century (Fairfax, 2002; Farrar, 2005). To encourage qualification the Institute publishes the accredited director list. While not yet mandatory there is an expectation published by the IOD that professional directors in the commercial sector will maintain their currency in their *field* of professional *practice*.

Leblanc & Gillies (2005) suggest that a requirement for formal qualification to be a director of a board will change the way directors are selected.

The power vested in the Minister to appoint four DHB members recognises that specific experience and skill is required in governance decision-making as, in the opinion of the Minister, appointed people must be able to assist the board in meeting its objectives (NZPHD Act, 2000, s.29). People offering themselves for election and their nominators judge whether they have the experience, intellect or qualification to make the decisions of a DHB. The judgment is based on the list of desirable attributes published by the Ministry of Health prior to elections. The materiality is whether those people understand the obligations of the role as board members which they accept. Certain persons are disqualified from membership (NZPHD Act, 2000, Sch 2, 17). In contrast, company directors are appointed based on the principle that they offer skill and experience to add value to the company. The democratic electoral process cannot assure the public that those elected have the skill and demonstrated qualification, understanding of the health sector from experience within it, and corporate experience, expected of a member of a DHB (Gauld, 2005). And, while the appointment process can not give that assurance, the formality of independent selection (such as that undertaken by the Crown Company Monitoring Advisory Unit) against a required set of attributes can mitigate the risk.

New Zealand authors have identified the need for and relevance of introductory training for DHB members (Mays *et al.*, 2007) and the NZPHD Act (2000), Sch 3 s.5 (1, 2), requires board members with deficits in knowledge and ability to have access to and a record kept of training received. Identifying the attributes of educational preparation of those board members considered effective would allow targeted selection of directors and therefore manage some of the decision-making risk identified in the literature. The conclusion is that while there is a risk to the public that the elected board will not have sufficient skill or ability to attain the skills to ensure probity in their decision-making that risk can be mitigated through ongoing education. How effective that is as a strategy was identified by Mays & Cumming (2007) who found that there was considerable reliance on the skills of chairmen to manage that risk.

Preparation of Health Professionals

The legal framework for probity in clinical practice is the Health Practitioners Competency Assurance Act 2003 (HPCA Act) which applies to all health professionals. This Act requires all health professional groups to attain, maintain and discipline their members using a similar framework and a common final authority, the Health Practitioners Disciplinary Tribunal. The HPCA Act, which will be further discussed in the section on clinical governance, assures the probity of health practitioners through requiring professional preparation both in initial qualification and the on going maintenance of currency in professional practice. The Act defines for each health practitioner the scope of practice (s.11), the qualifications prescribed for each health practitioner (s.12) and the requirements for registration (s.15). The conclusion is that, to practice as a health professional in New Zealand-defined standards of education, currency and demonstrated skill are required in contrast to the desired attributes required of board members and the training relating to members obligations and duties (NZPHD Act, 2000, Sch 3, cl.5) which is conditional on *the extent practicable*. The contrast is explored later in this chapter.

Governance across the organisation

As previously identified, the Oxford University White Paper (2006) offers a discussion which identifies governance as being a set of principles which has relevance across the organisation. Designed to strengthen all aspects of the university's operations, the Oxford White Paper highlights accountability, inclusive of probity, as being the dominant underpinning principle of governance across the organisation. However, other governance literature does not focus on the relationship of decisions made at the board table to the decisions made elsewhere in organisations. For example, Leblanc's (2003) original thesis was limited to identifying the optimal conditions for a board of directors to be effective in fulfilling its tasks and to identify the director characteristics essential in the composition of such a board. The concept of a set of principles underpinning governance decision-making as discussed in the Oxford (2006) paper, but including accountability, transparency and duty, similar to that identified by Proclus (1963) and more recently others (Garratt, 2003a; Sonnefeld, 2004) is not identified in the health and clinical governance literature. Through

in-depth study of the relevant literature this was identified by the researcher as being imperative to a common understanding of governance in healthcare organisations.

Some authors in healthcare services (Bamford & Porter-O'Grady, 2000; Boyce, 2001; Campbell, 2001; Deffenburgh, 1996; Deighan & Bullivant, 2006; Porter-O'Grady *et al*., 1997) describe integrated and shared governance. However, in these examples the concept is the integration of discrete concepts of governance - financial, corporate, clinical- defined by the context in which they occur. For these authors the concepts are not considered as a collective whole. The concepts of corporate and clinical governance are defined distinctly (Higgs, 2003) and assume different rules. Corporate and clinical governance will be discussed in the next section of this chapter.

Braithwaite (2005) suggests governance as a principled process beyond the corporate function or through which decisions are made across all aspects of an organisation. He (Braithwaite, 2005) describes axioms for governing health systems. These are propositions which remind participants in the system what the underlying values of the organisation are, and the patient is placed at the centre of any decision. Although he identifies axioms as the basic rules of the game, *the illusio,* the participants, directors, management and clinicians are still described separately, operating in different and separate dimensions. For example he proposes “engaging clinicians as a complement to top down corporate governance” (Braithwaite, 2005, p. 1032). However, if corporate and clinical decision-making are to be congruent the principles on which that decision-making is made need to be the same.

As discussed above governance is rarely defined as an autonomous concept. It is most often defined by the context in which it happens for example “corporate governance” or “clinical governance”. It is first necessary to define and discuss corporate and clinical governance as discrete concepts, then the commonalities and interaction between the two will be discussed as found in the literature and as applied to healthcare organisations. For the purposes of this study it is important to know whether corporate and clinical governance are two different concepts or whether they are the same concept located in a different area of practice.

Corporate Governance

Corporate governance is described as a process which aids the direction, monitoring and authority of corporate activity, thus allowing boards to function (Leblanc & Gillies, 2005). It has been recognised that governance issues are inherently complex and directors proposing solutions must recognise that (Norgate, 2005). The key challenge is for directors and managers to get right the balance of decision-making and the levels at which it happens. Garratt (2005, p. 30) states that "the real role of corporate directors: balancing prudence with progress". Garratt succinctly describes the role as conformance – the meeting of statutory and reporting requirements with performance – stimulating the company for growth, expansion and success.

Definitions of corporate governance encompass accountability, probity, transparency, direction, control and the achievement of objectives but vary in where the emphasis is placed. For some authors governance and corporate governance have no distinction. For example:

> 'Governance is the means by which management and the organisation can be held accountable for their actions, helping to provide overall strategic direction
>
> (Shortell & Kaluzny, 1994), and
>
> 'The system by which an organisation is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability, probity and openness' Controls Assurance Standard UK *(Boggust et al.*, 2002).
>
> 'Corporate Governance is the system by which companies are directed and controlled' (Cadbury, 1992)
>
> Governance is the process through which the decision-making in organisations is planned and executed (Leblanc & Gillies, 2005).
>
> 'Corporate governance provides an architecture of accountability – the structures and processes to ensure companies are managed in the interests of their owners.' (Higgs, 2003)
>
> 'Corporate governance is a self-regulatory system which each morning puts on trial and each evening passes judgment on it. The director is the heart, mind and soul of that corporate citizen and as such has an awesome responsibility. Whilst it is an awesome one it is also a privileged one. It should be carried out with dignity, hard work and intellectual honesty". (King 2002)

The focus of descriptions of corporate governance is on structures, process, control and strategic direction. Corporate governance and the relationship to organisational performance, including decision-making, is insufficiently studied (Garratt, 2003a; Leblanc, 2003; Leblanc & Gillies, 2005). Much of the writing on corporate governance focuses on the traditional commercial organisation approach based on the historical origins of the corporation (Grayburn & Garlick, 1998), joint stock companies and the limited liability company in the 18th and 19th centuries (Bowes, 1998; Charkham, 2005; Cumming, 2000; A. Smith, 1776). These historical events had the specific purposes, first, of establishing a system to decentralise some of the activities of central governments and second, to stimulate the business process through the pooling of *capital* and the reduction of personal risk (Bowes, 1998; Charkham, 2005).

By the middle of the 20th century, in New Zealand, the principles of care, skill, diligence and good faith had been codified in company law (Companies Act 1955) and were refined, increasing the threshold of accountability and personal liability, in more recent legislation, guiding the activities of companies and Crown Entities ("Companies Act," 1993; Crown Entities Act," 2004). In the aftermath of the share-market crash of 1987 at the instigation of governments, their statutory organisations and Institutes of Directors, codes of best practice were formulated to clarify the role of boards and the duties of directors. In the UK the Cadbury Code (1992) was instigated by the Financial Reporting Council of the London Stock Exchange as a result of the loss of investor confidence following financial scandals involving UK listed companies. The code provided the first Code of Best Practice for directors. A summary of the Code states that corporate boards should:

- Provide effective leadership
- Be able to be held accountable for their actions
- Provide for a proper exercise of power (to deliver soundly based decisions)
- Encourage individual and corporate learning (through an effective decision making process)

As previously discussed, the New Zealand Securities Commission (2004) adopted many of the governance concepts of Cadbury but retained the focus of public sector issuer (companies) reporting and not prescriptive codes or standards.

In contrast, DHBs are subject to more prescriptive legislation reflecting the Crown agent class, especially their accountability to the Minister and the Minister's right to intervene and require services to be delivered, as previously identified. Board members were found by Cumming *et al*. (2003) to be challenged in understanding the parameters of their roles within the boundaries of the NZPHD Act (2000). This study, in exploring the shaping of decision-making in governance, considers the influence of rules on decision-making and whether the concept of generic underpinning principles in decision-making is worthy of being explored further.

Separation of power from governance

The separation of power from the executive to the board has its genesis in the original United Kingdom Companies Act 1855; that allowed for multiple subscriptions to company funds, limited liability, the possibility of corporate immortality, a means to provide leadership and to hold that leadership accountable to the company. As companies grew to accommodate the financial arrangements for larger and larger projects of the industrial revolution, ownership and management separated. While power and duty to be informed is lodged with the board (Chew & Gillan, 2005), management often retains the technical and intellectual capital of the organisation. Conversely, there is potential, with attendant liabilities, for management to inject itself into board decisions through the control of information. A number of authors, for example Garratt (2003a) and Charkham (2005), specify that governance, that is, the *power* of the board in decision-making, should be separate from management. The board's delegation of *power* is through the appointment of the chief executive (CEO) and by which they are accountable for the activities of the organisation to the shareholders. However, the key company intellectual capital lies with the CEO and senior management and the implications of the separation of intellectual capital from the board may include governance decision-making based on insufficient knowledge of the organisation.

Separation of management from governance

In the twentieth century the relationship between governance and management started to be further explored. Proclus (1963) identifies the key attributes of governance - politics (how much and who), management (how) and leadership (what) – and where they overlap in the exercise of governance. In so doing Proclus links the politics and leadership with management but keeps them as separate attributes. Cutting and Kouzmin (2000) further develop these attributes into a decision-making trinity. Their model is dynamic, and further describes a number of trinities underpinned by these basic preferences of primary governance, politics, management and leadership. It is the movement between the various trinities which explains how individuals and groups come to an understanding and knowledge sufficient to make decisions and act on those decisions (Cutting & Kouzmin, 2000). However, neither Proclus, in his original work, nor Cumming and Kouzmin with their more recent model explore what it is that shapes the decision-making of individuals entering the group decision-making trinity, for example, a board.

The separation of the functions of the board and management has developed to the point where the principles of governance are not evident in management's role (Drucker, 1999). Specific roles are recognised which support board activities, for example, a company secretary. The separation of board and management functions compartmentalises their respective functions and exploration of their influence on decision-making was undertaken with participants in this study.

Conflict of Interest

Precedents set common law (Romer J. Re City Equitable [1925] 1 Ch407) and the Companies Act (1994) s.131, defines the fiduciary duty of a director to a unique entity, the company. As discussed on page 67 in contrast Crown Entity directors and board members have a collective duty to the responsible minister but not to the entity itself ("Crown Entities Act," 2004 ss 49-51) which allows direct intervention by the Minister. Correspondingly there is no financial liability for DHB members. Although the legislation makes accountability to the minister and management of conflicts of interest clear, elected members of DHBs have a *perceived* duty to act in the best interests of their electorates as identified by Cumming *et al*. (2003). The risk of conflict of interest created by the election

of directors from the community, and their inherent areas of interest, is acknowledged. Cummings *et al*. (2003) and Ashton *et al*. (2005) confirmed this in their ongoing study of DHBs, citing that while board members recognised the duties accompanying the board member role, some had difficulty in adhering to the guidelines because of the role of the minister and the *perceived* allegiance to their electorates. The latter is confirmed by Gauld (2005) in his review of the election process and by the Auditor General in the guidelines for public entities (Brady, 2007). Therefore there is potential for *perceived* conflicts of interest to influence decision-making and this is explored with participants in this thesis in Chapters 6, 7 and 8.

Potential and actual conflicts

The Crown Entities Act (2004) recognises the potential for conflicts of interest to arise within DHBs. The Act details the process through which conflicts should be identified and managed through disclosure prior to appointment and maintenance of an ongoing register of interests ("Crown Entities Act," 2004 s.62(2)). This is also highlighted by the Auditor General (Brady, 2007) in his advice to board members of Crown entities. But, as Ashton *et al*. (2005) found with Waitemata DHB, some members continued to have difficulty in recognizing when conflicts of interest occur, questioning whether they are acting in good faith. And while Boards and their officers have responsibilities in managing conflicts of interest once disclosed by members (NZPHD Act, 2000 Sch 3 s. 36), there is a gap in the understanding of how conflicts of interest can and should be managed within the healthcare services sector of a small country where conflicts are expected to occur.

The Crown Entities Act (2004) ss. 62-71, details what a board member must do if a conflict of interest is established. Those actions include not voting or participating in an activity of the entity that relates to that matter, not signing a document relating to the transaction in question and being disregarded for the purposes of forming a quorum. However, members who have made a disclosure (sch 3 cl 36) may continue to participate in deliberations if a majority of the Board permits them to do so. This is incongruous with the concept of managing conflicts of interest by removing the conflicted board member from the discussion. Board members with an interest have a duty to act, including exempting

themselves from discussion, but evidence from Hawke's Bay DHB suggests that this is not always done (Wilson *et al*., 2008).

The obvious conflicts of interest include the general practitioner board member in the allocation of funds for primary health care and pharmacists in the setting of dispensing fees funding by the DHB. Ashton *et al.* (2005) found that, on the whole, DHB members acknowledged and accepted their statutory roles as laid out in the legislation. But it was clear from their interviews that individuals took time to get to grips with their responsibilities as they have a duty to do (Ashton *et al*., 2005). Coupled with the Hawke's Bay DHB example, it is therefore questionable whether the processes for managing such conflicts of interest, once identified, are robust enough as judged in "DML v ARDHBs and Labtests", CIV 2006-404-4724. The influence of the potential for conflicts of interest on decision-making is explored in Chapter 8.

Duty to organisation v. duty to patient

In the internal organisational context of the healthcare services there is a tension between the duties of care, skill and diligence to the organisation as board members and managers (directors and officers) and the duties of care, skill and diligence to patients. The subject has been the basis for some rationing debate (Department of Health (UK), 1998) as discussed in Chapter 3, p.60.

The Health Practitioners' Competency Assurance Act (2004) has gone some way in placing the professional duty of care to the patient as a primary duty in healthcare services being at the same level as the health professional's legal duty to the organisation, as officers of the organisation. However, the health professional, as caregiver, may, at times, have duties which could be considered in conflict with duties as an officer or employee. Although tested between the role of practising clinician in a part time management role ("McGechan, J in Cullen v Preliminary Proceedings Committee AP 225/92," 1994) when the doctor's duty to his patients was considered to outweigh his responsibilities as manager of the service caring for his patients, this has not so far been tested between the duty to patients as clinician and duties to the entity as board member or director in New Zealand. The Health Commissioner's office indicates that this would be considered in relation to the Code of Patient Rights ("Health and Disabilities Commissioner Act," 1996) and considered on a

case by case basis.[3] Enquiry into the relationship between the health professional, as an employee, with their organisation and with their profession, may demonstrate an influence on shaping their decisions in the clinical environment and will be part of this study.

In a similar manner to the relationship between health professional and organisation, recognition of the patient as stakeholder in governance decisions will be explored with the participants. Andrews (1987) would contend that there is a moral /ethical perspective and that stakeholder recognition is appropriate to the desired level of contribution to society, in this case the desired level of a participation in decision-making in healthcare services. Therefore the level of patient participation in decision-making in governance has some importance. The level of importance was considered with participants in this study.

Another issue which is not explored in detail in the literature is the relationship between corporate governance and clinical governance within healthcare service organisations. Healthcare services raison d'etre is the provision of healthcare services but few writers identify clinical governance as the driver of the Boards' activities and, while DHBs recognise the input of clinicians through advisory positions, clinical governance is largely related to quality assurance (Crombie, 1999). Boggust *et al*. (2002) at the NHS Clinical Governance Support Team do recognise clinical activity as the driver of governance, however their strategies for changing to a model which reflects this are proving difficult to implement. This has resulted from the initial implementation of clinical governance as a quality issue, rather than a governance issue as identified by a number of critics (Boggust *et al*., 2002; Campbell, 2001; Harrison & Lim, 2000; Harrison & Lim, 2003). Clinical governance as a quality assurance initiative was easily explained to health professionals. But explanations of clinical governance underpinned by a set of principles, similar to that described in corporate governance earlier in the chapter, do not appear in the literature and needed further exploration.

Clinical Governance

Clinical Governance is defined as:

[3] Personal communication with the Office of the Health and Disabilities Commissioner, December 07

"…a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish" (Campbell, 2001; Harrison & Lim, 2000).

The concept was defined by the United Kingdom National Health Services (NHS) to confirm the requirement for standardisation quality of service (Secretary of State for Health, 1997) in contrast to the definitions of corporate governance which focus on structure, process, control and strategic direction of organizations, as discussed on page 87. Clinical governance was first mooted by clinicians in the United Kingdom in the early 1980s, as a way to hold on to the power and authority related to decisions about patient care, the associated resources and therefore political power within health institutions. This guise, as it is purported by Harrison and Lim (2003), was not about quality. A number of authors (Harrison & Lim, 2000; Harrison & Lim, 2003; Peirce, 2000; Sage *et al.*, 2001) suggest that this ideologically-based process is about wrestling the power from clinicians through the standardisation of professional practice, and therefore clinical decision-making, and the removal of autonomous decision-making in patient care issues. The researcher's view is that the challenge to the authority of professional decision-making is a challenge to the *social* and *cultural capital* of the professions and therefore their power. The tensions within the *field* of governance in the clinical environment and the impact on decision-making required further investigation and are a focus of the analysis in the *field of practices* in Chapter 6.

Risk management

Clinical governance includes action to ensure risks are avoided, adverse events are rapidly detected, openly investigated and lessons learned, good practice is rapidly disseminated and systems are in place to ensure continuous improvements in clinical care" (Department of Health (UK), 1998, p. 2). The key criticisms of this as policy is that these and other definitions do not identify, clearly, in what sense clinical governance actually constitutes governance at all as opposed to the processes of quality assurance (Campbell, 2001; Harrison & Lim, 2003). Campbell (2001) supports the contention that clinical governance, through its focus on quality assurance, has omitted its responsibility as a governance tool and he questions which services should be being provided. In the researcher's view the

strategic direction of clinical services and the ethical basis on which those decisions are made is neglected. Campbell (2001) goes on to question whether clinical governance is just a buzzword designed to create an illusion of innovation and reform.

Quality assurance programmes as a risk management tools are only one area in which governance is operationalised. Other aspects of governance are given much less attention by the authorities or left to the traditional forms of management; for example the moral and ethical principles in decision-making are often left to the debate of the professions. The separation of aspects of governance in clinical activity and its impact on clinical decision-making is seen in exploration in this thesis.

No matter what the arguments over power and quality the introduction and bedding down of clinical governance takes time, most especially in large cumbersome organisations such as the NHS of the UK (Boggust *et al*., 2002). In the New Zealand environment the focus on audit has been all-consuming for some organizations, over-shadowing the purpose of organisations as described by Kenny (2002) and Power (1997). For example the Waikato DHB [4] has withdrawn from the formal accreditation process because the value gained was considered insufficient to warrant the expenditure in light of the certification requirements under the Health and Disability Services (Safety) Act (2001). O'Neill (2002) too suggests that the focus on audit tells people that they are not trusted to undertake their professional roles and this has led to a crisis of trust. The conclusion is that audit has overwhelmed other attributes of governance and suggests the probity functions, including audit, of governance need to be embedded in the clinical activity. An important question to explore is how audit impacts on the shape of decision-making, specifically in clinical governance.

Power, authority and control

Campbell (2001) refers to the origins of corporate governance in business management theory in which business is managed according to a known course or plan facilitated by defined structures. Pfeffer (1997), however, highlights that one of the dimensions of managerialism important to health professionals is the reduction of status distinctions and

[4] Waikato DHB press release 29 March 2007, "WDHB withdraws from Accreditation"

barriers across all corporate levels. This key characteristic of employee behaviour has been ignored in some of our large healthcare organisations in the recent past (Sage *et al*., 2001).

Harrison (2003) has gone so far as to suggest that the introduction of clinical governance was a way for managers to keep control over the business of healthcare organisations. The researcher's view is that the deficits in managers' understanding of clinical practice and management of the clinical environment influence managers' decisions, which in turn impact on clinical activity. This also raises questions about whether or not the issue is one of power rather than decision-making for clinical excellence and quality.

Gray (2003) suggests that clinical governance is an elastic concept interpreted differently depending on the people and the context they are in. It is multifaceted in terms of both constituents and perspectives, it appears as structure (Rowland, 2003), as process (Rashidan & Russell, 2003) and as behaviour (Mahmood, 2003; Moran, 2003). Clinical governance embraces providers and their representatives (Harrison & Lim, 2003) and patients and their representatives (Quennell, 2003). It employs the carrot-and-stick metaphor to coerce health professionals into participation (Rowland, 2003); and it is informed in both study and practice by the history of the management of UK NHS health care services. Clinical governance is also used as a traditional command model to reinforce a rule-based system of care (Rashidan & Russell, 2003). We have similar experiences in New Zealand where there are strict guidelines and measuring tools to establish who should receive care and who should not in some services, e.g. cardiothoracic surgery guidelines (New Zealand Guidelines Group, 2003). The conclusion is that there are a variety of interpretations and understandings of governance in clinical activity, predominantly with a focus on quality assurance. The interpretation of governance in clinical activity as quality assurance masks the operationalising of the other aspects of governance identified in the literature, for example transparency, accountability and fiduciary duty. The potential for confusion in interpretation is high and has the potential to impact on governance decision-making in clinical activity.

The literature tells us that there are different definitions and interpretations including the power and control of clinical activity, but omits the effect, if any, that such differing interpretations of the concept have on decision-making in clinical governance.

Integrated governance

Integrated governance is a recent term used to describe the inclusion of clinicians on boards of healthcare organisations (Deighan & Bullivant, 2006). The purpose is to reflect the need for clinical input in corporate decisions and not necessarily to enhance clinical decision-making. In New Zealand Barnett & Clayden (2007) found very little evidence that senior clinicians had engaged with their boards. And Halligan (2006) found that few authors, for example Porter-O'Grady *et al*. (1997), have progressed to the patients (or populations) decision-making as being the centre of clinical governance. This means that there is gap in "integration" if the subject of the healthcare services is omitted from the decision-making process. In comparison, Oxford University (2006) offers a governance process which emanates throughout the organization, recognising the integrated character of the research and education services it provided with the student at its centre.

Porter-O'Grady *et al*. (1997) also propose "whole systems shared governance" in which the operations services and governance function must be reconfigured so that policy, direction and point of service decision-making intersect in a much more meaningful way. However, point of service decision-making can only happen within an environment designed and maintained to allow that to happen. This environment needs to be designed to include health professionals understanding the roles and functions of others within an interdisciplinary team and this needs to be coupled with an understanding of the discourse context of each health professional group.

Health Practitioners' Competency Assurance Act (2003)

The context of decision-making in governance for health professionals is framed by the HPCA Act (2003) which was the end result of the investigations into professional research practice at National Women's Hospital in 1986 and 1987. In that example, doctors conducted medical research on their own patients and without the consent of patients thereby thwarting the trust embedded in the fiduciary relationship with those patients. The investigations were popularised by Coney (1988) as "An unfortunate experiment". This was followed by the Gisborne Cervical Screening disaster (Duffey, Barrett, & Duggan; McGoogan, 2003) in which the pathologist was not current in his practice similar to the inadequate level of practice of a Northland gynaecologist (Cull, 2001). The key intents of

the Medical Practitioners Act (1995) have been assumed by the multidisciplinary HPCA Act (2003) which focuses on practitioners' duties of care, skill and diligence while practising as health professionals. That includes their preparation for registration and practice and the maintenance of that registration through competency measurement and the disciplining for misdemeanor. Comparably, the Health & Disability Commissioner Act (1994) is designed for protection of the public and their rights and obligations of healthcare service providers which are detailed in the Code of Patient Rights (Health and Disability Commissioner, 2004).

The relationship of the professional requirements within the HPCA Act (2003) and decision-making in clinical governance are yet to be explored in the literature. However, there is an expectation by health professions and employers, especially DHBs, that the requirement for health professionals to demonstrate currency will have a positive impact on the quality of healthcare services decisions and delivery (Godbold & Diesfeld, 2006).

Rationale of the thesis

The context of the structure and organisation of the New Zealand public healthcare service has had several forms in the past two decades (Mays *et al*., 2007). The rules which bind healthcare services through legislation have changed significantly in the past decade ("Companies Act," 1993; Crown Entities Act," 2004; New Zealand Public Health and Disability Act," 2000). The democratisation of healthcare services has not produced the outcome(s) of community participation desired by the current government possibly because of the complexity of the organisational structures although this has not been commented on by researchers. The public appear to be disinterested and turnout for elections has been low (Barnett & Clayden, 2007; Tenbensel, 2007) and the use and function of the statutory boards has varied between DHBs (Mays *et al*., 2007; Tenbensel, 2007). Contrary to the intent, democratisation at the DHB level makes healthcare more political and subject to the vagaries of the ideologies of the day (Gauld, 2002a, 2005).

Evidence from the governance literature suggests that the subject is now being investigated by many authors (Bosch, 1995; Brown, 1995; Brustad, 2000; Cain *et al*., 2005; Charkham, 2005; Chew & Gillan, 2005; Cutting & Kouzmin, 2000; A. Davies, 2006; Filatotchev, 2007; Garratt, 2003a, 2003b; Hilmer, 1993; M. King, 2002a; Leblanc & Gillies, 2005;

Sonnefeld, 2002, 2004). Governance is the process through which the decision-making in organisations is planned and executed (Leblanc & Gillies, 2005). Governance is underpinned by the principles of duty, transparency, accountability and probity (Farrar, 2005). Clinical governance has its focus on skills to assure quality clinical practice (Harrison & Lim, 2000) and in so doing it obscures the underpinning principles of duty, including care, transparency and accountability.

The deficits identified in the literature fall into five topic areas which are worthy of further investigation, with a focus on their impact on decision-making in governance.

Firstly, the context of the New Zealand healthcare services, particularly the response to changes in governance and organisational structures has been analysed and documented (Ashton, 2006; Ashton, Mays *et al.*, 2005; Barnett & Clayden, 2007; Cumming *et al*., 2003; Gauld, 2005; Mays & Cumming, 2007; Mays *et al.*, 2007; Perkins, Barnett, & Powell, 2000; Tenbensel, 2007; Tenbensel, Mays, & Cumming, 2007). However, while these authors have identified much that is right and wrong with governance in the public healthcare services, the role of individual decision-making has not been their focus.

Secondly, the need for further research into the impact of leadership, qualifications of individual directors, board and management relationships, the operation of the board and its decision-making processes, the human condition in board decision-making and the fit between directors was identified by Leblanc (2003). His thesis proposed a model of characteristic types of directors (2005). However, his research was not designed to delve into the reasons why or how directors make decisions and whether they were influenced by contexts outside of the boardroom. The impact on decision-making of specific attributes and characteristics, similar to the concept of *habitus* as described by Bourdieu (1990) and the impact of emotion of individuals, described by Damasio (2005), has been established as important. As discussed there is a dearth of qualitative research in governance (Leblanc, 2003) and no other investigations of the impact of personal characteristics on decision-making in governance in healthcare services were identified.

Thirdly, there is considerable discussion about the impact of duty on decision-making based on case law (Farrar, 2005), common law (Finn, 1977), agency, stakeholder (Freeman, 1984) and values theory (Seedhouse, 2005). While the impact of duty and conflicts of

interest are specified in the legislation and guidelines to DHB members, recent examples of the management of conflicts of interest have indicated both confusion over Boards' responsibilities and a paucity of direction to board members (Brady, 2007; DML v ARDHBs and Labtests," CIV 2006-404-4724; Labtests Auckland Limited v ARDHBs and Diagnositc Medlab Limited," CA154/07; Wilson et al., 2008).

Fourthly, health professionals are assumed to make certain decisions in favour of their patients based on both reproduced behaviour (Bourdieu & Passeron, 1977b) and the taking of symbolic oaths (Dock & Stewart, 1938; Edelstein, 1943). The assumption of duty is now legislated in the Health Practitioners' Competency Assurance Act (2003) through published scopes of professional practice. Decision-making in practice is supported by clinical pathways (Rashidan & Russell, 2003), best practice guidelines (Cochrane) and rationing guidelines (Feek, 1999; New Zealand Guidelines Group, 2003). The impact of duty, especially fiduciary duty, in decision-making in different areas of healthcare organisations is complex. Notwithstanding the different source of the trust, duty of care to the patient and duty of care to the organisation as the same duty has not been canvassed extensively by the literature. This is possibly because few cases have arisen or because clinicians have assumed that their duty to patients outweighs their duty to their organisations as employees or board members.

Finally, that the decision-making in corporate and clinical governance may be in conflict with each other has been identified in the literature (Harrison & Lim, 2003; Roland, Campbell, & Wilkin, 2001; Sage *et al*., 2001). As discussed, a few cases reflecting conflict in governance decision-making in healthcare services have reached the courts and/or professional disciplinary committees, and they have involved the clinician in manager decision-making rather than governance decisions of the board. From the researcher's personal experience coupled with that of others, duty to patient over duty to the organisation is often the subject of anecdotal discussion. On only one occasion is the interrelatedness of corporate and clinical governance identified and Deighan (2006) specifically recognises the "types" of governance as being separate and separated concepts. The categorising of governance by the context in which it happens, i.e. *clinical* governance, deliberately obscures the underpinning principles of acting transparently, with accountability and in good faith on behalf of others.

A summary: Key research issues for study

If what shapes individual and group decision-making in governance is identified, then the context of governance in public healthcare services can be made visible and therefore facilitate effective healthcare services. To do this the researcher must elicit an understanding of the impact on decision-making of:

- the attributes of individual board members and health professionals – the *field of practices*
- the context of the group in making decisions – a *social topology*
- the context of the healthcare services organisations - the *structure of the field*
- the principles which underpin governance decision-making in healthcare services – *the structure of the field*

That is:

The shaping of decision-making in governance in the New Zealand public healthcare services.

The study of people in the context of their professional decision-making requires a research process which includes individuals, groups and the environments in which they make decisions. The chosen methods will be discussed in the following chapter.

Chapter 5

The Process of Data Collection and Analysis

Introduction

This chapter describes the methods used to collect data, undertake analysis and provide rigour to the study. The methods used were chosen to best fit with the underpinning framework of Bourdieu. The primary concepts of *habitus*, *field* and *capital* recognise the place and practice of individuals as part of the governance team within the context of their organisations, the *economy of power*. Bourdieu's framework of *capital*, through the recognition of power and its use, allows the identification of the tensions and struggles within the participating groups and allows the individual responses to be analysed in relation to their roles as both an individual and as a member of the group being studied.

The steps taken to ensure an ethical process are outlined for the research based on Bourdieu's research method. The participant selection and interview process are described along with the active nature of both the individual interviews (Holstein & Gubrium, 1995) and the focus groups (Krueger, 1994), data collection and the analysis process. Trustworthiness of the data was assured using Guba & Lincoln's (1989) method and the triangulation within Bourdieu's research method.

Bourdieu's approach to research is an holistic approach designed to elicit data which recognises the individual as having durable dispositions simultaneous with being dynamic beings responding to their environments. Each individual may also be a catalyst for group and environmental responses.

Bourdieu's research method

The choice of Bourdieu's research method has been discussed in Chapter 2. In summary Bourdieu proposes a general research method:

- The *field of practices* is related to the broader *field of power* which allows for an investigation into the stratification of the *capital* base of the research environment.

- The research structures a "*social topology*", the relationships between the individuals or groups who hold opposing positions as they compete for their position to be recognised as the more legitimate.

- The research must determine the *structure of the field*(s).

Stemming from Bourdieu's sociological background, immunity from the ethnocentrism of the observer is a key characteristic of his approach (1977a). The ability to be reflexive, applying conscious attention to one's own position, one's own *habitus* and set of dispositions and their demonstration in different circumstances, allows the researcher to be flexible and responsive to data as it is presented during the research process.

Using Bourdieu's research method as a guide, the first stage in the research process was to consider the literature, to look at the wider *field* of the practice of governance and the social space of the healthcare services in New Zealand. Secondly, with the guiding concepts of *habitus* and *field*, the study needed to construct a "social topology" (Jenkins, 1992) of the participants as individuals. This was done by using a process of individual active interviews as described by Holstein & Gubrium (1995). The active interviews also allow exploration of the class *habitus* which the individuals bring to the *field* and their *social trajectory* in attaining balance within the governance *field*. Focus group method as described by Krueger (1994) was chosen to contribute to the construction of the *social topology*. Focus groups allow for people and the tensions between them to be considered in the context of the *field* in which they occur. Focus groups acknowledge individuals within the group in which they make governance decisions.

Lastly, the *field of practice*, the environment of governance in healthcare which is formalised through the electoral and appointment process of the DHBs was observed.

Experience in many of the roles of the participants allowed the researcher to take a reflexive approach within data collection and analysis, but at the same time Bourdieu reminds the researcher to be conscious of one's own *habitus*, thoughts and opinions which come from that experience (Bourdieu & Wacquant, 1992b).

To complement Bourdieu's research method Guba's (1989) model for the assessment of trustworthiness of qualitative data was selected and the study methods were triangulated.

Triangulation of the method

Triangulation occurs when several methods are used to study the same phenomena (Denzin & Lincoln, 2005). Denzin (1989) identified three types of triangulation: convergence of multiple data sources, the convergence of data from multiple data collection sources which he named methodological triangulation, and investigator triangulation where more than one researcher is involved in the research. This study triangulated data from multiple collection sources through gathering data from individual interviews, focus groups and formal board meeting observations. Triangulation is used for two distinct reasons, confirmation and completeness (Breitmayer, Ayres, & Knafi, 1993). In order to ensure that the data collected was as dense as possible several data collection sources were chosen, active interviews (Holstein & Gubrium, 1995), focus groups (Krueger, 1994) and non-participant observation.

Choice of participants

The sampling of participants was purposive in that the researcher invited individuals in governance roles who were known to be enthusiastic about participating in research and who were also known to be committed to doing things "better" in healthcare services. The participants in the sample were considered by the researcher to be knowledgeable enough to discuss the topic, to recognise the impact of organisational structure and relationships on the topic and to be able to give a sufficient range of opinion relating to governance in DHBs. In all cases the participants had demonstrated a heightened commitment to the provision of healthcare services which confirmed the participants as being suitable for the study for the researcher as they had deeply considered the process they were part of and able to provide rich data.

Four participants were chosen from three DHBs (n=12); from a cross-section of chairmen, chief executive officers and senior clinicians. The latter included doctors from surgery, medicine, and an alternate specialist involved in planning and funding. Nurses from both clinical directorships and management levels were included.

Chairmen and Chief Executives were chosen because of their breadth in understanding of the New Zealand public healthcare services, gained from experience and service as elected or appointed board members, directors and managers.

The clinicians were chosen because of their continuing roles in direct patient/client care and because they had been active in their professions for many years providing a view through a range of historical contexts. This included an historical perspective when appropriate and access to organisational memory. By choosing participants with robust credentials as business and health professionals the researcher was strengthening the credibility of the data provided for the study.

Access to participants

Three DHBs were purposively chosen for ease of access and researcher knowledge of the organisation over time. The DHBs are established under the NZPHD Act (2000) and therefore fit the criteria as public healthcare service providers.

The three DHBs serve populations ranging from 200,000 to 465,000 in metropolitan and rural areas. These DHBs do not stand out as having unique characteristics as healthcare service organisations. This allowed concepts and ideas of the organisations gathered as data to be considered transferable across DHBs. The influence of different organisational sizes and geographical locations on governance decisions was limited as governance decisions incorporate the characteristics of the organisation within its environment.

Initial contact was made by telephone and followed up by email with information on the study, time involvement expected and suitable dates for interview.

In the case of one senior medical clinician the request was referred to the Chairman of the Clinical Quality and Safety Board of the organisation to approve the participation in the study. For this approval process the full research proposal was made available for study.

After informal agreement to participate was gained, each participant was sent a pack including: Consent to participate in Research form, a Participant Information Sheet and suitable times for interview (Appendix 1). All interviewees signed a consent form (Appendix 2) having previously had full information about the project and an opportunity

to ask further questions prior to interview. Only the one participant mentioned above had required the full research proposal.

Ethics

Application was made to the university's ethics committee, AUTEC, using the official application form EA1 (Appendix 3).

Ethical considerations included the potential for identification of personal patient information, as well as the potential for the identification of sensitive commercial and political information relating to DHBs and their employees. No personal patient information was to be elicited or sought for the purposes of the study and any discussion concerning patients would be generalised.

All interview and focus group recordings and transcriptions are confidential to the parties involved. The transcribers signed a confidentiality agreement (Appendix 6).

With respect to the bicultural requirements of the Treaty of Waitangi, Maori participation was considered as being part of the overall governance within New Zealand healthcare services. Particular Maori participation was not considered as being germane to the subject. One participant was Maori. Participants were encouraged to consider their responses within the interview and focus group process from the perspective of the Treaty of Waitangi.

AUTEC sought verbal clarification from the researcher concerning the use of patient/client information. No identifiable patient or clinical information was to be used in the study. AUTEC referred the application to the northern regional ethics committee of the Health and Disability Commissioner's office because of the context of the study i.e. the interface between corporate and clinical governance. After deliberation the application was returned to AUTEC with authority to give approval for the study (Appendix 4).

Data collection process

The Active Interview

The active interview as described by Denzin and Lincoln (1998) was chosen as the most suitable data collection process to enable the researcher to explore topics with participants

guided by a semi-structured interview guide (Appendix 5). This provided the opportunity to uncover the individual's *habitus* and *field of practice*-the context within which they worked. This process allows assessment of the individual's *habitus*. Within the active interview both the interviewer and interviewee participate as equal partners in the discussion guided by the issues and questions of the guide (Appendix 5). In order to do that the interviewer must be informed of the setting and context of the discussion, the *field of practice*, so that exploring the questions may be undertaken with ease and, along with the interview guide, balance the power within the researcher/participant relationship. Both the researcher and the participant can develop their understanding of the issues of concern, and be reflective as the interview progresses. The immediacy of the process ensures that the participants and the researcher can explore issues as they arise.

The active interview is a dynamic process which accommodates "shifting narrative positions……throughout the interview" (Holstein & Gubrium, 1995, p. 77).

Holstein & Gubrium suggest that the active interview allows the participants to express points of view on one issue from different perspectives. "The contradictions and complexities that may emerge from positional shifts are rethought to signal alternative horizons and linkages" (Holstein & Gubrium, 1995, p. 78). The process allows parallel expression of Bourdieu's position that individuals can have multiple literacies, described as *metaliteracy* by Webb, Schirato & Danaher (2002).

Individual Interviews

Interviews were conducted during the winter of 2004, usually in the interviewee's office although two were conducted at the interviewer's place of business for convenience purposes only (the location was close to the interviewee's residences).

Interviews were scheduled and held to suit the participants both in time and venue and arranged to limit the opportunity for interruption by usual responsibilities. For two DHBs confidentiality was maintained at this time through the researcher personally receiving the participants at her place of business after hours or by discreet reception at the participants' offices. For the third DHB all interviews were undertaken on the same day and all four

participants were aware of each other's part in the research but other staff were not aware of the reason for the researcher's presence at the institution.

An individual interview, using the semi-structured interview guide (Appendix 5), was undertaken to enable structure to the data after transcribing. This also elicited some standardisation in responses and ensured that all issues/questions were introduced to the interview by the researcher which strengthened dependability of the data elicited. Responses in this initial interview provided the catalyst for further enquiry, in the critical manner (Thomas, 1993), both within the interview and later during the focus groups. Interviews were recorded and later transcribed with further transcription by the researcher. Two participants requested the interview guide prior to the event. Individual interviews lasted approximately one hour.

The first part of the interview guide focused on exploring the *habitus* of the participants, especially the *habitus* in particular cultural *field*s in which decision-making occurs. The questions were ordered from a personal introduction, to the topic of individual understanding of the role of governance. The next question related to how the participants saw themselves undertaking a role in governance and the place(s) where governance occurs. The interview guide then moved the interviewees to a more personal level asking what attributes, dispositions, they thought were important to have in decision-making in governance and whether the individuals felt that they had those attributes.

In the second part of the interview the questions were designed to explore tensions and struggles within the decision-making *field of practice*, that is, governance. The interview then moved to the context of decision-making in governance, within the DHB and a national healthcare service. For example, the participants were asked if they ever felt constrained in their decision-making and if so, by what?

At the conclusion of their interview, individuals were, based on previous information given, invited to participate in a focus group with other participants from their specific DHB. The focus groups were facilitated by the researcher, and recorded and transcribed. One participant from each of two groups was unable to attend the scheduled focus group; one because of change in role and one because of travel commitments on the day arranged for interview.

Focus Groups

Focus groups were identified as the means by which participants could be observed as individuals within a group and discussion could take place concerning the group decision-making process. Focus groups are also designed, through planning and active conduct of the process, to imitate the usual or natural context (Krueger, 1994), in this case, that in which decisions are made by the group. Focus groups were chosen as not only did they allow observation of the group but also allowed the continuation of reflexivity (Bourdieu & Wacquant, 1992b) into the data collection process by the researcher and the participants.

The focus groups were held in the early part of 2005. One was delayed until May because of sabbatical leave of one participant member. The data provided through the analysis of this participant's individual interview was of sufficiently significant quality to consider that his contribution was important to the study.

The focus group sessions lasted one hour and were guided by the emerging themes identified by the researcher from the individual interviews. This process also allowed Bourdieu's reflexivity to be continued as part of the research method.

The researcher observed a feeling that the focus groups did not offer the constructive dialogue expected at the outset of the study. There was repetition from the individual interviews and the researcher was challenged to move the discussions through the guide. The focus groups, did however, provide confirmation of the data through consistency in what had been previously stated within interviews.

Notwithstanding the repetition, the data has been analysed using the same process as that for the individual interviews (see page 107).

Observation of participants in formal governance process

Observation of the formal board meetings was chosen as the method by which data gathered from the individual interviews and the focus groups could also be confirmed. The density of the data, in some specific areas was improved as the board meetings demonstrated what the participants had said in their interviews. The researcher was able to observe from a perspective informed by the data gathered in the interviews and focus groups. This allowed for further reflexivity on behalf of the researcher.

Chairs, Chief Executive Officers and one clinician were observed in the formal board decision-making context. At two of the board meetings there was one member of the public other than the researcher, at the third meeting there were no other members of the public present. Notes were kept of the observations and interactions and formed part of the analysis process.

This aspect of the study did not offer any new material on the decision-making process; however, the outcome was positive as the data collected previously, especially that concerning the location of the shaping of decisions, was reaffirmed.

Data Analysis

Analysis of data collected within the active interview focuses on the process through which understanding of the question is clarified and built upon during the interview. The researcher was responsive and adaptable to the different directions the participants wished to explore in relation to the question. The analytical process enables a reconsideration of traditional or accepted notions of decision-making and understanding of governance. This process is no less rigorous than more "scientific" approaches. "This [a more artful approach to analysis] does not mean, however, that analysis has any less [rigour]; quite the contrary, active interview data require attention and sensitivity to both the process and substance." (Holstein & Gubrium, 1995, p. 79).

The transcripts were analysed in three phases underpinned with the generative structuralism described by Bourdieu (Harker *et al.*, 1990). In Bourdieu's theory the *habitus* is never really separated from a universal generative structuralism. Bourdieu appeals to strategies but not to rules, binarism but not to formalism (Schusterman, 1999).

The first phase involved the colour coding of statements reflecting the words and phrases which reflected *habitus*, *field* and *capital*, the three dominant concepts of Bourdieu.

As the researcher became more familiar with the process and the application of the theoretical underpinnings of Bourdieu to the data, the data coding was reviewed many times, enabling more accurate colour coding into the three dominant concepts. The review process allowed the researcher to be reflexive in the interpretation of data.

The second phase identified key words or statements made by each participant as examples of Bourdieu's concepts and the frameworks of *social, cultural* and *symbolic capital* including the supporting concepts of *reproduction, misrecognition, doxa and illusio*. These statements were grouped on individual interview spreadsheets. Because many statements could be explained as examples of several or a number of concepts or a crossing over of concepts, the researcher identified a need to unpack the data further in order to refine the emerging themes. This reflexive approach enabled the researcher to consider the data from different perspectives e.g. clinical, governance, and management perspectives which represented the *fields of practice* of the participants.

The third phase involved immersion in the data and consequential analysis which identified themes and their underlying characteristics within the statements made by the participants. Deeper immersion enabled the categorising of those themes to the characteristics of governance, accountability, transparency, probity and fiduciary duty, as identified from the literature search. Parallel themes identified during this phase were the power and tension in *fields of practice*, quality and safety, professional maturity and the conflict between duty to the patient and to the organisation.

The analysis was a cyclic process, which proceeded alongside the data collection, allowing for re-viewing of both data from the individual interviews and the questions created for the focus groups as the researcher identified a way forward in the research. It was a dynamic and emergent process allowing for rich descriptions of the data to be made.

The analysis of the process of decision-making at Board meetings demonstrated the formality of procedure rather than the thought-provoking discussions experienced in individual interviews and focus groups. Rather than being dynamic experiences where individual members were challenged to expand and retract their engagement with the others in the decision-making process they, (both the individuals and the boards), were bounded by the rules and etiquette of the board table (Leblanc & Gillies, 2005). Analysis of the formal process added to the analysis in that it confirmed the responses from the individual interviews and the focus groups.

Data triangulation occurred with that data recorded from observations of the decision-making processes and interactions at DHB meetings. As indicated previously, the paucity

of new data was disappointing but was relevant in confirming the data gathered from interviews and focus groups.

The analysis process involved researcher reflexivity and regular critique of the outcome of analysis in relation to the data using Bourdieu's concepts and frameworks.

Trustworthiness

Trustworthiness of the data was considered in relation to credibility, dependability, transferability and confirmability as described by Guba & Lincoln (1989). Trustworthiness is the concept that Guba & Lincoln substitute for reliability and validity when considering qualitative investigation. Some authors (Morse, Barrett, Mayan, Olson, & Spiers, 2002) maintain that reliability and validity remain appropriate concepts for attaining rigour. However, for the purposes of this study, the application of Guba and Lincoln's (1989) framework has provided the rigour required to attain trustworthiness of the data. Guba and Lincoln recommend specific strategies to be used in attaining trustworthiness. These include the use of negative cases, peer debriefing, prolonged engagement, and persistent observation. This study did not use the negative case strategy. The researcher was sufficiently knowledgeable to adapt and respond to changing environments, have an holistic approach to investigation, processional immediacy and to be sensitive. The researcher was skilled in clarification and summarizing as described by Guba & Lincoln (1981).

Each characteristic of trustworthiness will be discussed and followed with examples of how each was applied during the investigatory process.

Credibility

Criteria which ensures credibility of data or truth value of the study includes prolonged and varied *field* experience, time sampling, reflexivity, triangulation, member checking, peer examination by supervisors, interview technique establishing the authority of the researcher, structural coherence and referential adequacy (Krefting, 1991). For the purposes of this study the researcher ensured that a number of the strategies identified above were used to assure credibility. All participants offered robust professional credentials, qualifications and experience in public healthcare services. Often experience was in a variety of roles which ensured that, through their maturity and over time, more than one

perspective was available from which participants could draw. Triangulation helped to ensure credibility through measuring the same data through multiple methods of collection.

As a registered nurse with qualifications in management and governance the researcher offered credibility and an holistic approach to the subject and was able to respond quickly to the concepts being offered by the participants. The time lapse between the interviews and the focus groups allowed the participants an opportunity for reflexivity and the researcher was able to be reflexive during both the data collection and analysis stages of the study.

Dependability

The ability to follow the audit trail of the research process by people not involved in the study, to understand the raw data and the conclusions reached in the study makes the outcomes dependable. Supervisors have undertaken random audit of transcripts of interviews and focus groups and how these have been used and interpreted in the study. Tapes and transcripts of interviews and focus groups and notes from public board meetings are archived for academic reliability. Board meeting minutes are available from each DHB archive.

Colour coding in transcript analysis enables interested parties to follow the analytical process using Bourdieu's methodology.

Transferability

Krefting (1991) identifies four criteria for transferability; nominated sample, comparison of sample to demographic data, time sample and dense description. The nominated sample consisted of three organisations with the same responsibilities for their communities. The researcher was able to test the transferability of data elicited during interviews and focus groups. As previously indicated, while two of the DHBs were largely metropolitan in nature, the third, which included a mix of metropolitan and rural, was no different in its organisational structure, legal responsibilities or in the formal manner in which governance happened. The researcher considered that the DHBs were comparable and data collected was confirmed between organisations and individuals. On completion of the study evaluation and dissemination of the findings will occur.

Confirmability

The criteria for confirmability include audit, triangulation and reflexivity (Krefting, 1991). Each participant had an opportunity to check or audit their transcript for accuracy, and they were asked whether they wished to alter or delete any section. Both the participants and the researcher were reflexive in their consideration of responses. Reflexivity is a common characteristic of Bourdieu's framework (Bourdieu & Wacquant, 1992b) and is also valued by others writing about qualitative research processes; for example Koch & Harrington (1998). Checking of the data by the participants confirms the trustworthiness of the data. "It is claimed that the research report derived from this process authenticates data and contributes to the rigour of the research process" (Koch & Harrington, 1998, p. 6).

Participants did not make any changes to the intent of statements in the transcripts, but in two cases some topics were removed by the participants from inclusion, as not being germane to the research question. Participants reflected on what they said and on both occasions the words deleted related to personal relationships. Those comments were deleted from the transcripts and were not considered in the data analysis.

Triangulation of the methods of data collection has been discussed. Trustworthiness of the data was ensured by complementing Bourdieu's research method with Guba & Lincoln's (1981) method of ensuring trustworthiness.

Conclusion and integration

The method of the research elicited raw data of a personal and professional nature guided by the interview questions. The research question was developed from the identification of gaps in knowledge in the literature. The interviews and focus groups were fluid, allowing for both the interviewee and the researcher to investigate and expand discussions perceived as relevant. The observation of formal board meetings was passive.

The amount and type of data gathered is a reflection of the research method and the methodology framework of Bourdieu. The process was considered trustworthy (Guba & Lincoln, 1989) in that the credibility, dependability, transferability and confirmability criteria were met. The data was triangulated to support trustworthiness by taking a reflexive approach to the data collection and analysis. The concepts of Bourdieu (1992b) and

qualitative theorists (Denzin & Lincoln, 1998; Guba & Lincoln, 1981; Koch & Harrington, 1998) were integrated sympathetically, recognising the fit between them. The reflexive approach was important in making visible the complexity of the decision-making and governance within the context of the healthcare services.

The complexity of healthcare services and the dynamic nature of the interactions based on the histories and experiences of all participants are demonstrated in the data analysis which follows in Chapter 6.

Through analysis, researchers “translate highly abstract problems into thoroughly practical scientific operations” (Bourdieu & Wacquant, 1992b, p. 221).

Chapter 6

Introduction to data analysis

The following three chapters present the data and interpretations of findings using Bourdieu's (1977a) theoretical framework. The data presented is drawn from the participants' interviews, the focus groups and the researcher's observations of participants at public board meetings. Data is presented with accompanying analysis guided by Bourdieu's research guideline headings and the key research issues identified on page 100.

The field of practices, which facilitated exploration of the individual attributes of board members and directors; *the social topology* the study of which focused on the context of the group making decisions; *the structure of the field* through which the influence on decision-making in the context of healthcare service organisations and the principles which underpin decision-making in governance were considered.

The process of analysis was an expression of the cyclic reflexivity by the researcher enabling re-immersion in the data to ascertain and reflect what the participants said and how their statements would be interpreted. The complexity of the data and multifaceted approach of the methodology has allowed some abstracts to be analysed within more than one of Bourdieu's research guideline headings and therefore being discussed in more than one chapter. The reflexive cycle strengthened the triangulation of the data process and dense analysis recognizing the complexity of the themes.

Interpretation of the data identified 22 determinants which participants recognised as shaping of their decision-making in governance. Through the reflexive process and informed by the governance literature six themes were identified from analysis of the relationships between the 22 determinants.

Analysis of the *field of practices* located the decision-making determinants of personal and professional experience, education and skills and credibility. Attaining *metaliteracy* through experience and reflection highlighted the importance of leadership. Reflecting the generic governance principle of accountability these determinants were collectively called professional maturity. Also identified in the *field of practices* was the management of conflicts of interest, the influence of the personal and professional cultures and

understanding one's personal ideologies and philosophical base which underpins *practice.* Through reflection using the generic principle of governance of fiduciary duty these determinants were grouped together to support the balance between duty of care and duty of utility to the organisation. On reflection the determinant of professional thesis was considered a characteristic of probity and was therefore grouped with other determinants of quality and safety.

Creating a *social topology* identified the tensions in the *field of forces* created by the use of *cultural, social and symbolic capital.* Participants identified that the use of the *power* in *social and symbolic capital* carried with it the responsibility of maintaining trust. Informed by the principle of transparency these determinants were grouped as the theme of power and tension. Also identified in the *social topology* were structural aspects of healthcare services which determine the shape of decisions. These included the impact of professionhood and the related *symbolic power* and the duty to organisations, the impact of scarce resources and the need for economic rationality. These latter determinants, informed by the concepts embedded in fiduciary duty, balance the duty of care with the duty of utility.

Analysis of the *structure of the field* of healthcare services established the role of the legal context, the rules and the organisational structure at the time of decision-making. Time was defined by participants as including history, context and tempo. Analysis of the *structure of the field* highlighted the impact of power and tension which included the policy of democratisation and collective responsibility which exposed conflicts of interest which challenge the fiduciary duty of professionals in the healthcare services. The *field* is also *structured* by the requirements of audit and clinical guidelines and the rules of *practice* in healthcare services. These determinants were grouped with the influence of institutional memory and professional thesis to form the theme of quality and safety.

By aligning the determinants and themes with the generic principles of governance decision-making in governance in healthcare services is connected to the *practice* of healthcare service operations. However, the influence of each of the 22 determinants is not exclusive to the theme to which each has been aligned. The theme identified is where the

determinant has the strongest distinct and recurring relationship as indicated by the data and the reflexive process.

The grouping of the 22 determinants by theme has allowed for the construction of a framework which demonstrates how decision-making in governance is shaped by the participants who work in healthcare services. The framework provides a vehicle for understanding of the operationalisation of governance decision-making. It is demonstrated in figure 2 on page 209.

The impact of cultural power on the shaping of decision-making in governance – the field of practices

Chapter 6 focuses on analysis of data which allows for the description of the *field of practices* through exploring the personal *habitus* of the participants and investigating the characteristics of their power base of *cultural* and *social capital* and how it has been established. This allows for the construction of the *field of power* in relation to the environment and situation under study.

The Field of Practices

The *field of practices* is constructed from the interplay between the *habitus* and the *field of power* with which it interacts. In this study the *field of practice* is governance in the New Zealand public healthcare services. The *field of power* is Bourdieu's metaphor (1992b) for describing how cultural *field*s of individuals and groups interact in different contexts.

The impact of cultural power

The following impact of *cultural power* was interpreted through analysis of the data as including:

Experience: the personal and professional experience of individuals and the influence of the cultures of their professions

Education: the importance of ongoing knowledge development, credibility and having the right technical skills affects the ability to make decisions not bounded by structure and process

Ideology: the tensions that differing values and beliefs create within the *field* of power that is the public health sector

Although the development of each of these themes will be explored separately, integral to the analysis outcome is the understanding, as expressed by participants, that all themes are interrelated, linked and dependent on having impact on each other. Decision-making in healthcare service governance was seen by participants as dynamic but anchored in the

experiences of the past. The responsive nature of decision-making reflects individual and group *habitus*' bounded by the principles and rules of the game at the time.

Cultural Power

Cultural power, the ability to influence others through personal experience, professional qualification, and position in the community of the healthcare service, was identified by all participants as being integral to their ability to successfully contribute to and make decisions that assured positive patient and service outcomes. The participants identified experience, life experience and their experience as professional healthcare services directors or managers or health professionals and the influence of the cultures of their professions as shaping their decision-making. The data showed that each of these determinants was multidimensional and interrelated. These will be discussed further below.

Experience

All participants emphasized the impact that personal and professional experience had on establishing their credibility, their power base and, consequently, the quality of their decision-making. Their experience as both decision-makers in the healthcare service and as individuals developed from their unique experiences in life. Several participants had similar personal life experiences and the medical specialists, in particular, had similar professional experiences, but none were the same.

Experience, in the context of this study, has personal, positional and contextual characteristics which impact on decision-making. In experience in life participants described personal characteristics which encompass those derived from the relationships as individuals, within family, as a result of educational and professional experiences. They also described, in professional experience those attributes gained from their experiences in particular professional positions and roles. These positional characteristics encompass the roles played within those experiences including those as clinical professionals and their leadership roles within organisational structure. Participants distinguished their professional roles in particular contexts, distinguishing situations and environments, and at particular times. This included the period of time they were in those roles and the impact of those experiences. These contextual characteristics encompass those characteristics developed as

the result of particular experiences as individuals or professionals at a particular point in time.

The participants illustrated that the following experiences influenced how they make governance decisions:

- Experience in life as people with unique relationships as and with mothers, father, brothers and sisters and others
- Experience in health and other professions including their professional credibility
- The influence of the cultures of the professions
- The influence of different ideologies and the tensions that these created

Each of these will be discussed in detail in the context of the data.

Experience in life

Personal experience involved living within the wider community as mothers, fathers, graduates, and health professionals and featured as being the cornerstone to the shaping of the decisions of the participants. One participant talked of his personal experiences as a consumer of healthcare services. He identified the impact of poor interaction between professionals and consumers as the cause of many issues.

CEO 1: The most personal things are often your interaction with the health system that you have when you are not being the CEO. I have had two babies, I am a parent, I have a sister-in-law that has schizophrenia, a mother & father- in- law and a mother that have all had health problems. I have to say the health system still has a long way to go. It is quite depressing at times to see how inhumane the system is to people. We worry far too much about the technical aspects sometimes and we forget people are people and we just don't use the simplest forms of communication in human engagement…. We would alleviate a lot of the issues we have.

Another participant concurred with the above and believed that family experiences as consumers shaped their career choice decisions and impacted on the types of roles they chose during their career. Such influences could happen at a young age and provided an example of how the *habitus* forms from an experiential base. Later experiences are

influenced by the past and as the individual's values, beliefs, knowledge and place in the healthcare system mature.

Medical Specialist 4: I went into medicine because I happen to have a brother who was born in 1962 during the staph epidemic in hospitals in X. And he developed hospital acquired staph aureus resistant to penicillin and consequent to that developed meningitis…. Survived that.., but died one year later when his shunt blocked- and I happened to be holding him, and I saw and experienced the tragedy of that. I was 15 years old so that to me created the impetus to say there's got to be a better way of doing this and the focus of going to medicine was never for personal gain it was always to improve, to prevent harm.

And for others it was a midlife crisis which influenced choices that were made in their day to day work, sometimes resulting in major changes in direction.

Medical Specialist 3: I don't think there are surgeons who get involved in the kind of things I do which is a pity, but surgeons are busy cutting people, making a private living or whatever, with patients, research and cutting edge stuff, the academic stuff. They do not tend to get into community health thinking and I suppose at a time in my life I had a crisis which was I was not going to be doing this for the rest of my life or ' is there something else to do?' because I recognized that you didn't really impact the community's health by being a surgeon. And I am passionate about health and how to change the national health status. And I didn't think you could by just being a surgeon and that's where my public health thinking comes in

This participant experienced a major life crisis, a turning point when the recognition that the accomplishments of the past were not going to satisfy his need for creative, rather than responsive, interaction within the context of the *field* of professional discourse. This respondent articulated a vision for public healthcare. For Bourdieu (1990b) the *habitus* responds within the *field* in which the person is active. When there is not stimulation from a specific *field* e.g. a medical specialty, the individual seeks out experiences for stimulation. For example the medical specialist speaking below had actively sought out professional experiences to stimulate her career.

Medical Specialist 4:…. I had to leave the narrow focus and vision of the central government and came back into clinical practice to do a dual job director of emergency medicine and was also advisor to the Chief Executive around health systems policy and development locally. And at the same time I had a few national roles created by the Minister to the board of the XX Health Authority. I was also on the pharmaceuticals and therapeutics advisory committee, PHARMAC, and in 19XX

was appointed to be the Director General's representative on the Medical Council of NZ.

Senge (1990) proposes that a vision is necessary for personal mastery. This study did not set out to identify those situations and contexts in which a vision is created and nurtured but several participants talked of "being passionate" and having the "passion factor"; being committed to solving the problems and meeting the challenges of the healthcare sector through creativity and innovation.

Interestingly, the participants in this study demonstrated this passion factor openly. They expressed how committed they are to influencing the health status of New Zealanders. This confirmed the choice of participants as suitable for the study.

These examples identify the passion factor as shaping the decision-making of professionals.

Medical Specialist 3: And I am passionate about health and how to change the national health status. And I didn't think you could by just being a surgeon and that's where my public health thinking comes in …...

Medical Specialist 4: …..so that to me created the impetus to say there's got to be a better way of doing this and the focus of going to medicine was never for personal gain it was always to improve, to prevent harm.

Medical Specialist 3: My wife was appalled and my last operation was sad for me because I was quite good with my hands. But philosophically I felt I could actually do a lot more for society if I could get into this sort of stuff.

These examples show how the historical foundation created by our interaction within the cultural *field* of our society forms the base to our unique dispositions and characteristics (Bourdieu, 1993a; Swartz, 1997). It is the individual's ongoing experience within the context of life events which continually reshapes the way of thinking, the way learning occurs and each decision is shaped. Every experience is new and unique. There cannot be any replication of personal experiences, thought patterns and personality traits which influence decision-making (Buchanan & O'Connell, 2006).

The influence of family and the expectations of its members because of the way they were brought up and the context of that upbringing influences decision-making. The underlying family values, and the resulting ability or not to relate to others, were identified by participants as providing the foundation to their decision-making.

Medical Specialist 1: I have got some personal skills which I triggered mostly from my mother, who was a net worker. I have spent my life surrounded by extremely strong women. They taught me networking skills so I am a net worker, a go between, a negotiator, an informer and, as I tell the students now, the task of specialist medicine is to make claim to ordinary people, such as those I found in XX, to make plain to those ordinary people the nuances of the diseases, and it is not difficult, but people do not want to do it because they think it is hard.

This participant elaborates that one of the key determinants which shaped decision-making is the experience of interacting with others and having had the opportunity to experience the responses of others. It is that interaction which drives the *habitus* to respond, alter its way of responding and the response but based on the durable and transposable dispositions which remain firm. *Habitus* is dynamic, but it is more a slow moulding of change based on previous behaviours habituated in the person or the group. That dynamism is stimulated by the tensions created when interacting and collaborating with others, these being requirements to harmonious decision-making, attaining a balance of power within the *field* (Bourdieu, 1990b).

Professional Experience

Participants described their different career experiences, what they had learned and how different environments influenced how they made decisions (the process) and the decisions made (the outcomes). In order to achieve a harmonious outcome those perspectives must be recognised by other players in the *field* of power and accepted and incorporated into the process of making the decision if not the decision itself. Several participants gave career examples:

Chairman 2: I am Chairman of xx DHB, …….. I retired after having been a director of X (major company), …. Prior to that I had held various governance and operating responsibilities in (service industries), ran the xx Group as Managing Director, sat on the board of YY, ran YY earlier so I have been around a bit.

I Chair a company called X X Limited and we build facilities and run the XX Centre, I Chair a Company called ZZ which is a telecommunications network servicer. I chair a Company called XX Holdings, which we are taking to the market in the next couple of weeks, which is a (service industry)…. Oh, and am also involved in XX Limited which is a property development company which is more of a hobby of mine. Other than that I am retired, live in the country, 2 ½ acres of olive trees and a lake.

Chairman 2: I am originally trained as a lawyer… which is what gave me very good ethics base and financial base …

Medical Specialist 2: I have at least four hats: Clinician; HOD, xxx speciality; Clinical Director Intermediary Care, Chair to the Clinical Board and CAG (and part of that is being a member of the Executive Management Team); and Associate Professor of Medicine. So the whole time is spent in determining judgment calls so that you can sort those things out.

One of these participants clearly recognised the impact of his early experience in the healthcare service on his decision-making today and how it still shapes the decisions he makes today. He also recognises this early experience as a starting point to developing decision-making skills and through the *reproduction* of the *doxa* of the small town general practice and building on that experience in his decision-making in his specialist clinical practice.

Medical Specialist 2:…it's important because the things that happened to me in the very early phase of my career shaped the way I think now. …..I was sent to M Hospital and was a 2nd year house surgeon along with one other ….. Immensely practical year; I got a lot of responsibility, probably more than I should have had being a 2nd year house surgeon, but it was the 3rd year which was the most interesting.

I was sent to be a general practitioner in a rural town, XX; 800 people and I looked after them. And I did everything thing for them. I behaved like a rural general practitioner. I did house calls a lot, attended to the schools; I did first aid lessons for them and coached the local rugby team. I had a visiting appointment at the hospital…. I was the only one who could half operate, so I did caesarean sections, I gave some anaesthetics there, I did a tonsils list every Thursday, this is three years after qualifying.

Medical Specialist 2: I had to sit down with hard bitten, skeptical, difficult, ornery, uniqueness of miners and talk about the world at three years qualified, so had my negotiation discursive skills honed by these people to a fairly fine edge…. so that is when it started.

All participants identified the impact the early professional experience had on their personal development. *Habitus* is seen by Bourdieu (1977a, 1990) as central to the development, creation and ongoing maintenance of the individual in relation to his environment. Diversity of professional experience was also recognised by the participants as being an important credential to the mature state, that it is experience which allows the building up of *cultural capital* placing them on the *social trajectory* suited to future professional requirements. The seeking out of new experiences, of looking at professional life

creatively, was recognised as complementing those experiences acquired within the structured healthcare systems in which they worked. The next participant related a career where expertise in a variety of specialties, and in different roles (clinical, planning, policy, governance), were beneficial to personal growth and the development of broader perspectives within the healthcare services structure.

Medical Specialist 4: ….. I didn't want to die as an xx specialist, I went to the XX Area Health Board in service planning and did that for a year, followed by a move to X where I was the chief medical advisor for the XX, the interim programme director for the core health services committee and managed the personal health services portfolio at the X. While I was there I had an opportunity to do a lot things like be on the X Council of New Zealand, chaired the XX and XX registration Boards and was involved in a few national enquiries like the Hepatitis B enquiry and chaired the XX advisory committee for the Minister of Health.

Medical Specialist 4: …. I had to leave the narrow focus and vision of the central government and came back into clinical practice and came to XX to do a dual job director of XX medicine and was also advisor to the Chief Executive around health systems policy and development locally, and at the same time had a few national roles created by the minister to the board of the XX Regional Health Authority. I was also on the XX committee, and in 199x was appointed to be the Director General's representative on the xx Council of NZ.

A wide variety and depth of experience in the New Zealand healthcare services was exhibited by the participant above and the previous participants. All participants identified their individual set of attributes as a personal professional thesis on which they based the governance decisions that they were now being asked to make, but at the same time recognized the importance of the attributes of others to the decision-making process. The following participant related early professional experience which had not been recognised for its worth until much later in the specialist's career.

Medical Specialist 1: Prospectively those two years looked like absolute disasters and they would be career-enders for most people, so I thought, but in fact, retrospectively too, now thirty years later you look back at it now and see it is the best thing you ever did, which is why I am the way I am ...

Experience is recognised as a key determinant of their development which leads to the ability to practice in a mature state. Participants elaborated on the impact of their intimate life experiences and how they shaped their decision-making.

Other participants stated that they learnt through the example of actions of others they held in high respect. That role modeling was an important part of learning how to make decisions in relation to the context in which they were being made.

CEO 2: I think at a young age back in the XX days Area Health Board days, when B was General Manager; I mean B was tough task master as was G who followed B. Both were very different characters, but very good CEOs to work for and I could recall a number of stories from each of them. G was fairly black and white, what was important at the end of the day were the results that were going to be delivered and had very strong principles. Some people would say they were wrong, but they were his principles that he believed in …

Through role modeling this participant recognised the *capital* and therefore influence of the *habitus* of others and wanted to emulate that as he could see the rewards that came from those examples of balancing the tensions in the *field of practice* of the healthcare services organisation. His predecessors were recognised as successful in the performance of their roles and with that success came *symbolic power*; the recognition by others that they had skills of value and with that came respect and the ability to get things done, to achieve for the organisation.

Participants indicated that the past activities and experiences of the organisation influenced the decisions made or not made in current times. This was termed by one respondent as 'institutional memory'. However, the concept of 'institutional memory' was thought by participants to be integral in maintaining the quality and safety of services, that past experiences shaped current practice and will be discussed under quality and safety of organisational activity.

Professional maturity

The different perspectives, knowledge and skills that individuals bring to a decision when they are secure in their identity was termed 'professional maturity'. The term arose from the data as participants recognised that the focus of the decision-making was the patient and not the person making the decision. It included the recognition that this was a key attribute of keeping the power balance, for being accountable for one's *practice* and that one needed to be professionally mature to do that. Each individual's opinions have value, are *capital*, to be considered and reflected upon and included or not in the outcome decision. For example

one chairman was quite clear that the right of veto was both activated and relinquished. The decision must be based on "doing what is right" for the organisation which will be further expanded in the discussion on quality and safety.

Chair 1:.. at the end of the day it doesn't really matter if they like or dislike me it's not the issue, the issue is… are we making the right decision here, whether it is going to annoy someone or not?

Chair 1:I said I would trust my instinct this time and if nobody else is going to agree with them that's absolutely fine we've had a chance to say it I've said what I thought. "You go back and think about that because I am not convinced yet".

This chairman recognises that all opinions within the group are valid regardless of whether the opinion is included or not in the decision. Bourdieu recognises that individuals are capable of multiple literacies, understanding different points of view. Webb *et al.* (2002) termed this *metaliteracy* and described it as the ability to recognise and include the opinions and knowledge of others and the capacity to move across different perspectives.

CEO 2: He (chairman) does not expect me to go to the sub-committees, he has confidence in our general managers to manage the key functional relationship of each of the sub-committee's so I do not get imbedded in all of that activity, I will always attend finance and audit I will sometimes go to hospital advisory and I am only going to CPHAC once or twice a year.

CEO 2: I will have my Chief Medical Officer and Director of Nursing to give free unfettered advice on nursing acuity, on ratios, infection levels, to the hospital advisory committee with my not being there and I think it is important that I am not there if we are to really give adherence to the clinical governance model, but they can do that directly to the board.

The interpretation of the data indicated that *metaliteracy* is a key attribute of professional maturity and the personal development of the individual's literacies (Bourdieu, 1977a). As well as being able to take on the opinions of others without threat, professional maturity auto-stimulates interest in other subjects/topics. The researcher elaborates on this argument by suggesting that professional maturity allows for the demolition of the personal barriers, the tensions, that exist when there isn't confidence in technical competence and professional barriers put up by structures created by professions.

Participants were asked to describe themselves as health professionals or professionals within healthcare services with governance decision-making responsibilities. Overall

experience was identified by all participants as being a key determinant of how and why they shaped their decision-making in a certain manner or way.

Medical Specialist 2: I am probably able to evaluate the information and make a decision and I continually need to improve this; extending the number of perspectives, so that I am able to incorporate view points that are quite different from mine and recognize that they have just as much value.

Professional maturity is located within professional *practice*. The example above is of *metaliteracy*, the ability to look at ideas from a variety of perspectives (Webb *et al.*, 2002). The depth of the particular knowledge enhances the personal professional thesis and *cultural capital* and the influence on others in support of the leadership role.

Individuals do not consciously separate their personal and professional roles from the positions that they hold at various times in their lives or in various contexts, but, as discussed above, they do behave differently in different situations. For Bourdieu (1990) the *habitus* interacts in both conscious and unconscious ways. One participant described this as "instinct". Some nursing theorists describe this as intuition (Brunt, 2005; Ruth-Sahd & Hendy, 2005). This research supports Bourdieu's notion that individuals and groups have *habitus* which is grounded in the personal history of the individual and the history of experiences of the group in a particular context.

Reflecting on practice

All participants expressed that there was a time when they realised that they had confidence in their own competence to make decisions in their practice. For some this was a dawning of realisation for others it was when professional maturity was recognised by others and expressed to them. No matter how the turning point happened all participants expressed that knowing that one was confident, and that others saw the confidence, was an integral part of being professionally mature.

CEO 2: I don't think there was ever a point in time if I reflect back when I you know felt you'd had enough experience and gained enough qualifications to be able to draw a line in the sand and say I'm fine from now on but if I was to reflect back ……I think the things that have improved with experience, say for the next 10 years, have really been the range of scenarios settings within with you have worked, relationships you have formed and so it's really been that experiences that you've had since becoming technically competent that has supported what I'd call better decision-making. You

know, knowing when not to jump in boots and all, knowing when to get a second opinion and to bounce something by someone you know…

CND: For me it's actually more of a dawning. I think it actually is just very subtle and kind of… and I think certainly that technical confidence certainly paved the way to get recognised …. that technical confidence held me in good stead for the role modeling of right clinical behaviour in practice.

Reflecting on practice was identified by Schön (19920 as important in establishing proficiency in professional decision-making. However, for some it was the adage that recognising "knowing what one didn't know" was the realisation of *metaliteracy* and that this included the ability to reflect on ones practice and/ or decision-making.

Medical Specialist 3:… the technical competence is recognising what you know and what you are competent in and what you don't know and where you can call for help to do that and not feeling less of a person for asking for help in areas that you know that you're not competent. I think the real worry is people who effectively don't know they don't know and therefore don't delegate.

Medical Specialist 1: … in terms of maturation …. I became professionally mature when the number of surprises diminished; that there were less surprises and it was more the case "oh yes I know about that that's happened to me before"…. good judgment comes from experience and experience comes from good judgment.

That's how you learn clinical medicine by making mistakes …. the effect of the mistakes is a surprise, it's an "oh my God" situation but you just have less of that… I think you realise you're professionally mature when people come and ask you things, that's when you've become professional mature people ask you questions what did you do.

Researcher: Because you have to reflect?

*CNM: … I think because you **can** reflect. (respondent emphasis)*

*Medical Specialist 1: You **can** reflect (respondent emphasis)…… And you develop a track record of opinion that's valuable and valid… I think it's the remarks that you receive…….. the relationship between competence and consciousness,*

….. So when you do become….at the level of conscious competence rather than unconscious competence you're probably professionally mature.

Reflexivity

Another example of *metaliteracy* identified in the data is when an individual peaks in the ability to reflect on one's decision-making actively. The reflective process slows and individuals start to have diminishing ability in their professional maturity, including the ability to learn.

Medical Specialist 1: … you have to be reflective about it, you can't clearly see that. … you're on internal personal notice ….. you are always quite careful about what you say because there's always the worry that you might be giving the wrong advice or the wrong view on something, it's rarely the case that you, but you do have watch yourself. When you stop doing that I think you're on a downward slope actually.

Researcher: You think you stop learning at that time?… Or there's a reduction in the amount you can learn?

Medical Specialist 1: … you assume because it's an expediential business you never get to the full level of professional maturity there's always something that will surprise you, almost something that will surprise you either management, or a med student, or a surgeon it's always a surprise.

To be reflexive is how Bourdieu (1971; 1992b) describes the responsiveness of the individual to the *field* in which they are participating. Bourdieu (2004) sought to check and strengthen science through reflective practice of both individual scientists and the scientific community. Current experiences are reflected back to the total experience of the individual or the group that is the *habitus*. One participant identified reflection as a tool he used in self appraisal.

CEO 2: So,…. I think the other thing for me, just reflecting on what experiences made you better, you know I think having been a general manager and experiencing two quite different chief executives…

Therefore it was not the turning point in time that participants considered important but the recognition that a new phase of reflective and reflexive ability in one's life had been entered into.

Effect of aging and tiredness

The effect of age and tiredness was an issue by several participants. Clinical nurse managers and surgeons in particular had made conscious decisions about their ability to continue in that role.

CNM: Faster, because we've been there and done that, but you never take where you are now for granted because the next step in our mature lives is perhaps to start going downhill. So now how long can you sit here……it is so fast and so furious and you have to be so on the ball so what can you expect, you know if you're 62, how can you keep working 50 hours a week flat tack without starting to say well hey I'm starting to go, you're losing your …motivation.

Medical Specialist 1: It's actually the case and there's good objective data to support that contention. The job can affect your hand-eye coordination (as a surgeon) is not as good no matter how good you think you are you're objectively not as good. I recognise, well I knew about that data, so I made a conscious decision to opt out of big major difficult surgery. I never had a problem with it. The biggest operation I do now is a laparoscopic chole-cystectomy but only with another surgeon holding the hammer I believe I'm fine absolutely no problem at all doing it but I know that the really big cases come with fatigue, come with all the other things, you'll never be as good. The same thing happens with decision-making about management; I'm sure that's the case. But you know as long as you have no sleep deficit and you're physically fit I think you can still do it no matter how old you are but you've got to really look after yourself. Fatigue is a major enemy, it's quite insidious.

Chair 3: and as you get older your analytical skills are not as sharp as they might have been

These participants identified the effects of aging on both their physical abilities to perform tasks and their ability to make decisions effectively. However, these participants, and several others, recognised their declining efficiencies and had developed strategies to manage that situation. For example the two surgeon participants had modified their scope of practice through reflection on their abilities to perform; one had changed specialty and the other had sought out other interests in education where the credentials and knowledge of past learning are not impeded by physical aging and the demand of acute decision-making. They did not consider that they were devalued in any way because of that.

Reflexivity and understanding the current reality are exemplified through the recognition as an individual that a person is not only tolerant of the opinion of others but also that individual power comes from a variety of sources including the ability to manage people. This was recognised by one participant in the following statement.

Medical Specialist 2: I think that the Doctor by training is often perhaps less tolerant of other points of view and I like a quote that says I think it was relating to specialists in general…, saying they didn't mind being team players as long as they were the captain. I've come to realise that you're an important player but not necessarily have to be the key player in that……..is relating to people it's a people issue and managing people is managing people's feelings

This participant is also alluding to the characteristics of medical training which are *reproduced* from one generation to the next (and which will be discussed later in the chapter).

Influence of professional cultures

The personal *cultural capital* that participants brought to the study was readily identified as underpinning their decision-making as health professionals. The attributes of their professional cultures were highlighted by the personal backgrounds and the things they held dear in life. They understand the dimensions and tensions in the *field*s in which they work with others well, as in the example below.

Chair 3: I bring a good sense of how health works and what is the art of the possible. I think I bring a good sense of community in the sense that what we are doing is not affecting the health of the community and we are actually not wasting our time here. I think I bring a good business sense as well, and a reasonable financial understanding so that I am knowledgeable about how businesses work, particularly this business. I think I have reasonable analytical skills, …. and at the end of the day quite good persuasive skills as well. If I want a decision I can kind of talk about it, explain it and talk about it and put it out again.…..…

This participant talks about persuasion, explaining and putting ideas out to others involved in the decision-making. All the participants recognised how integrated their own decision-making was within the context they were in and how their decision-making was affected by the context. These experiences not only developed the personal *habitus* but also gave them the skills to function in their personal and professional *cultural field*s. All the participants felt they had *cultural capital* and that there was value in their knowledge of the healthcare sector. The *sens practique* ensures an understanding of the political rules attached to different decision-making situations. For some their *sens practique* is well developed.

Medical Specialist 3: It is important to understand that I have a network and there are important parts in that workforce that feed ideas, concepts, strategies etc and as the Chief Medical Advisors forum in Midland, where we share all our issues and problems, ideas. There is a wider group at a national level which has a meeting three or four times a year has a relationship with the Minister, key people in the Ministry, ACC and Medical Council and so there is a Pandora's box of information, ideas and sharing that allows us to feed on that and bring it to the organisation. As well as within the organisation there is a planning development unit led by a colleague who is renowned, we loosely work together in designing the future.

Medical Specialist 4: They don't know, they don't know. Central government has no idea about what DHBs are developing. I have made it my personal mission to go and talk to people in the ministry, to go and talk to agencies around what the vision, focus and direction, have got in our strategic plan a move to first of all develop processes systems and tools to enable what we are going to do to engage

community to work towards self management. And we began this very early. It was the first thing we did before we did a strategic plan. To move from that into the systems that are required to do it and then to move from there into actually motivating the community around the social determinates of health. Because, otherwise we are never going to get there. And it is not something we want to impose: it is something we want to work in partnership.

As health professionals, these participants show determination in networking, knowing the health sector, and developing the ability to engage others in their quest to achieve change in the healthcare services. Understanding and knowing how to respond in particular contexts through having the practical sense, *le sens practique*, enables individuals to maximise their position in the *cultural field*. Understanding the rules of the game, the *doxa*, is paramount to success. The way to do this is through objectification of aspects of the *field*; to gather the trappings of what we perceive (arbitrarily) as successful players, the *cultural capital* required to influence, through decisions, the actions of others.

CNM: I think those things come with your experience as a charge nurse manager. Your accountability, I am very strong on those I employ being accountable for their practice and if they are to be accountable I have to be accountable so I have to develop skills as a charge nurse manager and I expect my staff to develop skills and then we become accountable for our practice by the knowledge we've got and by the expertise we've got and also knowing the policies and protocols of XXDHB.

Researcher: So it is a duty to the organisation as well.

CNM: Absolutely.

This nurse manager aligns the nurses' accountability for nursing practice along with that accountability to the organisation. The duty to both the patient and the organisation is recognised but not elaborated upon.

It is the culture within the professions, gathered over time and experience which shapes the decisions both individual health professionals and professional teams make. Individuals learn how to behave as a doctor, nurse or any other health professional, through being educated and inducted into the profession and being rewarded for the behaviours which the profession values. Through that process of reproducing the behaviours, professions embed the behaviours into their junior members as they work in teams. That process ensures the continuation of the profession as it is recognised by all who interact with it. Tensions which occur within the *field* are dissipated through the ability to anticipate the behaviour of

members of the health professions. The reproduced behaviours carry with them the *cultural capital* of the profession.

Traditions

The health professions place considerable importance on the traditions of their professions. Participants did identify the impact of the learnt values they had as health professionals and the learnt perspectives they took in decision-making.

Participants gave many examples of how the professional culture impacted on decision-making.

CEO 2: It's a combination of things, I have a whole set of experience and my professional background has taught me to think in a certain way, it's a particular professional background I see the world with some aspects around the medicine and health issues. In the last ten years I have had a slightly wider view about what you are trying to do, the importance of values in an organization like this, we spend a lot of time trying to have a set of values we believe in and actually behave to them.

Medical Specialist 1: The reason is on a philosophical basis: - the ethic that drives most medical care is the ethic of duty …

On occasion participants identified that learned behaviour as being a hindrance to the decision-making necessary in some situations. In the case below professional inculcation to the practice of isolated decision-making defines the parameters of the individual's ability to make decisions.

Medical Specialist 1: …. there is a problem with what I call parameteral behaviour, where people are identified as medical leaders and such people often have a parameteral view of the world where there is one of them, two Assistants and four sub-assistants 8,16,32,64 etc. and that is not the way it works and that is a problem. That way of thinking comes quite naturally, particularly to doctors and some nurses, because they have to make decisions [about] that have wide implications for a whole lot of things, not just only a patient's life, patient's family, other carers and so forth. I think they are used to making isolated decisions about patient care, and that is a problem.

Tribal behaviour

Several of the medical specialist participants identified the notion of tribal behaviour, the inculcated behaviour of health professions as they herd together, within their hierarchies, in

order to exert *cultural power* over others. Tribal behaviour was not identified as a positive attribute to the professionhood[5].

Medical Specialist 1: There is a Chief Medical Officer, but that does not work that well because they are infected with some of the same problems. All doctors particularly have hidey holes they go to when things get tough and their clinical environments go on, they have ward rounds, outpatients and theatre, so there is always the clinical excuse and for governors that is a very good excuse. I would like to challenge the senior medical cohort to get involved more with governance and the trade off would be this: - Let's get involved because of governance and we will expect the board to do some exercise to improve their ability to think critically.

Medical Specialist 2: I happen to work on it very hard because at times of stress people retreat to their own tribe. It's either the surgical services tribe, or medical services tribe, nursing tribe or doctor tribe. What my vision is that people would say look it's at these times that we really need to all be working together because that is our strength because otherwise we will be spending an awful lot of the energy fight each other, like the manager tribe.

These examples suggest that tribal behaviour impedes collective responsibility for decision-making considered by these participants as necessary to organisational success. Collective responsibility is discussed later in the chapter.

The behaviour of the health professions is reproduced from generation to generation through formal education, hierarchical organisational structure and reinforcement through recognition by others. It is the internalisation of the expected future as articulated by significant others (Jenkins, 1992) and it impacts on the basis of professional decision-making.

Education

Education and ongoing knowledge development

All of the participants had formal academic qualifications and some combined them with health professional qualifications. The Clinical Nurse Director explained the value of Master's preparation.

[5] Professionhood is the collective membership of a professional group with whom individual health professionals identify

CND: I think the actual robustness really I think that even valuing the notion that everything should be quite academic. I can look at a piece of research and actually just query it. I've got a proposal that came through to me from a consultant wanting me to send nurses off to X to be looking at this new clinical practice over there and I'm actually just looking at the reasons why I said no. Because we haven't done our homework yet. Like the research article is actually quite flawed and everything else. So I mean it's really good to have that debate anyway.

The key characteristic was the identification by the participants that ongoing education was important and in most cases this was in a formal academic environment at Masters level, supported by short courses targeted at specific topics. This was seen as a key source of *cultural* and *symbolic capital* and participants reported that this gave them an edge on colleagues in the decision-making process.

One participant felt that it was the recognition of the *symbolic capital* built up from title and through experience and education that she had to offer the organisation that was the very reason that she was in the position.

Chair 1: I am originally trained as a lawyer and I was professional standards director at the Law Society where I investigated complaints against lawyers which is what gave me very good ethics base and financial base because by and large…

There is also the recognition that the participant acknowledges that being well educated is not only important to the role but that education has value, *cultural capital* which translates into power.

Chair 1: I am pretty well educated and I have had quite a lot of experience.

This participant saw that the academic qualification was the base on which she was able to grow her experience as well as giving her the skills to get things done. The developing (professional) *habitus* was based on the durability of her original qualification; it is integral to how she thinks and responds to the challenges in the *field* in which she functions.

Post-graduate experience included the attendances at senior executive programmes (at world renowned universities) designed to stimulate 'later in life' learning for excellence in management and governance. Some of the participants (chairs in particular) had completed the specialist courses in governance offered by the New Zealand Institute of Directors.

Chair 1: I more recently did a Masters in Business Administration,… and that gave me quite a good boost really because it was some 20 years since I had done a degree.

Managers who were former clinicians, in particular, had diversified their academic experience through the completion of Masters of Business Administration degrees. All the other clinicians had specialist qualifications with only one not to Masters level.

CEO 3 : Professionally, I originally trained as a nurse at XX Hospital; I have an MBA from Auckland University and worked for the pharmaceutical industry for 18 years.

Chair 2: I have a degree in Commerce, Economics and Finance ….

CND: My clinical background is that I hospital trained in the late seventies …. And I did the post-graduate course at that time, went overseas and came back in the late eighties….. I came back to XX Hospital and worked in the Intensive Care Unit. I did the post-graduate course…..

..was student full time to complete undergraduate degree; …did my Masters part-time through Victoria University and graduated at the end of 1999.

While all the participants indicated a strong academic base, many, like the participant above, demonstrated that their desire for learning was ongoing, throughout their career and they were aware of how learning and experience altered the way they thought about some issues. Currency in both knowledge and thinking was identified as being important to both their decision-making and to maintain the value of their *cultural capital*.

Interestingly, the type of education was not considered important. As the individual *habitus* develops there is recognition of the benefits that other individuals and alternative thought bring to a decision regardless of the specific topic of education. While many had health professional qualifications, these were not perceived as being a necessity for quality health governance decision-making.

CEO 3: If you had asked me five years ago I would have said it was quite important for those sort of roles to have some sort of clinical knowledge or background and now I am not quite sure, I think that swings from side to side to be honest.

The *habitus* changes as the individual responds to different experiences. This participant has changed his opinion with regard to a clinical background being critical to healthcare management. Previously his thinking had been that it was important to have that clinical experience in order to understand the decisions being made. Now it appeared that clinical

experience was used as a base for and to inform decision-making. However, understanding the language of health which comes with exposure and experience was identified as important in healthcare service decision-making.

There was also the recognition by several participants that they were “bright” and had the ability to undertake academic study with comparative ease.

CEO: I am lucky because, I am not boasting, but I am quite bright in terms of academic things. I have always been incredibly bright academically.

This participant demonstrates a confidence in his own ability. Such confidence allows people to participate in academic pursuits as the sensible way, the practical sense, to gather information for self-development and application to the decision at hand. There is an underlying sense of familiarity with the academic system, not something to be scared of entering and very much a source of ongoing *habitus* stimulation and growth through reflection. The ability to search out new information or substantiate an argument not only enhances the cultural value of education in that the decision this individual makes is held in esteem by others, but also that it shapes the way in which this participant makes decisions. It leads to the confidence to think independently and the ability to think laterally (De Bono, 1990).

Credibility

Participants identified credibility as an important attribute in their ability to make decisions and get things done. Credibility is the linking of experience and education and maintaining currency in all areas of practice. These areas of practice include technical skills and governance and the ability to make credible decisions.

Some participants sought to ensure their power base through credibility; that the value of who they are is established not only from recognition of actual experience which others have witnessed but that their current professional practice is credible. They had achieved a level of confidence which enhanced the symbolic power that came with the position. The symbolic *capital* is complimented by both the political *capital* which is attached to the designated position and the status attached to the *cultural capital* of professional

qualification. The next example demonstrates how active credibility maintenance is for those who aspire to professional maturity.

CND: I came back and did a few shifts on the ward clinically just to actually touch base find out what's really happening at the coalface, listening to the staff about we're always busy complexity of care and not enough staff so I did some clinical shifts on a few of the wards with xx Hospital over about a two month period. And what it showed to me is the reason I went nursing because I really really really loved patient contact I just loved it. I made a difference for the patients I actually cared for …

This participant was establishing herself through personal change, growth and the development of the confidence in her own competence to practice. She was allowing (ensuring that) others to see that change in her practice. That others recognised that the characteristics of her *habitus* were crucial to the position she wanted to establish, and was establishing, for herself. This recognition ensured the balance between the *cultural capital* of the qualification and the social *capital* of her leadership position. This balance was necessary to carry out the new role well. She recognised the value in that *social capital*. Her point of reference remained nursing and this is important to her as it contributes to her *cultural power.*

Credibility is also established through offering a wide range of experience. Some participants demonstrated that broad experience offered a better understanding, a *'sens practique'*, of the *field* in which they were working. They brought to the *field* a variety of professional experiences which made up their *cultural capital*. Participants also recognised that we actively seek personal mastery (Bourdieu, 1971; Senge, 1990) through seeking out a wide range of professional experience.

Medical Specialist 4: My previous experience is thirty plus years of health sector experience starting in 1967 with medical education with a Doctorate in Medicine in 1973, followed by specialty training in internal medicine with a fellowship with Royal College of Physicians and Surgeons, three years of practical general intern medicine in a community of 100,000, followed by speciality training in renal diseases and nephrology, followed by a year in Saudi Arabia followed by a year with the xx Hospital Board, the first 1983-4 doing a temp renal physician role followed by move to xx Hospital in xx, where I did part time intensive care and home dialysis training… I spent the next three years at xx doing both those roles and in 1986 went full time intensive care became the director of the intensive care unit there. In 1991 I decided I needed a new challenge, and to save my life, because

I didn't want to die as an intensive care specialist, I went to the xx Area Health Board in service planning and did that for a year followed by a move to xx where I was the chief medical advisor for the Ministry of Health, the interim programme director for the core health services committee and managed the personal health services portfolio at the Ministry. I had an opportunity to do a lot things like be on the Medical Council of New Zealand, chaired the Occupational Therapy and Physiotherapy registration Boards and was involved in a few national enquiries like the Hepatitis B enquiry and chaired the National transfusion advisory committee for the Minister of Health.

For this participant, the point of reference remains the profession but there is an active seeking out of new experiences and new knowledge within what the wider profession and the whole health sector has to offer. The participant is comfortable and familiar using, in the working life, the profession as the base; the profession carries immense *cultural capital* which can be used to access all sorts of experiences. She also demonstrates *cultural capital* in the intellectual *field* of healthcare service decision-making which can be applied in a variety of ways.

There is also the clear recognition that the actions or needs of others impact on the individual's decision-making. The *habitus* adapts to the tensions in the *field of practice*. New experiences are tested against that knowledge, those dispositions already embedded in the *habitus*. The *cultural capital* which one gains through achieving recognition of attainments through qualification requires maintenance in order to continue credible activity. Currency of practice is an active part of credibility. Having the "award" is not enough.

Medical Specialist 1: What equips you to make decisions? Experience and credibility,… so you have got to have "street cred", you have got to have credibility with your colleagues about decision-making

The participant recognises that it is not only experience that matters and that, through the interaction with others credibility is established and that credibility is *cultural capital* of considerable value in the context of the hospital.

CND: And now he has said now he realises that (not being appointed to position) would have been a mistake. He realised now the value of having my experience and expertise within the CND role because it's a very senior nursing position, very strategic outlook certainly essentially operational support to the junior service managers as a surgical team. Also you need to think just outside the square. So it's

only now that perhaps this GM has respect for nursing to a degree or for me as a person I would think. The CD is not a problem I think that's a separate issue. But I think certainly that governance structure between the nursing and management is actually pivotal and I think at times it does actually get lost up at times.

This example demonstrates that the context offers the political structure and the positional power which comes with high office. This interaction with others was recognised as being beneficial to one's own development as well as to nursing as a profession. The pivotal relationship between managers and nursing in ensuring smooth ongoing operations in an acute hospital is recognized, as is the risk in not having senior operational support in that context.

Technical Competence and Professional Skill

Technical skills were seen as encompassing those skills required to undertake the professional roles of the participants. For example, for chairmen this included having an understanding of finance and accounting, for nurses these included the procedures undertaken which complemented total nursing activity and for Chief Executives technical skills included understanding finance and accounting, human resource management and using the legal structures to ensure the business of healthcare services continued. One participant distinguished between skills need for specific roles and generic skills.

CEO 2: I think in some key managerial roles it would be a problem if you're not technically competent but I think it's essential in all roles. I'm not sure if that makes sense, but I think there are some jobs, some managerial jobs where a technical competence is a given as opposed to perhaps some other you know competence decision-making or having very effective interpersonal skills.

Professional skills were seen as encompassing the professional decision-making – as in clinical governance for example, those skills that are able to provide justification for a decision. Technical and professional skills gained from experience and maintaining currency were identified by most participants as integral to the accuracy of their decision-making. Participants were also able to identify the points in their experience when they knew that they were technically skilled, as in the case below, as a manager.

CEO 2: I don't think there was ever a point in time if I reflect back when I you know felt you'd had enough experience and gained enough qualifications to be able to draw a

line in the sand and say I'm fine from now on but if I was to reflect back on my management career and going into management at a fairly young age sort of late twenties into senior management positions I think I was technically competent like, you know, I had a good understanding of the budgeting process, annual planning process, the accountability models you know even personnel and you know performance issues how to address performance issues. I think the things that have improved with experience

Others support an holistic approach to decision-making. Senge (1990) in *The Fifth Discipline* describes a concept similar to professional maturity as "personal mastery" in which he combines the technical skills of reason with the experiential skills of intuition.

Ideology, values and beliefs and the tension created

Participants described personal experiences which moulded their way of looking at the world of healthcare. These experiences lead to the philosophical foundations to their practice, the *cultural power,* and are based on their personal *habitus'* dispositions. The data showed the impact of individual philosophies on governance decision-making, as well as those experiences gained through induction into their chosen professions. Those who choose the caring professions as a career enter it with a collection of caring characteristics gained from their life experiences and which have shaped their *habitus.* It appears that these characteristics are fundamentally compatible with caring as a profession. It is the experience as a caring professional which in turn shapes their decisions as caring professionals.

However, as individuals mature into their roles as health professionals, managers or directors they identify a tension between their caring role - the duty of care, and their roles as good employees or stewards of the public service - the duty of utility. This terminology was presented by one of the participants.

Medical Specialist 1: The reason is on a philosophical basis: - the ethic that drives most medical care is the ethic of duty and what drives management is the ethic of utility and there is a problem with the reconciliation of those two theories

In this context the term "duty of care" is not limited to that defined in the legal sense established in law. The term includes that defined in the various oaths taken by health professionals when they commence practice as previously discussed in the review of the

literature. The tensions between the duties of care and utility lead to conflicts of interest which influences decisions.

Personal, group and organisational philosophies were identified as being the foundation for decision-making. Several participants stated clearly that they not only thought about the philosophies and principles which underpinned their decision-making but that they applied them to the decisions made in everyday life.

CEO 1: I am very principle based, I have strong views about the public health system and that there needs to be equity in that system and that we should not spend more resources than the public of NZ provides to us, that we need to be really open and transparent more now than ever before in the DHB model around how we allocate funding to our provider arm and pass on price increases to funder arm. I think it is crucial that we treat the two with openness, transparency and equity.

This statement provided the researcher with a direct relationship between the philosophies of the individual and the principles of governance. They are closely linked for this participant. And others were blatant in expressing their philosophies and indicating how that shapes their decision-making. One participant imparts and lives the values on which he wants the organisation to base its decision-making. These personal traits underpin the governance principles on which decisions are made.

CEO 2: These are the sort of things that I hold important as a leader. I go through a set of traits that I try humility, integrity around the values and being available at least, …..basically admitting that you do not know or you have made a mistake being not afraid to do that and being open and honest about that.

CEO 1: Unfairness! I hate unfairness and I have made myself very unpopular with the Ministry and a few other people but a lot of it is around issues that I perceive as not being fairly dealt with. I can stand losing, but not if it is something really unfair.

Chair 1: I do think that your care should be free.

In the next quotes the medical specialist is describing the Chief Executive's commitment to a particular philosophy for service delivery. The result being clarity of vision which all people can understand and therefore make an informed contribution to the organisation. It is recognised that philosophical commitment must be supported by accurate and relevant data. Philosophy was identified as being closely linked to vision and therefore leadership and the impact on the health delivery system.

Medical Specialist 2: I think that the clinical advisory group, which is a board-wide structure of primary and secondary care, fits in with that philosophy of looking at the organisation from a "patient in a community perspective". You have to have a core major health delivery system and I think we've been successful at that.

Medical Specialist 2: The original values of an organisation are important principles when things are getting tough. The former CEO and I formalised a "can do" attitude in decisions based on data. They are very head type things. What it means is you can have an innovative idea but then you explore and you shape it you see what can be done, and, again the interesting thing is that this is the culture of this hospital.

Professional morality was discussed as part of ideologies however, it was identified by participants as key to the probity exerted in healthcare service decisions. Professional morality forms the basis for practice decision-making and will be discussed under quality and safety of clinical activity.

Conflicts of interest – professional

All participants discussed the tension they felt when making decisions which forced them to choose between their allegiance to personal and professional values and the demands of an organisation styled using a particular ideology as discussed by Boston (1991). This tension may lead to a conflict of interest.

Examples of conflict of interest were identified throughout the organisations in the study. Conflicts were identified in personal, professional and organisational contexts.

Medical Specialist 1: Clearly, the utilitarian view to get as much good or as many people as possible is not to always consistent with a duty-based ethic which is "the person, sitting in front of me is the only person I am interested in today and I have to get the best deal for her and I do not care about the fifteen outpatients I have to see today, so there is probability of conflict.

This participant was expressing his concern that some of his colleagues continued to provide care in a manner in which it had been historically set and not in relation to the resources available within the organisation. He was identifying the personal professional risk that was perceived as being taken by confining the individual patient-care decision to the context it was in rather than the context of the organisation as a whole on decision-making. Another example, below, suggests that there is tension for practitioners at the

bedside in relation to their responsibility for individual patients and the population as a whole.

Medical Specialist 2: I think that there focus is very much on the patient and what is required from a day to day basis for all the patients and that's probably where the tension is occurring. You know, what is the best for this particular patient that I'm looking after versus what is the best for the population as a whole.

Several participants discussed the concept of duty of care in relation to the medical model myth which is "allowed" to influence decision-making. The concept of medical model is ill defined. It is promulgated as being the scientific, positivist and proven method of providing treatment and care but little is available in the literature which assists definition. What was evident from the data was that when in doubt the medical model took precedent but on some occasions those with a higher sense of fiduciary duty, especially in relation resource expenditure, challenged that presumption.

Chair 1: To a degree, to a degree, but I still think that corporate governance has to impinge on clinical governance because it's never black and white in clinical either. A clinician would say if we don't spend all this money people will die. Well I'm sorry people die. It's a difficult one because there is always the myth they will know better.

CNM: I think there's a new wave of medical students, house surgeons, registrars and nurses, it probably came to me about five years ago, that they don't feel an allegiance to the health board as perhaps we did and do, I think that has gone

Researcher: Because you trained within the system or because of your length of duty since then?

CNM: Not altogether no. I think a different way of thinking.

Medical Specialist 1: I think we do, I think we do.

Medical Specialist 2: I think we have always had it from the CEO Where it has been difficult at times is when there are other pressing priorities such as sorting out the budget. The fact that the CEO is equally busy and has hundreds of competing priorities, and has to work out where he appears and who is seeing him at the time because he can't be all places.

Cultures of partnership were valued by some professionals and were considered to be fundamentally important to the ideological way they worked and how decisions were made.

CND: … the principles of governance are obviously being able to actually have your voice heard, have your decisions or actual recommendation to go forward for debate and also for consultation.

This participant distinguished between the groups in the healthcare services who made decisions and that fundamental to successful governance was the incorporation of decisions from all groups and levels within the organisation's structure. This will also be discussed in the structure of the field - Complexity, Conflict, Power and Tension on page 194.

Summary:

The *field of practice* is established through the individual or group gathering *cultural capital* through which decision-making is enabled. Coupled with the embedded dispositions of the *habitus, cultural capital* forms the *field of power*. Getting balance between the tensions created through inequality in *capital* is the role of those with *cultural, social and symbolic power*. Analysis of the *field of practice* was highlighted by the theme of professional maturity, which is determined by personal and professional experience, education and skills, credibility, attaining *metaliteracy* through experience and reflection resulting in a personal professional thesis and the importance of leadership. Identifying and managing conflicts of interest, the influence of the personal and professional cultures and understanding one's ideologies and philosophical base underpinning practice, were identified as features which support the balance between duty of care and duty of utility to the organisation.

This analysis demonstrated that there is more than *cultural power* present in the *field of practices.* Further analysis within the construction of a *social topology*, in Chapter 7, identified the *economic, cultural* and *social capital* demonstrated by the participants within the complexity of New Zealand's public healthcare services.

Chapter 7

Power relations within institutional and organisational complexity - a social topology

Introduction

As individuals or groups, the healthcare services team functions in a changing, turbulent, healthcare system environment as described in Chapter 3. The findings presented in Chapter 7 focus on the relationships between individuals and groups, the tensions within and between those relationships and the impact of the different types of power.

Social topology involves analyzing the *cultural*, *social* and *symbolic capital* which people bring to relationships and the impact of power that results from that *capital*. Healthcare services are complex and offer opportunities for a variety of tensions within the *field*. *Field*s are where the configuration of *economic*, *symbolic*, *cultural*, *social* and *political capital* interplay shaping interactions and activities of individuals and groups in their practice. In the analysis presented in this chapter tensions are identified and are interpreted, according to Bourdieu as power or the *capital* to influence, control or help understand the conflict or how 'the game is played' within healthcare services.

The *habitus*, whether group or individual is more than its whole, only existing in a particular *field of forces*. Establishing a *social topology* allows for an understanding of the *field* and for a way of coming to know the rules of the game, the *illusio,* which enable an individual to anticipate the behaviour of others in particular environments. The players understand not only what they do but the process through which activities are undertaken and the tensions that are created by individuals and groups, bringing different forms and amounts of *capital* to the *field*.

The *social topology* situates the various *field*s of *cultural production*, i.e. governance, management, medical and nursing, in relation to the *field of power*. In this research project the participants were encouraged to talk about the relationships within the healthcare services in which they practised.

Participants highlighted the influence on decision-making of:

- The role of leadership in exercising power
- The role and use of symbolic power
- Change management and managing people
- Roles within the healthcare service organisations
- Sharing the leadership role
- Demand and supply of resources

Each of these will be discussed in the context of the data.

Leadership, the exercising of cultural, social and symbolic power

Bourdieu (1984) posits that the desire for ongoing social distinction, the marker of social value and therefore the maintenance of *symbolic power*, underlies all social action. For Bourdieu *power*, which results from the interplay of *capital* within each *field* is the centre of all social life (Swartz, 1997).

One participant talked of seeking to reproduce those behaviours which he recognised as being successful. In this case the reproduction was through experiential role modeling rather than the formal education environment or professional membership. The participant not only sought to reproduce the successful behaviours but also to gain the symbolic *capital* which was attached to the successful outcomes of those behaviours.

CEO 2: I have a significant profile amongst other CEOs…New CEOs will come to me for advice so I would like to think that they respect my judgment on certain issues, the ministry has probably confirmed that judgment by requesting me to review two of the 3 outstanding annual plans

This is an example of *illusio*, the participant is expressing how he feels that what he does is important and meaningful, not only to himself but to others. He feels comfortable with the *doxa*, the set of cultural arbitraries established by those in governance in the healthcare services. Understanding this logic of practice allows each individual to negotiate to their advantage within the *cultural field*s in which they play a part (Bourdieu, 1990b).

Negotiation is through the use of *capital*, the power they bring to decision-making in governance.

Others learned the value of observing examples of poor management behaviour.

Chair 2: And I said at the time if ever I get in that position I sure am going to behave differently. It's that word experience, and often you just slot in without thinking about it too much.

…. so you do learn without thinking about it too much from those things earlier on;

The team of managers he was referring to recognised the impact of an individual's (chairman of company board) self-interested behaviour on the group and on the organisation and the use of the symbolic nature of the position. The participant described the negative nature of *symbolic power* when it is used to maximise an individual's position ahead of that of the organisation and he identified the impact on his own future behaviour.

Self-interest, or the pursuit of self-interest, is the foundation of Bourdieu's economic metaphor (1977a). The important principle of the economic perspective is that self-interest underpins all decision-making.

The quote from Chair 2, above, is also an example of having an understanding of the *field*, knowing the rules of the game which enable an individual to anticipate the behaviour of others in certain environments.

Social stability of the profession, based on shared values and norms (Jenkins, 1992) allows for continuation of the profession. It is the *cultural and social capital* of the profession which enables its *reproduction* and influences decision-making in similar ways over generations. It is through the *reproduction* of certain ways of doing things and certain associated expectations which make healthcare professions strive for their *doxa*, the set of cultural arbitraries recognised as the norm in healthcare services. This gives the professions the authority in decision-making through the use of their *cultural* and *social power*.

The medical fraternity was identified by participants as having the *cultural and social* power to influence decisions. The same level of *cultural and social power* was not seen as being available to other groups. For some participants this presented a demonstration of the

interface between corporate and clinical governance and how the *social capital* that was so familiar for the medical profession was being challenged by the need for utility. Chair 1 was quite specific in identifying that the medical model (as being the one right way) was a myth.

Chair 1: … I still think that corporate governance has to impinge on clinical governance because it's never black and white in clinical either. A clinician would say if we don't spend all this money people will die. Well I'm sorry people die. It's a difficult one because there is always the myth they (medical staff) will know better.

This challenge to the medical profession underlies much of the tension between the corporate and clinical decision-making. Conversely, one medical specialist suggested that, for him at least, there had been changes in how he interacted as a doctor with other health professionals, especially those who were new to New Zealand.

Medical Specialist 2: ….. there are now a lot of people who have come from other cultures and sometimes we are reminded when things don't work out well and why they are not is because you have not taken account of the other cultures and able to meld those cultures into our culture.

Nevertheless it was evident that, although some individuals change their behavior as they mature, others around them have expectations of the traditional, and therefore known and understood roles. On the occasion below, as a doctor, the participant assumed that because his behaviour had changed so had the client's expectations of him. In this example, another health professional was suggesting that the relationships stayed in a form that was more reminiscent of what the clients understood as traditional doctor behaviour.

Medical Specialist 2: "No, don't assume that the patients want to take that control". And the abstract says that one of the things in developing a relationship is working out exactly what the patient wants. And I had an adolescent patient about the same time, who was with the adolescent health worker, who said that "you've (I've) written to the patient saying that her muscle enzymes are getting worse, are you weaker? and what ever…." "She might not want to know that". And I said, "well, if she doesn't know that she won't understand that [why she is getting weaker]."

The example from the patient shows that the shift in decision-making power to the individual receiving care is not recognised. The mismatch occurs because the behaviour of the doctor differs from that expected by the clients. So tension occurs because the *cultural*

power is not put to effect as expected by the client or their agents – in this case the health worker. The decision-making responsibility remains symbolically placed with the doctor.

Most of the participants, especially those with health professional qualifications, identified that their profession was their point of reference in decision-making no matter what the context of the decision was. That was not to say that they felt that they were narrow in their focus as there was a level of *metaliteracy* demonstrated (Webb *et al*., 2002). But no matter how mature they perceived themselves the allegiance to their fundamental training was evident.

Medical Specialist 2: My name is xx, I am a "medical specialist" by training. I still practice medical speciality. I have been at Hospital since the end of 19xx

Medical Specialist 4: My previous experience is 30 plus years of health sector experience starting in 1967 with medical education with a Doctorate in Medicine in 1973, followed by specialty training in internal medicine with a fellowship with Royal College of Physicians and Surgeons ….

The collective *habitus* of the professions provides a base point from which their health sector history has been able to grow. The health professionals use the profession's *habitus* as the point from which they take their particular perspective on healthcare decisions. The profession also gives them the *cultural capital* and credibility attached to the decisions they are involved in making. That perspective shapes their decisions. They cannot be separated from their profession without considerable experience and engagement with different decision-making processes.

Notwithstanding the identified impact of the 'professionhood' on the individual, a commonality of profession characteristics was recognised as in the next example; characteristics that circumvented the formality of organisational structure.

Medical Specialist 2: I think it's an egalitarian culture and board members, senior managers, senior clinicians, nurses, doctors, others have always been prepared to exchange points of view whether it's in a sort of formal subcommittee structure or just in the cafeteria. For years they have done that …

Role and use of symbolic power

A number of the participants demonstrated the relevance of generalising their behaviour to include expertise not confined to their professions. This was a way of increasing the

cultural capital available to those individuals and in some situations assured an equalisation of the *capital* base with others in the *field*.

CEO 1: It's a combination of things, I have a whole set of experience and my professional background has taught me to think in a certain way, it's a particular professional background. I see the world with some aspects around the medicine and health issues. In the last ten years I have had a slightly wider view about what you are trying to do, the importance of values in an organization like this. We spend a lot of time trying to have a set of values we believe in and actually behave to them.

Bourdieu (1990b) names the fundamental principles on which a *field* bases its activities and decisions *doxa*. This is the set of core values and discourses which are the rules of play in that *field*. They are regarded by the players in the *field* as being inherently true and necessary and there is an unconscious allegiance to these principles although they may be arbitrarily established. The arbitrary establishment of rules based on such philosophical principles influences decision-making as they are perceived to enhance all forms of *power*. This was exemplified by the fact that all but one participant had sought Masters' level education. Practising clinicians chose their clinical speciality to study at this level but all managers and chairmen chose business (MBA or similar) qualifications. These were perceived by the participants as having value in the form of generalisation of skill or because they were aligned to business per se. People who are successful in business have *cultural capital* in the form of material possessions.

The chairman cited below demonstrates the use of *symbolic power*, a position supported by *cultural capital* in the form of educational qualification, to extract a decision from a group.

Chair 1: I do think I have a responsibility to ensure that the shareholders strategy is implemented whether I am chairing or not. I've had a lot of political experience and I know how to do a resolution and get it out. I don't often do that because I think it is better to do it with consensus but at the end of the day if everyone else is going to fluff it out I am going to do it. The biggest responsibility I have is for everyone to walk out of that room feeling they have had a chance to have their say and that whatever the collective decision was we are not going to go out there and bad mouth the staff or each other. And I think we have been very successful at that and I feel good about that of course there have been decisions that some of us disagreed with or not but at the end of the day we all felt I had my say. Collectively we have decided "this".

The example gives inherent recognition through the experience of the chairman that others may not have the *cultural capital* to make the decision but that the contribution to consensus is just as important as the decision itself.

Change Management

All the participants recognised their leadership role as change agents, in meeting goals and achieving what they set out to do. Change was seen as integral to the survival of organisations.

Using the *social economy of capital* framework the purpose of leadership is to maintain order in the organisation and to ensure that change is anticipated and managed by leaders who have both *cultural capital* in the form of experience and qualification and the *symbolic capital* which comes with legitimation of roles.

Leadership was considered not only about the setting of direction to enable change but also establishing the standards by which a plan was going to be achieved. Leadership was not always perceived as a personal attribute but as part of the process of decision-making. These examples support that notion.

CEO 2: ….more about the leadership of setting the direction and those standards.

Medical Specialist 3: There are two bits to that, one is that the Director of Nursing and myself have executive leadership role communicating the information we have into strategic planning, annual plans etc and there is a role with the chief operations officer and the CEO in that as well in the sense that they are a part of a clinical board and clinical directorate…. That is the concept.

All participants described their success as a leader as having impact on both how they made decisions and how these decisions were considered by others. Their role as change managers within their own organisations, managing the behaviour and recognising the abilities of others and the lack of leadership from outside the organisation were all identified as shaping the way they thought and their activities within the healthcare services. Several participants linked the impact of values on the organisation's ability to manage change.

CEO 1: We are quite strong on values, behaviour and the way people behave to each other and the influence type stuff, from my understanding it is important there seems to be

a lot of leadership evidence that those sort of things are probably key to an organization's ability to deal with change and to actually be able to attract people that can work together and deal with change.

Key to the establishment of strong leadership was the integrating of the organisation's values, the organisation's *habitus* with the guiding of decision-making by the leader. As well as values, leadership was aligned to the establishment of ethical boundaries inside which employees could make decisions.

CEO 3: Like anything, it is a matter of leadership. I am a strong believer in practicing what I believe how the organization should behave and I think consistently I try to have a fairly steady level of ethical behaviour and the organization picks it up.

Leadership, from this participant's perspective, included the recognition that people have feelings and that the good leader knows how to recognise and manage those emotions as well as his or her own response to emotional situations.

CEO 1: The other set of things that I spend a lot of energy on now, which is equally important, that a lot of our leadership needs to be able to deal with some of the emotional intelligence issues. Essentially a lot of the leading is about how you interact and control yourself and how you persuade people and what is the legitimate way to involve people and try to get them on board and have that debate.

Nurse participants identified the perceived lack of value placed with some professional groups as having an impact on both leadership and the recognition of the leader's *symbolic capital* and therefore the reception of the decisions made by those leaders. Some actions by managers were identified as initiating tension rather than creating either a balance in the *field* or an understanding of what happens in their organisations' environments. Recent experiences were compared to those with past managers who had demonstrated an affinity with staff which was interpreted as being valued.

CND: …perhaps the corporate world do not really, really, really value the role of nursing with professions. ….. on international nurses' day, nothing really came out from the general managers,

Researcher: So there's no celebration of the major chunk of the workforce and what they do …

CND: No, they got actually handed a box of chocolates; but so what, you know? I just remember for example, like the previous CEO, had the personality as a front

person. He would know Jack in the mail-room for example, and also be there up on the ward 14 in three in morning walking the floor.

Researcher: but also getting the feel for the organisation

CND: And that's actually the x-factor I think and I think nurses don't want that box of chocolates which is demeaning

Roles

The impact of changing roles within the healthcare services was also identified as influencing decision-making. Role change was seen as being a result of structural change, as one participant (CNM) identified. The symbolic *capital* attached to titles was recognised as important and as outweighing the *cultural capital* of the nurse.

CNM: …I think their (younger charge nurses') goals, their idea of a charge nurse manager is completely different. I think the "Manager" on the end of charge nurse is perhaps more important to them than the earlier part.

Reproduction has a valuable role in transferring the cultural behaviours from one generation to the next (Bourdieu & Passeron, 1977b; Jenkins, 1992; Swartz, 1997; Webb *et al*., 2002). However, unless challenged there is the risk of the unwitting transfer of negative behaviour through generations. *Reproduction* of behaviours able to be anticipated by others is an important part of the development of the health professional and their ability and confidence in decision-making.

Recognition of the symbolic *capital* available in positive professional role expression was demonstrated by several applicants describing how they became good role models and how they continue to maintain good role modeling behaviour.

Clinical Nurse Director (CND)….. this year I came back and did a few shifts on the ward, clinically, just to actually touch base find out what's really happening at the coalface. And what it showed to me is the reason I went nursing because I really, really, really loved patient contact I just loved it. I made a difference for the patients I actually cared for. I was precepted, buddied, and the staff were just brilliant.

I saw myself actually being able to expert nurse, actually pick things up really, really quickly and problem solve very quickly also.

CND: also I still know I would have been the best person for the role ….. so I feel really comfortable saying that so and I now have the skill set and capability.

The data also shows the recognition of credibility combined with confidence in one's own practice as the basis of *symbolic capital*.

CND: It's credibility; it's credibility by doing isn't it? You know by actually sort of saying 'yep I'm going to do that or I promise to get back to you by this time next week' so it's a realistic timeframe and do get back either completed or not completed but you do get back to that person… isn't it?

Credibility does not happen in isolation. It is inextricably linked with both the knowledge and understanding of others within the professional environment, the *field*s of practice. Each of the players in an interaction brings tension to the interaction. The next two statements are examples of the recognition that few decisions are made in isolation and that many are made with reference to a more experienced individual in whom *cultural* and *symbolic capital* are recognised.

Medical Specialist 1: … and the second thing is that you cannot make isolated decisions, the one-person decision in healthcare is, I think, a thing of the past, …..… you have got to have credibility with your colleagues about decision-making otherwise it is never going to work.

CEO 1: I mean obviously you get a feel of accomplishment when you get feedback from your peers, which helps to reinforce your view of the world. I think sometimes it depends on whether you have any key sort of entering or key relationships with people that are well respected at the end of the day. I think that's pretty important.

The medical specialist cited in this interaction also presented a frustration about getting people to recognise problems before they manifest themselves. Decisions don't get made because the problem has not manifested itself yet. The problem is not recognised because some players (other than the participants) are not familiar enough with the *field* in which they are playing. These participants expressed clearly that it is the lack of general understanding about the healthcare services that impedes decision-making process.

Medical Specialist 1: In the corporate governance structure there is not a lack of imagination about potential, it is a lack of knowledge. What troubles me is that clinicians do not always provide accurate depictions of what the options are because they do not know either sometimes what the issues are. And there are things, say in the secondary care environment, that have profound primary implications and possibly tertiary care implications.

Medical Specialist 1: It is more than that, it is getting people to be engaged in the process. If you say there is problem X here, can you not see there is a problem?

Medical Specialist 1: Well not really tell me about it. So I would say "here is the problem, the delivery of a certain resource to an increasing number of people who are going to have the condition", well…"show us the evidence". Well here it is, its demographic evidence. So, it is getting people into the game of seeing that there is a problem before you solve it.

Other participants explained that better working environments were developed when the perspectives of others were actively and formally part of the decision-making process. This also stimulated a personal response, broadening their own understanding of the professional base of others and that contribution to the decision-making process. In this example the respondent describes how the *metaliteracy*, in the form of accepting the roles of others which the medical specialist brought to the discussion, allowed the tensions in the *field* of the decision-making group to be equalised through understanding the roles of others.

Medical Specialist 2: So, again it is getting into the stories of the people, understanding and getting alongside. We learn an awful lot by osmosis and by having the right people round the table and I think that [one group] we had very early on the Clinical Board was the midwives who reminded us that they were not nurses and therefore they had to be at the table. Just having the midwife saying… whenever we were talking about a policy involving nursing and midwives, I think that those members of the clinical board now know the difference between the midwife and a nurse. It is a quite a good example because if you are not round the table you can be ignored in that process. We have had in the last year a consumer there to represent the consumer perspective and that is already starting to make a difference to the way we think.

Through understanding and accepting the roles of others a balance is attained in the *field* and achievements can be made. This is an important aspect to change management. Finding a common goal was also cited as effecting change and the associated decision-making.

Medical Specialist 2: ….the first talk I think that the clinical leader of orthopaedics, he said well look we'll never agree because our motivations are different and her (new chief executive) first tasks was to point out in fact they were very much similar in relation to the true specifications and they were both able to contribute to this and getting that understanding they became one of the more successful orthopaedic units in the country. Whereas in the past I think people would retreat back to their colleagues and say well look you'll never make clinicians understand the importance of this…

Although this example was given from a paper given in the United Kingdom, the respondent recognised its significance and related it to the changing environment in his own organisation.

Managing People

All participants referred to managing of people as a key leadership role. Getting people to participate in change and/or contribute to projects was identified. But it was Chief Executives in particular who linked leadership with being the personal attribute necessary to the change process as well as leadership being a concept that is embedded in the organisational culture and therefore influencing the decision-making process.

CEO 2: A whole lot of it should be smooth because it is about me developing my staff, developing an annual plan, and putting it in conjunction with the board around the direction, but the actual wording, the emphasis, the priorities in that plan are given to our board who say that is what we want to do, goes back to the organization, goes back to me to give it to the Ministry of Health to sign off. So that is the process.

CEO 3:…it is about leadership, not about me as a leader, but about leadership through the organization. and it is unlike clinical leadership. It is people stepping up taking the leadership role. " I am a surgeon who is interested in post operative infections so I will take a leadership role in working out why we are getting this and what is happening. Not as clinical director, but that is a leadership role that I want people to understand."

Sharing the leadership role

Many of the participants had had many years of experience in their current roles. This CEO was specific about his leadership style and process.

CEO 2: I tend to operate with the executive team or some of the general managers in particular with the executive team being a second opinion and more a coach as opposed to you know feeling, giving a clear mandate or directive over how some things should occur or equally sitting back and not offering any advice and letting them sink or swim.

CEO2: … I would tend to think more words like sharing of power, involvement in executive decision making, involvement in strategy, determination of organization's priorities, allocation of resources and funds, I would talk less about fiduciary responsibilities which I would relate very much to some of the statutory requirements that exist more around boards, perhaps with the upcoming Health Practitioner's Act, links with the Medical Council. I think there are responsibilities that key clinical positions have which may be considered of a governance nature that is linked with those authorities and bodies.

The participants had learnt the notion of sharing or spreading the leadership role so that it is put into effect throughout the organisation. Hesselbein (2004), Pfeffer (1997) and Shortell (2004) focus on organisational leadership. Hesselbein (2004) highlights the collaborative nature of leadership in the twenty-first century and that individuals do nothing alone, from the small group through to huge corporations or even countries, they work together. Shortell (2004) has a broad view of leadership ranging from the level of individual motivating capabilities through the level of groups and teams to organisations at large and Pfeffer focuses on the role of leaders as change agents. This need for multi level leadership requires greater integration of leadership programmes.

The recognition of the value of sharing, the confidence to delegate responsibilities reinforced his power, his *social, political* and *symbolic capital*, as the leader of the organisation. The value of sharing was put in the context of formal academic leadership programmes being applied to DHB management.

CND: And also C (manager) is doing this leadership course at Harvard just at the moment and it's completely about post-heroic leadership where you actually sit at the table all the key people obviously in the management team, including me, and it's all about consensus decision-making, collectively and so it will be really interesting to see when he comes back to see how he actually leads the team again…

Researcher: Do you feel you have much collective decision-making?

CND: Umm I think a lot more so. At the end of the day, decisions have to be made and so C manager can do that and he does listen, I think he does acquiesce.

The Clinical Nurse Director recognises the value of shared decision-making but is unsure whether the shared outcome is a reality or not or whether the political power of the manager has greater influence on the decisions than the consensus.

Participants identified the reality of being familiar with the situation. Understanding the *sens practique* in their organisations was important in maintaining their leadership role.

CEO 3: I can pull the team together and that is good I think

For CEO3 above, having the confidence to lead the team influenced the personal attitude actually influencing the way the participant thought and therefore the way decisions were

being made. Others, like the participant below, used experience as the analogy to getting people to perform.

Medical Specialist 1: Yes, I captained a few rugby teams when I was playing rep rugby, getting people up to the game…

This participant recognised that leadership included ensuring that there is a familiarity with the circumstance, the *field* in (on) which they are playing and that the leader uses both *symbolic* and *cultural capital* to balance the power through managing the tensions in the *field* just like a game of rugby.

Mintzberg (1996, p. 67) in his Musings on Management describes a craft style of managing based on his observations of a nurse manager of a surgical ward. He identified the importance of credibility in his statement "about leadership based on mutual respect rooted in common experience and deep understanding".

Chair 2: I learnt at a young age not to be frightened by good people around you and have learnt the value of that over the years. So I pay particular attention, if I am on a board, to the appointment of the CEO…

This chairman identifies that the individual *habitus* is alert to benefiting from the qualities of others. Individuals respond to the activities, the tensions in the *field* around them.

Leadership and the management of people do not stand in isolation. On occasions participants expressed that the decisions made were affected and effected by human and other resources.

Demand and supply of resources

Participants identified the availability or not of resources as influencing, enabling or disabling a project to be undertaken. The demand and supply of resources encompasses decision-making in all environments of the healthcare sector. Resources are allocated and managed at many different levels within the healthcare service and considerable power was attached to the authority to allocate or withhold. Both public choice and agency theories (Boston, 1991) assume rational utility maximisation. The interrelatedness or flow on effect from the Health Vote in Parliament to the bedside was identified by several participants.

The following examples identify the *political, symbolic* and *economic power* associated with the *economic power* of funding in the public healthcare sector.

In the clinical environment, participants who were nurses identified clearly the relationship between having the authority to allocate funds and how clinical professionals were recognised as having a valued role in the organisation.

CND: … for example, the nurses from the XXX unit… the fundraising to go to the Australasian XXX Conference, they are becoming a national centre, now I would have thought that these two expert enrolled nurses that actually won the XXX Fund Trust, $2,000 fantastic stuff and I was one of the judges, fantastic applications great stuff second level nursing; really pleased. I would have thought that these two nurses should have actually been handed or given further money to say 'listen we really value you guys, you're two expert enrolled nurses within the XXXX unit becoming a national centre what can we do to actually bridge this gap. Lets talk to the GM, to the chief financial officer, whatever, to actually assist you".

Why are they having a meat raffle last Friday or selling cakes last Friday?

CND: And I'm not a budget holder you see.

Researcher: So is that a constraint in your decision-making, it constrains the impact that you have on decision-making?

This participant was also connecting the availability of funds with restrictions on how the new national unit was established and the limited skills which were being made available to bedside clinicians to prepare for its introduction. It was also identified that on occasions the structures around the allocations of funds unnecessarily restricted how they could be spent. In this example the nurses' collective employment agreement (MECA) was identified as restricting decision-making for up-skilling.

Researcher: Is that and it's not part of the planned budget for ongoing education?

CND: No, no, they (nurses) get $500 per annum and it's not rolled over either so if they don't take it all …It's not to make sure the service goes….

… It's very discretionary in a way.

The tension created by the lack of input into clinical decisions by management, the limited authority that those who spend funds at the bedside have in resource allocation, and the inability to be guaranteed effective use of funds was expressed by the next participant. He also indicates that there are few tools which can guarantee cost effective and efficient expenditure.

CEO 1: I mean I criticise both (corporate and clinical governance) processes sometimes because often the organisational process overrates the money side and underrates some of the other things and then you look at some of the critical analysis and …. even the effectiveness of clinical practice and the good use of resources…. often the case is not well made. Quite frankly it's incredibly ad hoc…. The actual health evidence is actually appalling in cases and hasn't been well thought out and it's a random knee-jerk reaction from clinicians. You know spending hundreds of thousands of dollars without…. if you actually put that in front of the jury of peers it would not stand up to scrutiny. That's what we now try to do in our clinical procurement process…. they're supposed to be going through a process where they justify to their peers which is a good thing to do…… if it's got major resource implications it comes to organisational budgeting type processes...

This participant clearly separates the corporate and clinical functions in decision-making, identifies the lack of good evidential data to support resource expenditure decisions and explains the actions his organisation has taken to attempt to manage the resource procurement process. This CEO brings both *cultural* and *symbolic capital* to the decision-making but, although the decision-making process is defined, the *cultural capital* of clinicians is not sophisticated enough to prepare them to contribute to those decisions from a cost benefit perspective. The outcome is a power interplay based on the *social capital* each party has to balance the tensions which arise in resource allocation.

Another participant recognised the interrelatedness of resource expenditure and its implications for clinical activity. There is an indication that if it cannot be afforded then the clinical service won't receive the resource. There was no indication of cost benefit analysis, need analysis or any other economic evaluation. Budgets influence decision-making.

Chair 3: That (resource allocation) needs to be handled through both management and clinical governance people, but how it was meant to be looked at clinically, we need to look at whether we can afford or not and unless it is a major equipment buy, a major change in the way we do things, I do not see much of that stuff getting as far as the board.

Staff performance in resource use was identified as important to decision-making. Creating incentives for staff to perform effectively is a complex process and perversity is easily established. This chair describes a full time surgeon and the volumes achieved giving comfort to procure services from the private sector, but also commented that the decision is dependent on having the data available.

Chair 1: … those people are a very good example of somebody who will allow you to influence is JJ of orthopaedics. He is very good, focused, 100% works here, he did not always, even more except that's what he has done now. And you can see his production rates are fantastic. He can do it and I said to him at one stage… – I was congratulating him about how efficient he was. And he said "Oh I can get smarter than that, just give me the money and I can get smarter." He didn't mean to waste but to do the operations. And, of course, then we did get a boost in Orthopaedic money from central…. Production rates are up. Fantastic! We can now tell who is slack and who is not but the next trick is what are we going to do with that information.

Chair 1: …we know who is not producing …. fantastic analysis. We were in a very fortunate position with JJ because, as I said, he was producing so dramatically and then we got an opportunity to give him more money for it and we have gone out and used some private facilities. I felt comfortable about that knowing that he was getting the most out of his team. The difficulty is that there is so much private and public mix there that if you go out and buy from private it can be rewarding inefficiency in your own system and that's a big concern for me that we can't do it all in here why can't we because we are working at capacity not because we are being slack. I need to know so that was great to know that was fine.

From the same participant it was clear that economic rationality, funds and how they are budgeted, underpin all decision-making for the corporate organisation. This participant's response also demonstrates the conundrum that can arise when the funder (purchaser of public and private services) allows the poor performance of the DHB services to be rewarded through purchasing from the private sector.

The DHB can be subject to not being able to make the decision that that board feels is right for its organisation. In the following example a decision not to provide a service was overruled by a political decision to ensure that it continues. The *political power* outweighs the need for efficiency in the DHB.

Chair 1: And it's like the F service which is a good example, we (this DHB) made a pragmatic decision that there is a whole lot of criteria that the shareholder gives you with priority observed. The F service comes down at the bottom. Is it something the public system should be providing? I don't think it is, if you are short of the money and have an endless supply of money it does not matter. That costs us nearly $2 million a year and by default they are white middle class two income people it only costs $3000.

The power associated with *economic capital* takes precedence over other forms of *capital* on most occasions (Bourdieu, 1990b). But in this example government policy outweighed the decision of the local decision-makers in the DHB.

The *field of power* can also mean the dominant class (Bourdieu & Wacquant, 1992b). In the previous example the Minister of Health is identified as the dominant player, and member of the dominant class, having the *economic and political power* to rescind the decisions of a DHB.

Summary

The *field of forces* is characterised by the tensions created when people and groups interact. A *social topology* creates a map of those tensions and the durable characteristics of the *field* which are not affected by the continuous distortion of tension. Those with power, the *cultural, social and symbolic capital*, have a responsibility to manage tensions toward a balanced environment and need to trust and be trusted to do so. This *social topology* added to the findings in Chapter 6 with particular emphasis on the impact of leadership which encompasses sharing leadership, managing change and managing people and the roles they play. Participants gave examples of the tension created when getting a balance between their professionhood and their duties to their organisations. That included tension and power, especially *symbolic power*. The impact of resource availability and/or constraint was emphasised by all participants. Economic rationality was identified as influencing decision-making in governance in healthcare services indicating complexity in healthcare services.

Further analysis in Chapter 8 identified complexity created by the complex *structure of the field* in which healthcare services and the impact of that complexity on decision-making in governance in New Zealand public healthcare services.

Chapter 8

The influence of Healthcare services structure on decision-making in governance - Structure of the field

Participants cited complexity of the organisations they worked in and the healthcare system in general as a reason for decision-making being cumbersome. The tensions which arise in the *field* of healthcare services governance are influenced by the structure of the healthcare services system which shapes the decisions made. Decision-making in governance is bounded by the formal and informal structures of the governance in healthcare services *field*. The *structuring structures*, described by Bourdieu (1993a) as durable dispositions which form a base and guide the structures of practice, are embedded in the culture of the healthcare services as institutions and located in time.

The data presentation and analysis in Chapter 8 will focus on the group *habitus* of a DHB and the class *habitus* which the group brings to governance in the New Zealand public healthcare services. This includes the impact of collective decision-making and decision-making across the organization, including decision-making related to ensuring quality and appropriateness of healthcare services. These are discussed within the boundaries of legislation and Ministerial direction. This last discussion structures the *field*; the structure of governance in the New Zealand public healthcare services.

The data illustrated the impact of:

- Time in the context of decision-making, over time, sequence and consequence
- Organisation structure as facilitating or impeding decision-making and the influence of healthcare systems as institutions within legal frameworks
- Quality and safety of organisational activity, complexity, conflict, tension and power, and conflicts of interest
- Collective decision-making and collective responsibility
- The commoditization and democratization of healthcare

Each of these topics will be discussed and elaborated upon in the context of the data.

Time in the context of decision-making, over time, sequence and tempo

All participants highlighted the effect of time in position, time as professionals and time as maturing human beings as influencing the way they shaped their decisions. And while time was recognized as not developing maturity by itself, the ability to include a wider range of variables in the decision-making process came from time spent experiencing similar decision-making processes in the past, and the time available to make a decision.

Nurse manager: …ultimately that decision will be mine and in 16 years I have only made one decision that perhaps wasn't the best,

CEO 2: I think the things that have improved with experience say for the next 10 years have really been the range of scenarios settings within with you have worked, relationships you have formed and so it's really been that experiences that you've had since becoming technically competent that has supported what I'd call better decision-making. You know knowing when not to jump in boots and all, knowing when to get a second opinion and to bounce something by someone you know….

CEO 3: So I think yeah it's the passage of time has aided more effective decision-making and I guess its stronger strategic outlook on what's really important at the end of the day.

Participants identified experience over time as an important aspect of developing their decision-making ability. Bourdieu states that it is time that gives practice form. "…that it is constructed in time, that time gives it form, as the order of a succession, and therefore its direction and meaning" (Bourdieu, 1977a, p. 7).

Time is not only important in developing the skill in decision-making but also in the formulation of the decision itself. Time is both a characteristic of the *field* as having a place in time and tempo and as having reached a certain place because of time.

Experiential learning over time and in the space of [health care service or professions] allows the development of an element of sophistication and depth to our decision-making (Swartz, 1997). That depth is called upon so naturally that it becomes our second nature or instinct to respond in particular ways.

The next participant was quite clear in articulating that instinct in decision-making is not a random thing and that it is based on experience and having information on which to base

decisions. Instinct is the personal collective history. It is that history which shapes thinking through the experience of individuals interacting with others and their environments impacting on the *habitus*.

Chair 1: I think you hone it but at the end of the day you have got to trust your instinct recognising that you had all that experience that comes in and your instincts are not random but you hear all the information.

Managing the speed and sequence of decision-making were recognised as a particular attribute of governors, the way in which their symbolic power is actualized.

Medical Specialist 4: Governance comes out of a definitional term which has to do with holding control over something, so a governor holds the speed at a particular level, and governance in general refers to the ability to manage or control the direction, speed or development of a particular entity.

That symbolic power is influenced by the ideologies of individuals and groups.

Impact of healthcare system structure

As previously identified decision-making may be shaped by the ideology of the government of the day. The clash of ideological thought was raised by participants, both that they agreed or disagreed personally with the ideology of the current government, and that they longed for governance which was based on logical decision-making and robust data as discussed in the previous section. However, there was not the recognition that the structures of the healthcare services inhibited individual personnel from making their own decisions.

Chair 1: I have a belief that there is a certain section of the population who can't look after themselves and therefore society should look after them.

CEO 1: I accept that it is governance responsibility in terms of the board to actually decide on some of those policy decisions and in some cases it is obviously the Minister's decision to say what some of those policy issues are. If I do not agree with the policy decisions or if I have a contrasting view I believe that it is my responsibility to get the pros and cons and to certainly express what I think,

But participants also relied on the structure of the organisational and political processes to explain their governance in the healthcare services context.

CEO 3: The way I see it being enacted both here and elsewhere and in my history of public health organizations it tends to be that style of governance, the one that people

combine with corporate governance stuff with the public ethos in a political environment and working for the government.

Chair 1: Personally I think I am accountable to the Minister… because I am just appointed by the Shareholder (the Government) and must implement their philosophy

This later statement was given as an explanation that the role of the board was to implement the policy of the government of the day. The data was an indication that DHBs do not have the freedom of decision-making or accountability experienced by their predecessors registered as companies and guided by the Companies Act (1993). Making meaning from corporate decisions was considered an important part of understanding the change needed in the healthcare services sector.

The next participant identified the rules, based on data, underlying decision-making in governance as being the same in any functional area. For example this medical specialist stated:

Medical Specialist 1: The rules that govern the corporate and clinical governance are exactly the same. Francis Bacon in the 1700s said "data is the enemy of controversy" and rationality was important and I agree with it. And what corporate governance has to do is, and this is the reconciliation point between clinical and corporate governance, there is no doubt about, is evaluation of objective data. That is the issue.

While he specifically distinguishes between corporate and clinical governance he states that the rules are the same.

However, another participant indicated that there were no rules in governance decision-making and that was a problem in that people did not know how to respond because of this deficit. This quote also alludes to the arbitrary nature of establishing governance and organisational process.

CND: Well that's interesting because I remember my general manager saying well, 'how do I talk to her' …..and it's interesting isn't it? You're kind of looking at what you really expect people to just to know… you know that the general manager… how would he actually engage with the clinical nurse director? I mean there's no kind of rules there so then you set up this governance and partnership…

Other participants identified individuals as having their own set of principles for governance decisions which together form the governance of the organisation. As above,

there were responses which identified the principles of governance as underpinning the decision-making.

CND: ….and also obviously within that is that (individual) governance of the clinical director, nurse director, clinical director and the manager.

Medical Specialist 2: I think there is a huge gulf between the philosophy behind governance which is accountability, and transparency in the delivery of governance which currently has more to do with looking backwards rather than strategically looking forward, and to not engage in change in a sort of positive way towards the improvement. It depends on what the rule of the agency is as to whether the governance is leading by its objectives or not. I think the focus is too much on yesterday and not enough on today.

In the latter of these two examples the respondent identified the historical focus as impeding a strategic or future focus for decisions. This participant also identified the principles of governance and the role in change. Most of the participants were very clear that how they thought was fundamental to their decision-making no matter in what context of the healthcare services they functioned.

CND: I think that's actually critical fundamentally,….what are your values that essentially describe you A or you B, the person?

Historical arbitraries of structure were identified as shaping decisions. This was particularly in relation to historical service specifications and even budgets. For example:

Medical Specialist 4: In fact in the last three years there has been no development around that and I think that is because the strategic plan is been very much locked into current health services. And the government took an unusual punt with this whole thing and putting and investing in district health creating an infrastructure from hospital-based systems that were competitive, saying that these hospital-based systems with this heavy reliance on hospitals infrastructure would suddenly be able to move out of that role and manage and support community health and innovation.

At the clinical level the health professionals gave examples of how the recipients of services expected (or demanded) that decisions were made for them because that was the way the public expected doctors and nurses to behave. This was in turn interpreted to mean that the decision was easier if the authority, the fiduciary duty and therefore the *power*, had been given to the health professional.

Medical Specialist 2: And another who said, "I know your game, you want me to make the decision". She was an older person and she was quite comfortable for me to make the decision. And that's a useful decision.

Actually, it reduces the pressure on doctors because it then becomes a shared decision.

All the clinicians in the study had the best intentions to provide the best quality of decision-making in the care. None recognised that the cultural arbitrary established by their professions and the within the *cultural field* of the hospital had an ideological base which inhibits the freedom of the clients to make unimpeded decisions about their own care.

Social structure and the *reproduction* of those attributes deemed (arbitrarily) to be positive enhance some of the experiences; others are discarded (again arbitrarily) and the impact of that can not be measured or evaluated. An example is a Clinical Nurse Manager describing the (arbitrarily) historically designed system where the medical staff do not join with other health professionals in making a common decision but rather information is passed on to them in another forum.

CNM: ….in saying that it is getting more multi disciplinary - like the physiotherapists and the OTs have far more input now than they used to. So we have a ward meeting and mention every patient and they will ask the question why is that being done for that patient and it's up to me after they have had their say to take it to the medical people.

For Bourdieu (1990) the dispositions of the *habitus* are rooted in the group and are not easily changed. Rather, they can be slowly modified to reflect the ongoing nature of the way their thinking, action and decision-making changes. Tensions arise when individuals block the change strategies of others by exempting themselves from the same decision-making space.

Other examples related to the organisational structure of the healthcare services system especially in relation to the centralisation of decision-making, away from the DHB. The next participant suggested that while the historical structure of the 1990s was too decentralised the current system had limited flexibility.

CEO 2: I think you know there were maybe then (late 1990s) the sector was a bit too autonomous and there was the need to become more semi-autonomous in terms of how organisations operated because I think there were, particularly around capital planning, you know some approval development that has come back to just sort of

haunt the sector but equally you know there is a need to I think have a greater level of flexibility for boards and the right incentives in place to be able to plan their capital requirements more easily than having a national structure oversee any implications that we have at the moment.

Healthcare systems as institutions

Institutional *habitus* is structured by systems, rules and laws that allow large numbers of people to interact with some anticipation of the expected behaviour of others.

Structures, both formal and informal were put in place by participants and their organisations, to legitimize differing behaviours. For example workshops or discussion groups were reported by participants as happening outside of the transparent governance process of formal DHB decision-making.

Researcher: Is that one of the problems with the DHB open board meeting, public, transparent or seen to be system?

CEO 2: I think if I felt there was going to be an issue that was going to cause some debate and disagreement at a board level or from a management level with the board then both I think, the chairman and myself would have a discussion about that prior to. We have very few issues that have been referred back from management to have another bite at it and come again in a month's time. In my two years here I do not think I recall one issue that has been bounced back.

Researcher: That is pretty impressive. So a lot of the final decision-making is actually based on groups of homework that is done before hand?

The effect of this behaviour, the circumventing of the formal process designed to ensure transparency, is both a potential and actual flaw in the decision-making process. In the next example the medical specialist indicates that not only was debate held before the formal board meeting but that board members wished to deal with complex models at a superficial level rather than challenging the staff on the underlying assumptions.

Medical Specialist 4: And what is really interesting is there was a debate, just at the meeting before the most recent board meeting one of our board members said don't give us too much of the social determinates Health needs another said we can trust what the simple bit is because we know that it is being well thought through it is interesting that nobody has ever really challenged me on the ----------

In yet a further case the format of meetings had been altered to have discussion prior to the formal meeting and in so doing limiting the transparency of the meeting to the public.

Chair 3: I presume (that decisions are made) in the board meetings, and that is probably true but then I would like to run reasonably tight meeting, every body has had their say which is fine so we can make a decision and move on or not…..and not that people haven't got enough information. As a result of that we have changed the format of our meeting, so that now we are taking an hour and a half at the beginning to do discussion, planning, looking at issues that need to be reported on like the regional cancer services, everyone gets a chance to talk about it and then start the formal part of the meeting a bit later. So that we are taking out things that we feel people might like the opportunity to discuss a bit more.

Researcher: Is that discussion open to the public?

Chair 3: Yes.

Researcher: Do you keep a high standard of attendance?

Chair 3: No, no, the press, sometimes one or two others sometimes if there is interest.

All DHBs indicated that transparency can have its disadvantages. An example given was the impact of media presence in impeding effective decision-making or the discussion necessary to get to a decision. Again, in the next example a pre-meeting discussion was held to ensure that there are no surprises in public

Chair 1: In terms of the board we haven't done deals at all. We have been fortunate in that we only get one person who comes if we've got ….not like Auckland with the media and all that… and maybe we would need to do more. And we can have our discussions in public that is no big deal but if the media are there it is more difficult to do that. We have half and hour before a meeting but that is just generally for me to just get a heads up if anyone has any real issues with anything so I know when I have reason to I need to allow a bit of time when I am working through. We don't discuss the topic it's just the process. Is this all going to go through smoothly or whatever.

Participants also identified how conflicts of interest were raised and dealt with prior to a board meeting and, although the chairman felt that the board was well qualified in terms of cultural equity some had positions in the community which were in conflict with the DHB.

Researcher: Do any of the board members speak to you about anything before a meeting, do they seek extra advice or extra information?

Chair 1: Some of them do in terms of if they have a conflict they will ring me and say I don't quite know how to handle this and quite a lot of them are on a lot of other things in the community. And that can cause a bit of a problem. So that's fine, and some of them will write to me so we do a bit of e-mailing, but to be honest very little stuff. Which is quite healthy that we are not second-guessing each other all the time. We've been lucky actually. There is only one person not tertiary qualified in that

room, and there has been a lot of experience; even though there is a bit of "own barrow" and stuff.

Other participants felt that the structure they were being asked to work within was unworkable as board members did not understand fiduciary duty to the organisation.

CEO 1: Not hugely, but for us it has been particularly prominent primary care especially because of our three GPs. I think it is just too close to home and people have not been able to separate their governance role their role as a general practitioner or some of their own business interests quite frankly they just have not been able to do that and it is hard even in the private sector you get people that mix those sort of things.

Researcher: Is that a problem with the structure of the DHB?

CEO 1: Inevitably when you allow employees or providers to be on the governance, it is in intrinsic in the system to allow that conflict and the government took the view that NZ was so small and to loose some of that expertise was a greater of the evils and it is better to try an manage it and is a very real issue and certainly for me as a CEO and I know other CEOs have some of those things operating.

In x DHB there has been a medical staff member giving away information to do with sensitive industrial negotiations that he gained in the governance role that is pretty basic stuff. It has improved insurmountable, but it certainly is unhelpful that people cannot seem to understand a governance role, Stewardship or fiduciary is absolutely to that organization and when you are acting in that role that is the primary and over-riding set of interests.

This response identifies the risk the government took in structuring the legislation into allow employees, providers and others who would benefit financially or otherwise from board decisions, apparently knowingly.

Other participants demonstrated confidence in the formal board meeting system but felt that there was little risk because the public showed little interest in board matters unless there was a problem under discussion.

Researcher: How much doesn't happen in the open session?

CEO 3: Very little now, most of it is around privacy or commercial reasons.

Researcher: So the public could generally have confidence that what they see is what they are getting.

CEO 3: I am confident that, that is the case.

Researcher: Has that been hard to manage?

CEO 3: Nobody turns up to the public meetings any way, but the minutes become public so it they do not have to turn up.

Researcher: Physical engagement with the public has been hard to do.

The community was not encouraged to participate and the next example questions the engagement of elected members with their communities.

Medical Specialist 4: I think it has to do with central control versus local initiative and innovation. It has to do with an intrinsic difficulty that DHBs have in managing community expectation and community participation and being centrally controlled with what we can and can't do. An example of that is the Act, the New Zealand Public Health and Disability Act, around developing DHBs to participate with communities in achieving community health. However, the application of the Act is heavily rated on the side of what I would refer to as central accountability. So the ability to engage with the community is something that is not valued. It's not really put into the governance persona even in most of the governing board and DHB is community elected, the relevance of that to the community is very minimal.

Researcher: Why do you think that?

Medical Specialist 4: Because from the moment they are elected to the moment they continue the business the engagement with the community ceases. The advisory committees were put in place in the Act to assist with that. The control over how those are able to do their business is very, very stringent.

Not only does this participant identify the difficulties engaging with the community but also the demand for central accountability through the legislated control over the advisory committees whose very existence is to engage the community in healthcare decisions ("New Zealand Public Health and Disability Act," 2000). The following example demonstrates how one community committee member, with a particular area of special interest can frustrate the board decision-making process.

Chair 3: ….. In fact we have just changed our board meetings as well, because some of the committees were kind of running away with their own agendas on issues that were very important to the board to participate in.

Chair 3: … issues that are very important to the board, that they have raised as issues were being passed around the committee on Maori health, runganga and other people and then coming back to committee. And the only reference that the board had to those issues were in the minutes of the committee meeting, instead of participating in what the recommendations and decisions should have been. So we have changed that just this last month, so we look at the board directing what needs to go to those committees rather than the other way round.

Researcher: Nevertheless it gives you quite a good feel for what the community and others expect and it is formalized.…..…

Chair 3: It does and it is formalised. Yes. But it is important that the board makes a decision; for example the board made a decision about fluoridation for example; not unanimous but seven out of eleven, eight out of eleven, you know. And then a local doctor from one of the committees, a local doctor who is absolutely vitriolic, anti-fluoride, rang the chair of that committee and said "I want to come and talk to you", and they said "yes". And I said no, we have made the decision already, sometimes, through lack of judgment, the committees get carried away.

This chairman gives a good example of the limitations of the democratisation process applied through the legislation (NZPHD Act, 2000). The people on the advisory committees understood that they have the power to make decisions, or at the very least to have their contribution recognised when the decision-making processes do not allow for that at all. In this example the chairman had changed the sharing of information in order to regain control over the processes.

CEO 1: None of these people have a particular background of working in this particular environment. They come from completely different environments maybe they do not feel what they do not feel, they do not know what they are taking on.

The decision-making was also impeded by the lack of understanding of the healthcare services environment. Participants suggested that "Health" had different governance needs to commercial corporations. The next quote suggests that the definition of governance as applied to the corporate sector is not appropriate to the healthcare services.

Researcher: … do you think in terms of probity, fiduciary duty to the organization, the transparency the accountability, the sort of words that the corporate governance books would list down?

CEO 2: Not to the extent you would in the corporate governance model.…… I would talk less about fiduciary responsibilities which I would relate very much to some of the statutory requirements that exist more around boards, perhaps with the upcoming Health Practitioner's Act, links with the Medical Council. I think there are responsibilities that key clinical positions have which may be considered of a governance nature that is linked with those authorities and bodies. I would not use the terms that you outlined because I think they are more aligned to the corporate model as opposed to what I see as the health executive and management model.

This respondent continued to describe the executive function as the linking of corporate and clinical governance. The two concepts are distinguished by their context.

Researcher: So there is quite a distinction between corporate and clinical governance, how do you link them?

CEO 2: For me they come together at the executive level in the organization so that is myself, general managers, and key clinical advisors. That's where the organization's plan becomes a reality and the mechanism upon which to deliver those is often where we would use clinical governance as a means to that end so my view very much impacts at an executive level.

The plan for the organisation is not seen as a reality for those providing clinical services; the plan is a tool of corporate governance which is connected to clinical governance through senior management and professional advisors. In *structuring the field* the organisational plan separates the functions of governance by context.

Legal frameworks

Participants recognised the legal frameworks within which they were expected to work. For some, as below, the legislation underpinned the governance structure of the organisation and the resulting accountability to the Minister of Health.

CEO 2: It is the way our system is structured, if you look at the legislation that under pins DHB's then the settings that have evolved to support that and I am thinking about population-based finding, some of the national health strategies that drive our priorities, then I place the corporate responsibilities very clearly at a board level and that those accountabilities to the Minister are clearly reflected in the annual planning process.

For others it was the legislation (NZPHD Act,2000) which confined the Ministry, and consequently the activities of the Ministry, which were of concern. Most participants identified the ongoing nature of the problem which was reinforced by the researcher. The chairman responds from a commercial corporate perspective.

Researcher: Let's go back to the Ministry

Chair 2: I think for a simple person like me it's just over bureaucracy, we are over administered as a sector and I don't think it's probably been any different but perhaps it appears in different places. I am told the Ministry is over 1200 people what do they do if…..my mate at Auckland say's send the 400 (cause Auckland's a third of the population) send the 400 who look after our affairs and we will agree together what is necessary. Call it over-regulation. I don't know.…..

Researcher: Is there interference?

Chair 2: I think we are getting much better as a DHB. Again this is not really a board issue it's a management level. I think the early communication method is a much better one with the ministry and I think one of the major issues apart from a Deputy Director, is there's a personal group of people, the staff turn over is too high and you spend a lot of time, at least our people do, in bringing new people into the loop. And that is hugely wasteful. They seem to have a high staff turnover in people at middle management level and so there is time and effort gone into rearranging what you have already agreed somewhere else. For example radiology recently, our radiology programme is two years old now… Deputy Director in Wellington and a fellow called XX……said to me "You haven't got approval for your radiology programme" and I said "Well I would be surprised". Anyway within three or four days they had found we had. But it is a waste of time, bureaucracy whether it is justified or not I don't know. I don't criticise.

This response also demonstrates the constraints that the centralised capital allocation system imposes on the DHBs. Other participants described the bureaucracy involved in complex planning and funding decisions and the constraints of the funding frameworks within which the DHBs have to work.

Medical Specialist 4: So our focus isn't just on funding and I get really upset when they talk core DHBs funding because those are DHB rules, we are just working to give ourselves determinants of health assessment; funder planner regulators chaired and they were facilitator, reader, collaborator, advocate, joiner co-ordinator, broker, evaluator, monitor, auditor, strategist, catalyst, community supporter. And if we don't understand all those rules the planning DHB requirement then we will never ever get health and independence and we're trying to work out the frame works that we can connect our social determinates imagine other difference. Don't get me started because our health needs assessments under the Act we are required to do a health needs assessment when we first started we said well what does that mean is that just a demographic profile and not it's not we agreed quite earlier on that it is 4 streams of information it's the health stages demographic profile of our community the geographic profile as well it's the issues around disease and mortality and all that it's community themes, it's provider themes and it's forces for change what are we learning, what are we engaging so everything we do around health needs assessment involves those four streams and we do a health needs assessment frequently not just once a year so in our

One aspect of the legal framework which gave concern was the combined appointed/elected DHB. Opinion was divided on whether there was a problem with members elected by the community prior to appointment by the Minister. As discussed above one Chairman felt comfortable with the level of *cultural capital*, qualification, that the elected members brought to the board table, but was concerned about the opportunity for conflicts of interest while others felt that the process had considerable difficulties. Another chairman, appointed

by the Minister following election, was concerned at the election process but showed reluctance to challenge the legislation.

Chair 3: I think the election process is fraught … but you know what do you do? I don't think about it because it's legislated for so I can't do anything about it there is no point in going there.

Researcher: So are you standing again this time?

Chair 3: Yes I think so…but it is fraught.

A further issue with the electoral process was talked about by all Chairs and Chief Executives. The example below identifies the tension which arises when the elected member thinks that they have a duty to their constituency when, as discussed in Chapter 3, the legislation is clear that the board is accountable to the minister.

Chair 1: Well it is difficult with a certain amount of elected people although I do think that's created an interesting mix and I think it has worked here quite happily. The difficulty there is you would say in theory you are accountable to the people who voted you in but in reality it's not. A local body is such a small turnout and it is such a hit and miss. Personally I think I am accountable to… because I am just appointed by the shareholder and their philosophy.

This example also identified the limits to the democratic process when so few people show interest in health and other local matters at the time of local body elections as identified and discussed by Gauld (2005).

The legal frameworks were recognised as providing the context for governance in public healthcare services but those frameworks did not necessarily ensure quality and safety within those organisations.

Quality and Safety of organisational activity

The theme of quality and safety encompasses the concept of probity, organisational activity including clinical decision-making, and consequent safe decision-making. Quality and safe practice is based on the moral and ethical bases which are established by the collective *habitus* of the organisation and society at large. Decision-making is underpinned by the ethics and morality of the individual health practitioners and directors and the philosophies adhered to by their professions. Quality and safe practices are learnt through the experience of the organisation, the institutional memory of the organisation against which individuals

or groups can test their present decisions and the recognised standards set by professions. The impact of external compliance programmes was identified as shaping decisions at all levels within healthcare service organisations.

Quality and safety of decisions and outcomes are also influenced by demand and supply of resources, as previously discussed.

Participants described the ability to recognise both the positive and negative outcomes of testing models and ideas.

The data revealed the following concepts in relation to quality and safety:

- Guidelines and the relationship with Clinical Governance
- Audit and the impact of compliance relating to the organisational and clinical decision and activity
- Institutional memory in the context of personal experience and experimentation
- Professional morality including personal moral base
- The rules of the game – being fair

Each of these will be discussed within the context of the data.

Guidelines and the relationship with clinical governance

Participants identified that the first hurdle with the introduction of clinical governance as a concept was the terminology as the established (United Kingdom) definition does not define governance. The medical specialist below explains how the concept was introduced using more specific terminology and inclusion of audit which allowed for better understanding.

Medical Specialist 2: We were more comfortable, I think, with the terms quality improvement, quality management, but clinical governance was introduced in the UK, as a term a number of years ago. And the essence of what they were talking about was first of all the structures and processes regarding the clinical decision making but also to look at the environment within those decisions were made, looking at the culture so there is a combination of head and heart issues. That's

often hard to explain to the person working on the shop floor so a simplified frame which a physician in Brisbane came up with identified four elements which were consumer involvement which is often left out in some of the other definitions, the quality and risk management including clinical audit

However, for the same respondent the relationship between clinical decision-making on behalf of one patient had been separated from the clinical governance of quality and audit processes.

Medical Specialist 2: Linking the clinical decision-making and the clinical governance? – We had a meeting of clinicians who had been on leadership courses and one of the things that I was saying there was that the more I had done in clinical leadership and management the more I realised how generic the processes were and how similar the management processes were with the clinical ones. In clinical practice you have to have a clear goal of what you want to achieve for this particular patient once you have gathered all the appropriate facts. You then have to communicate that vision to the patient so that they co-operate with you so that they are also a part of the team in making decisions. Then you have to have a series of clear but simple steps as to how the patient actually reaches those goals. The other thing that has become apparent in clinical medicine is not just the individual doctor or patient- you are part of a multi disciplinary team and if you do not include all those members including the patient then you will not succeed. And the parallels of that with project management or clinical leadership become more and more apparent to me. The success and learnings from one help me in my other roles and I find that very interesting.

This participant does however recognise the relationship, the continuum between corporate and management decision-making and the process used to make clinical decisions inclusive of the patient. It is of note that this physician has been involved with quality improvement programmes for many years and that his own process of reflexivity has led to this conclusion.

A second dimension to this discussion was the recognition that professionals need both skills and structured processes to assist them to make decisions.

Researcher (in response): Unpacking all the parts so that when they are actually making the decision at the bedside they have all the skills they need.

Medical specialist 2: Absolutely.

Other participants placed clinical governance within the clinical environment but indicated that there were boundaries between the clinical and corporate decision-making. The

example below also suggests that there are not clear roles and responsibilities in relation to what is termed clinical governance. The example chosen by this respondent, "handovers" related to a management issue, the passing of clinical information from one shift of staff to the next and not to clinical decision-making per se.

CEO 1: Oh no we're looking at it from a system level. Like you know there's supposed to be floor operating group like XXHOSPITAL has its own quality group so we do challenge them and say you know what are you doing, how, that's all the operational stuff, I suppose we're looking at it from a you know, how does this organisation deal with guidelines, how are we dealing with handovers in general, how are we dealing with some of these systems we're wanting to face the boundary issue. You know that's what the board is supposed to be focusing on and asking well who's actually doing something in this organisation and achieving what we're doing, what we're supposed to be doing you know we're actually doing what we're supposed to be doing it's more challenging. Quite funny eh?

The role of clinical guidelines and audit of clinical activity play an active but defined role in clinical governance, supporting clinical decision-making at all levels in the organisation. Participants referred to the role of structure, particularly what was commonly titled clinical governance, including the role of guidelines in informing clinical decision-making and the audit of clinical activity.

Researcher: What about decisions, how are you influenced if you are making clinical governance decisions around say guidelines for care and all those sorts of things. What do you do then - do you have a process?

CND: Yeah we do there is a process in place. It's pretty ad hoc though….. I mean I just saw a guideline today from a nurse educator and she said and it was a nursing guideline, admittedly just about skin tears, and I said to the person well there's other areas that actually would actually look after the skin tear. It could be in the outpatient environment, primary healthcare for example or anywhere really where ever it may be. So where is the imperative to actually send it out for comment or just for discussion? And we don't have that forum set up so it's actually quite ad hoc. From a nursing perspective we'd do that through the nursing credentialing and privileging committee. But to actually get the wider context up for discussion we don't have that at all. I could take that guideline to my clinical director and discuss it on that kind of level but …

Researcher: But it would go down and it would never come …

CND: Come up…. that's right yeah.

This example reinforces the idea that although the professional groups are making some progress with establishing governance within their locus of decision-making there remains

a disconnection both with other health professional decision-making and within the corporation. This example also demonstrates the *symbolic violence* between medical and nursing professions even within the leadership of the organisation. Another participant had similar examples of disconnection. In the next example the professional team, excluding the medical staff, especially the registrar, met and made clinical decisions and then those decisions were taken to the medical team.

CNM: Patient-wise it is a group decision between the staff and I. If we don't agree with something that has been prescribed medically because we know that patient and we are advocates for that patient, then we discuss it as a group.

Researcher: So there is a bit of collective responsibility there.

CNM: Absolutely, and then we will talk about that step to the medical staff

Researcher: Do you think collective responsibility is a nursing thing?

CNM: I think it is, but in saying that it is getting more multi disciplinary like the physiotherapist's and the OTs have far more input now than they used to. So we keep ward meeting and mention every patient and they will ask the question why is that being done for that patient and it's up to me after they have had their say to take it to the medical people.

The medical team is aloof from the clinical decision-making of other members of the patient care team in the clinical environment due to process established by the cultural arbitrary of *reproduction* and over time.

The disconnection at the national and district interface was identified by the next participant. This example highlights the incongruence between the legislated requirements and their operationalisation through directives.

Medical Specialist 4: It is under central government, it's the policy and the rules and regulations the Crown funding agreement and the performance accountability connected to that. And performance accountability to my discomfort has no frame work that encompasses health incomes. The health is explicit DHBs are required to improve the health and independence of their community and are also required to improve access to health services and the Act is quite good around what access means it does not just mean physical access to a particular professional. It means access to health, independence, knowledge, information and there are very explicit requirements under sections 22-23 for the DHBs and yet when we receive the rules, the guide book around strategic planning and district annual planning for DHBs, they completely separated the objectives and requirements for DHBs under the Act from what we needed to do under the strategic plan.

Researcher: So the …

Medical Specialist 4: Disconnection.…

The impact of the availability and accuracy of data on which to make decisions was identified as having implications not confined to the project but also in allowing people to feel as though they had the power to make decisions, and that they were in control.

Medical Specialist 2: What it means is you can have an innovative idea but then you explore and you shape it you see what can be done, and, again the interesting thing is that this is the culture of XXH . I can remember when …..., we had produced data that showed that our productivity in theatre was three times as much as YY Hospital. And I think that the new thing, and with the dividing into three DHBs, is in the past people would say "yes that is interesting but we are different and we don't have enough resource to pass onto you". Nowadays, we have the data and we control of our destiny and we can make decisions within the organisation.

Researcher: The control of destiny is actually quite an important part of the structure?

Medical Specialist 2: Absolutely important. Very important. It is part of the decision-making. If 80% of the influences on your decision are outside your control it is enormously difficult to try and shape those influences whereas if it is only 20% then you can make the decisions and go forward.

Researcher: Do you feel in control?

Medical Specialist 2: I personally feel in control and I think the organisation is in control. And I think that when you are in control and producing, it does not matter whether it is, [whether the control is a reality or a perception].

This interaction emphasised for the researcher how important *cultural power* can be. In ensuring that decision-makers have the right data or information the organisation was empowering them to make decisions with confidence and in so doing the employees were happy with their decision-making role and confident in their clinical practice. Being in control confirms *cultural power*.

The forces in the *field* require tension and balance in order to create practice.

Audit and the impact of compliance within governance

Accountability for the organisation's success was achieved through audit and compliance ranging from the formalised 'Statement of Intent" (SOI) to quality and safety audits by external providers. The CEO below is clear about the accountability tool for his role.

CEO 2: The DHB has one accountability document being a statement of intent which is really a summarized version of it's annual plan, the DHB in itself only has one

employee being the CEO, and it is the job of the CEO to be accountable for delivering on that annual plan through the statement of intent. So my job is to put in place the people, the structures and systems in-order to deliver on that accountability document.

The Statement of Intent, a fixed template, responds to the expectations of the Minister and provides a framework for personnel in meeting the organisations goals. There is also a clear understanding of the monitoring role of the board.

Chair 3: Part of our governance role is to make sure those monitoring frameworks are in place and that the objectives are being met on a regular basis. We happen to do it quarterly, but some others do it more often or less often.

One CEO related this to his role as a steward of public funds and policies. While stewardship is a legitimate attribute of governance (O'Neill, 2002) this same participant did not think that, as CEO, he had a governance role per se but that inherent in the role of steward was an audit and compliance function to ensure that decision-makers had the information and advice required.

Researcher: How do you make decisions in your governance role as CEO?

CEO 1: I do not see my role as a decision-making role, but to present a professional, managerial or leadership view on important issues for the organization…..., but in the system I accept that it is governance responsibility in terms of the board to actually decide on some of those policy decisions and in some cases it is obviously the Minister's decision to say what some of those policy issues are,……. I believe that it is my responsibility to get the pros and cons,….. ultimately they (the board) have that accountability, and if you get to a point where you can't live with being overridden all the time, then you would find another organization.

The last sentence in this exchange suggests tension between the Board and CEO when advice is given and not taken. Stewardship seems to lie outside the governance role for this participant although a collective responsibility is recognised in the response.

CEO 1: … in the public sector is the role is more stewardship perhaps than some of the financially focused and compliance focused stuff that you sometimes get in the corporate world. We obviously have compliance issues around health sector standards and a whole lot of other things, but it is much the sense of stewardship on behalf of the government, around delivering its policy objectives.

Others identified the extension of the monitoring and compliance role in health as being beyond just the financial health of the organisation and including frameworks which monitored clinical safety.

CEO 3: Well there is a huge compliance cost in time, resource now around OSH, Health and Disability Commissioner, employment law. One of the problems around that is that the legislation is put into place because of the lowest common denominator not the people who would probably be doing that, but having to report. OSH would be a good example where some industry sectors have bad compliance with OSH so we are all wearing a huge onerous reporting structure and obligation because of that….

This participant is demonstrating a frustration at standards being set to the lowest acceptable standard, rather than a standard of excellence. Others delegate the role quite transparently. The second example below links the issues of safety firmly with the responsibilities of the board.

Chair 3: they (clinical board) have the role to make sure that all issues around audit, risk and safe practice and all things that go with clinical issues across the board are being dealt with appropriately within the organization.

Chair 2: We have a clinical board and we have an audit of that and we have an external audit report, for years we used to talk about safety and the board used to get told about it every year. Previous management.. "it's safety it's safety!" and any board whether it is aviation or health…when somebody mentions safety you better pay attention. Even transport networks…… we have a safety committee, only a board committee by implication of where it finishes. But the safety management is run by management. So I guess I am satisfied that we have enough confidence and protocols in place to ensure that the technical competency are managed appropriately. But there is a risk that you will never get it right totally but …

All participants could relate the safety programme pertinent to their level of activity. Safety was crucial to the risk management programmes and was inclined to take precedent over other tools used to ensure probity.

CEO 2: I should also say that quarterly we have an external clinical advisor, Dr F, a senior physician, he also reviews our key incidents or major sentinel events, and he also comes quarterly as an external clinical audit. Like we have external audit providing finance and audit committee, Dr F will also come and provide free unfettered advice to the hospital advisory committee into clinical board.

This CEO directly couples the traditional audit of finances with the clinical audit recognising that both are integral to ensuring the quality and safety of the organisation.

Institutional memory in the context of personal experience and experimentation

Institutional memory as a contextual variable in decision-making was identified by a number of participants. All participants had longevity in the health sector either as health professionals or healthcare managers or in corporate governance roles. Some verbalised a frustration at repeating projects which had failed in the past and while recognising the value of application in a different time frame they expressed frustration at not being listened to by younger colleagues. The participants also identified the loss of valuable experience and data because people in healthcare organisations are mobile and move on to other positions and other organisations.

Medical Specialist 2: Over the last 25 years there have been some absolutely wonderful ideas in this organisation, but probably half of them are sitting on shelves somewhere and new people come in and they start from scratch spending a lot time reinventing a lot of things.

Researcher: Yes, yes so you're still being very much recognised as being the professionally mature people onsite but also there's that institutional memory and that came up with both of you we know how, it came up with everybody actually, we know how things work and with your chairman it came up "oh the CEO knows who to ask in the organisation" he knows who has got the institutional memory so it's obviously a very important part of governance decision-making.

Medical Specialist 1: No. I made the point it's about looking at it, it is a somewhat unusual machine that apparatus over there (the hospital) and we all make it work with the people. And the temptation of management sometimes is to change the machine whereas in fact the oil has run out.

The Clinical Nurse Director saw the loss of information as lack of accountability in the particular role, as well as being an expensive way to manage.

CND: And I think that's the loss that actually occurs when people do come and go so you don't build upon anything. And to me that's actually, that is an issue to me about accountability as well because you're always going to try to redevelop or actually rebuild again aren't you?

Institutional memory was also evident as complementing symbolic power and facilitating the use of that power. The nurse manager below explained the *capital* gained through time and familiarity.

Nurse Manager: I have the respect of the consultants and the consultants will always listen to me….Probably because of the length of time I have been here

The participant above also identifies that those experiences took place over many years and that over time the individual *habitus* synthesises the experience to allow the shaping of decisions in a different manner (Bourdieu, 1993a).

Professional morality

All participants described the impact of their professional morality on their governance decisions. For some it was like the examples previously described in personal experience. For others, as described below, there was a profound experience that made them the way they are. That, coupled with a sense of altruism, especially demonstrated by those who were or are practicing health professionals, resulted in descriptions of decision-makers who think carefully about their role in the health care environment.

Medical Specialist 4: I suppose it comes from my basic sense of values and principles and I am not out for personal gain, I am more out to achieve success for others and for the system. Because I have a kind of feeling that if you do that you end up getting rewarded in a way and I can guarantee that happens. It's happened often in my life and that's just how it's been.

CEO 3: Quite strongly actually, even much stronger than I thought and I think part of my management philosophy is a fairly strong moral and ethical approach to the role.

This CEO is responding to whether or not the characteristics of governance influence his decision-making. He goes on to say that the manager can use ethical and moral boundaries, probity, to ensure safety and that is achieved through others knowing specifically what those boundaries are.

CEO 3: There are good reasons for having strong ethical boundaries and practices in that it protects the organization and individuals and it dictates the level of behaviour for the organization staff to adopt.

A number of participants identified the need to do the "right" thing indicating that personal morality underpins decision-making and that this personal morality is born out of the impact of one's *cultural field* of family on *habitus*.

Medical Specialist 3: I suppose where I come from is the potential for modern healthcare to harm is so huge and we really balance, in a systems way, the homing benefit of

what we do. And what I try and do in making connections, critical connectiveness, is to reduce potential for harm to increase the potential for benefit.

Similarly one of the clinicians described his form of clinical governance specifically focused on the process of clinical decision-making related to the testing of hypothesis based on his prior knowledge and the established clinical standards and practices of that specialty. This is an example of the process of decision-making in clinical governance.

Medical specialist 2: So in my area it is a male Maori. I am thinking, probability gout and immediately I am tossing. Once he has said his story I told what his problem is, and what he hopes to get out of it; when we get into the negotiating in questions I am testing that hypothesis. And if he says something that then makes it obvious that it's not going to fit into that particular paradigm then you start a new hypothesis and you move on a base of probabilities to the likely and apparently that is faster. The risk is if it is not something common then you can miss the rare conditions cause you don't have sufficient of those in your database; unless you recognise that it is not going to fit anywhere.

Researcher: That is a really interesting description, it is an experiential based system, but you recognised that and you work that, and you manage that.

However, throughout the data an element of frustration with how moral issues were discussed was expressed. This demonstrates that the achievement of a common understanding of what and where the healthcare services should be doing and the direction they should be going in remains debatable. One medical specialist aired his frustration at not having an avenue in which to vent his opinions and feelings as part of establishing the principles on which decision-making should be formed.

Medical Specialist 1: …. it is the idea of a moral conversation…. the relevance of a moral conversation……... If you present to somebody a particular view about a moral issue, an issue of probity, that seems different to what they might have imagined the situation to be. There are a variety of responses, the commonest of which is silence.

Medical Specialist 1: The inability for moral conversations to take place that troubles me most and the reason there is no frame work for moral conversations if that there is not real discussion of alternatives, which brings us back to getting multiple opinions about things. In the corporate governance structure there is not a lack of imagination about potential, it is a lack of knowledge. What troubles me is that clinicians do not always provide accurate depictions of what the options are because they do not know either sometimes what the issues are. And there are things, say in the secondary care environment that have profound primary implications and possibly tertiary care implications. So it is an absence of the

ability to hold a moral conversation which weakens corporate governors in their research for probity.

Smith (1999) suggests that in environments where non-indigenous governance structures have been introduced the opportunity to be heard in a culturally safe manner elicits participation. In this example the doctor wanted an opportunity to have his say in the traditional manner medical staff have come to expect which he indicates has been lost and is the cause of tension in the healthcare services governance *field*.

Medical Specialist 1: "What is the definition of quality", how do you define quality? As a lecturer with students, I bring them in a taro plant and ask is that a quality taro, a couple of them at the desk are saying is that a quality taro? How do you know? So in many cases now the definition of what is a quality product is very hard to determine.

Researcher: Because it is individually subjective.

Medical Specialist 1: So personal. As you well know as I do too, quality from a patient's perspective is so protient-------. There are some indices that are quite valid. Just think the clinical governance…. I mean the definers of the indices of a quality programme…. take it in surgery….. all the unexpected things death, return to theatre, transfers to other services or readmission. They should be looked at because they are the best indicators, for when you are offering a quality program and so just fallout, hopefully. I was never actually that attracted to the British notion of tying, so closely, quality to clinical governance.

Participants offered many responses to where and how governance occurs and, as indicated above, were critical enough to challenge the established [British] notion of clinical governance as, exclusively, a quality concept.

The section on quality and safety of organisational activity demonstrates the multifaceted nature of healthcare services decision-making. Quality assurance is shaped by guidelines, rules and regulations but also based on the personal and professional morality of individual practitioners.

The "rules of the game" in health sector decision-making - being fair

As demonstrated by many of the responses the participants had experience that gave them considerable understanding of the rules of healthcare service governance. Most were perplexed when asked directly about where decisions were made and therefore their

influence on the decision-making and outcomes. Getting common understanding of rules was considered a challenge.

Researcher: Where do you think that governance, that is, decision-making about basically organization and patient care, actually occurs?

Medical Specialist 1: It occurs right…. its here…It's an interesting question. The reason? This allocative dimension occurs up towards the corporate end scale of the governance spectrum and then clearly what happens to the patient happens down at the coalface. It's the in-between bit, it is getting the landscape, the rules defined for a general situation that I think is what we all wrestle with.

Medical Specialist 1: The rules? You have to have some…Think of the rationing system, you can go to ration by price, go to the private sector or you can ration by waiting lists or you can ration by rules. Now the rules are protocols. Certain people will be treated a certain way and, what has happened unfortunately, is that some of those rules have come in drag, to want for a better word, as a fiscal, as a resource constraining thing, the classic one being the 'waiting list' initiative, where the waiting list requirements for intervention was based on a financially sustainable threshold. Which in drag was put up as a clinical threshold but is not, actually. Having said that it is beyond the spectrum, that you might want to be talking about it into the Ministry.

This participant was critical of the rationing process including the veil of clinical qualification required to receive care when it was actually because the financial resources were not available. He understands what the rules of the game are no matter how they are presented. This was another example of there not being a set of rules, or principles, common to all aspects of healthcare service on which decisions are based. Bourdieu (1990a) states that behaviour can not be regulated without rules however, when new challenges in new situations arise the *habitus* loses its utility until new rules emerge.

Recognition of, and familiarity with, the context of governance was identified as being important in understanding how and where decisions are made. Two chief executives were former health professionals who recognised the impact of their history in healthcare services in understanding the rules of the game and were able to incorporate it within the management perspective rather than retain it as their point of reference.

Researcher: One of the comments I get is that the health sector is so large, broad, complex etc that if you come in actually having even the most rudimentary understanding it is an advantage.

CEO 3: It is certainly an advantage, it's in the language, systems and understanding. I think that successful people, I will put myself in this category, give up their clinical experience but use that then as a basis of their knowledge to going forward and the people who are not successful are the people who take forward their clinical experience into the practice they are incorporating now.

This chief executive was clear that in order to understand the decisions and their implications it is necessary to have an understanding of the language which explains governance decisions in the healthcare sector. Having the ability to categorise and name the concepts that one is making a decision about is paramount to the attaining and maintaining *symbolic power* (Bourdieu, 1985). This includes the ability to establish groups through the *symbolic power* attributed to language which is specifically applicable to the context of the healthcare services environment.

Medical Specialist 2: So again it is getting into the stories of the people, understanding and getting alongside. We learn an awful lot by osmosis and by having the right people round the table and I think that [one group] we had very early on the Clinical Board was the midwives who reminded us that they were not nurses and therefore they had to be at the table. Just having the midwife saying whenever we were talking about a policy involving nursing and midwives, I think that those members of the clinical board now know the difference between the midwife and a nurse. It is a quite a good example because if you are not round the table you can be ignored in that process. We have had in the last year a consumer there to represent the consumer perspective and that is already starting to make a difference to the way we think.

The participant above also recognises the different roles health professionals play and the value of the lay opinion.

One participant recognised that the autonomous nature of the DHB structure does have an impact at clinical governance level but, as stated previously, it is dependent on having systems in place that produce evaluable data. In the absence of good data tensions arise.

Medical Specialist 1: It gets very confused because clinicians look at corporate governance they are not using valuable robust data or they are taking a punt or a guess on something and we are in an evidence based healthcare environment where we have to use objective evaluable data to make our decisions on, so there is a problem there. I think however, to give some support to corporate governors to do more and more

The subject of availability or lack of objective data was identified by participants, especially as a way of establishing a common understanding for all participants in a decision-making process and as a way of integrating corporate and clinical governance, as previously identified under ideology. Others felt that they had the data and reinforced the need to use data to exert control over the organisation in a manner autonomous from the Ministry.

Medical Specialist 2: Nowadays, we have the data and we control of our destiny and we can make decisions within the organisation.

Several participants felt that the principles which underpin the decision-making in an organisation should be the same no matter where in the structure the decision is taking place, but that didn't always happen.

CEO 2: Ideally there should not be a difference in the way that board individual members and collectively behave ethically to how they expect the whole organization to behave. But I do not think that actually happens.

Medical Specialist 4: I think it is because the Ministry of Health is so big and so disconnected. Still, despite all of the attempts to reduce the silos, the silos are very much in evidence.

Researcher:….twelve hundred employees

CEO 1: I think the biggest problem is that we have a wonderfully bureaucratic ministry with way too many people in it producing way too many ideas that are incapable of being implemented.

All participants indicated that they perceived a lack of leadership from the Ministry of Health personnel. The lack of leadership limited the activities of DHB personnel in actioning key aspects of the annual district plans. The lack of expertise, *cultural capital* (on behalf of some Ministry personnel) compromised the symbolic and political power the Ministry staff should have had in their role in policy development and regulation of healthcare services.

CEO 1: There really is a failure of leadership in a sense. One of the skills of leadership is about priorities, focus and getting people behind you to so something that is really important and I suppose what we have got is that we do not have those skills at a ministry level in general, so that leaves the sector with a huge menu of possibilities. It is up to them to find their own leadership and maybe that is not a bad thing.

This frustration with the lack of knowledge or industry maturity in the Ministry was identified by others. The participant below was explaining that there could not be a leadership response if the people involved were not carrying the *cultural capital* necessary for credibility.

Medical Specialist 1: Having said that, it troubles me that there are not more recepticides, to use biologic term, in the Ministry, for the sort of protocols that I am talking about.

The participants demonstrated a range of opinion about the role of the Ministry in governance. In the following example the Ministry attempts to lead through governance by over-riding a decision by the DHB and in so doing constrains the autonomous decision-making of the board.

Chair 1: I don't think the Ministry have a governance role, I think they try and exercise one and I find that difficult. It's like "well don't have a Board, make up your mind….If you are going to have one let's do it. If you don't want one don't have one". You know what Wellington is like….its full of these…I have to be careful (laughter)

In this next example the leadership the Ministry should have through its symbolic position and political *capital* is compromised by the lack of *cultural capital*. Participants did not recognise many of the players as having credibility in the health sector and as a result some cynicism had developed. There was a general recognition that Ministry personnel were unfamiliar with the activities of DHBs and that expectations were unrealistic and unable to be achieved.

CEO 1: I do not get a sense of that really. The minister can be quite clear she has her "start here" list, which only has about seven or eight things on it. We go through this process with the board and the minister where we go develop a district annual plan, which has a whole set of accountabilities, which is formidable in itself. And I do feel if we promise to do them then we do try hard to do those things. We have this great plethora of other things, which is as far as I am concerned are interesting, but I have not signed up to those and if they are not important, they just float by. But I do not get the feeling that sometimes the people in the ministry understand that. They suddenly ask 'why are you not doing that piece of paper that we sent you?' And it has no basis in accountability. It is like a 56-second micro issue in the world… so just ignore it basically.

The conflict and tension created between the Ministry, the DHBs and their staff will be further discussed in 'Complexity, conflict, tension and power'. The relationships between the Ministry personnel and the DHBs are the subject of lengthy and time-consuming discussions within all DHBs. All participants expressed a feeling that their roles, complexity and sophistication especially the realities of clinical practice, were not well understood by Ministry personnel.

Complexity, Conflict, Tension and Power

Conflicts of interest

Throughout the data there are examples of conflict, examples of the professionals struggling for *social* and *symbolic power* in the *cultural field* of health sector governance and conflict between boards and the Ministry of Health. In this section, conflicts of interest are considered a much broader concept than those which compromise fiduciary duty to the organisation as previously discussed.

At the interface between all sections of healthcare services there was tension related to decision-making or influencing decisions based on advice. Quite simply, that there was advice to be given and advice to be taken or not as explained by the next participant describing a situation in a tense context.

Chair 1: We have to be careful about the Ministry. But I am quite clear that the Ministry offer us advice and I can choose to take it or not to.

This chairman was giving an example of the conflict of interest created by the organisational structure. On the one hand the chairman must report to the Minister and on the other hand the chairman must maintain the fiduciary duty to the organisation which she was the leader. The need to maintain the *political capital* of leadership was identified as obstructing quality decision-making. The leaders of organisations were accused of not being able to be critical because they might denigrate their power base.

Medical Specialist 1: One of the qualities of leadership is optimism, and support and the ability to say 'we messed that up big time and it was my idea'. Governors have a problem with that; they can't do that.

Researcher: They can't go back and analyze the mistakes and learn from them?

Medical Specialist 1: It is not critical thinking at all.

The example above demonstrates how the structure and roles played in the structure can inhibit decision-making or place others in hamstrung positions. Symbolic systems not only provide an understanding of the role of structure but are also 'instruments of domination" (Swartz, 1997, p. 83). The political structure from the Minister and Ministry, to the DHBs and their employees is one of dominance. The position the decision-maker holds, in relation to the structure, will influence the decision because maximization of self-interest will always prevail. As described by Bazerman and Chugh (2005) as individuals it is foreign to us to undertake any activity which is not in our interest either immediately or in the future. All participants recounted examples of how their decision-making was influenced or constrained by the actions or expectations of those above them in the hierarchy.

Medical Specialist 4: That is very interesting, I have taken the models to Australia I've been invited to go and talk and work with the Western Australian government and the state health sector I've been invited by health Canada and the Province of Alberta to work more collaboratively with them, I am working around safety quality issues with the National patients safety foundation in the UK in a collaborative way and I have also got colleague in the city of Toronto doing a similar sort of thing with the Toronto system who is using some of the models that we are developing and collaborating. So internationally there are people who value it. Locally I think well we will just carry on doing what we do best and I have to admit that we probably got away with it because every time I have been challenged by central government I go back and go to the people I know in the Ministry talk to them in depth and say don't stop us don't put road blocks in the way.

Researcher: And what is the response there?

Medical Specialist 4: At an operational level - terrible.

This specialist had created models of care which were innovative and in response to the health needs analysis of the district. Although the models were eagerly sought after by services in other countries, they were not valued by personnel in the New Zealand Ministry of Health. Those without the *cultural capital* to recognise innovation in service development chose to stymie projects rather than seek out an understanding of them. This is an example of the lack of qualification impeding decision-making. Notwithstanding that this specialist persevered and used her own social connections, *social capital,* to get what she wanted in an informal way.

Another response relied on the robust culture of the organisation to ensure that all contributors to a decision were thinking in a similar way. Organisational cohesiveness, the influence of leadership on decision-making, is demonstrated in this response.

CEO 3: Something I am always surprised about, that if I behave in a certain way, 2500 people would behave in that way and because there is a culture and organizational cohesiveness people who sit outside that behaviour actually get chastised by the individuals within the group and I see that quite frequently.

Researcher: Is there constraint on the decisions you make as a CEO, is there fragmented governance there or that it is not consistent?

CEO 3: It is difficult because it is not consistent and I think where the problem is that there could be political drivers vs. good practice drivers or evidence based drivers or the reason for doing things might be political rather than anything else. I do not say that is wrong in particular, but frequently the political component is individualised rather that collectively a board response. So I think there is a problem with individuals on boards with their own agendas rather than realising that collectively they have a duty as a board rather that as individuals. And that is where the conflict is in what drives people as individual board members to the idealistic model which would be the board acting and even if an individual is different to that, they are a board and that is a board decision.

Collective decision-making is also influenced by the interests individuals have in other interests. The Chief Executive above links the challenge to collective decision-making as a board to the lack of understanding of the board's function as a discrete entity or understanding of the fiduciary duty to the board above other interests. Conflicts of interest arise.

Participants alluded to conflict with Ministry of Health personnel who were considered to lie outside the governance stream for healthcare services. A distinct separation of the Ministry from the DHBs governance and decision-making was demonstrated.

Chair 1: I don't think the Ministry have a governance role, I think they try and exercise one and I find that difficult. It's like "well don't have a Board, make up your mind….If you are going to have one let's do it. If you don't want one don't have one. You know what Wellington is like….its full of these…I have to be careful (laughter)

Further conflict was indicated at a personal level for senior DHB personnel. Both the influence of the political priorities at the time and the reception by the Chief Executive

shape decisions. In this situation described, the Chief Executive indicates personal threat if political strategy is not adhered to.

CEO 1:I think that is a problem and depending on which way the political priorities happen to be floating they push for one or another of these and you get a feeling that if you do not do something the risk is with you.

The organisational and political structure of the New Zealand healthcare services was considered to influence the freedom and independence which chairs and chief executives felt they should have in decision-making. The lack of *cultural capital* brought to the board table by some members was not sufficient to be able to contribute to decisions being made. Those with the skill and knowledge were at lengths to be inclusive of others in decision-making whether their input was valid or not. The majority of DHB members are elected by their communities.

Commoditization of healthcare

Two participants thought that by making health services commodities to be bought and sold conflict arose, especially for some professionals. They also felt that there were opportunities for professional care to be compromised when the skills and knowledge, *cultural capital*, was considered a commodity.

Medical Specialist 1: There was a time in the 90s where health gain, health needs, health care were all relevant drivers and there was a commoditization. Healthcare was a commodity that had to be sought, and that of course still has some validity, but, what has happened in the environment that I work in, which is secondary care, is that those concepts of, descriptors of health status, however have been usurped, supplanted, replaced by disease, which has to be addressed. It is quite pressing and is a harder concept to grasp in some ways than health, and it does not obey normal distribution curves, and it is governed by a lot of caprice, does not behave in the way you want it to do.

This response also identifies the change in terminology in response to commoditization. Another conflict identified was that between the demand of patients, as clients, and the established practices of some clinicians.

CEO: Yes that is right, a whole lot of stuff that is happening is really around that rise in consumerism, which has an important effect on clinical governance and not necessarily complimentary in this sense. People wanting, being resistant. The

traditional clinical roles are, in my opinion, quite resistant to consumerism. The degree that the patient has say in what goes on does not sit well with many people.

Researcher: How does it sit with what you are supposed to be doing in terms of the act and what national policy is?

CEO: Society has a general trend towards consumerism not necessarily all good, some of it is the McDonalds sort of mentality… if I don't get it in ten minutes I will get my money back. And you see that creep into healthcare as well, particularly in the acute settings. And people expect good customer service instantly and are not worried about what degree of priority they have. So that is the societal movement that is rubbing up some degree of clinical leadership.

Researcher: Or clinical leadership has not been able to respond to it,

These examples identify the tension which exists between what the patients/ community want based on the egocentric society they now live in and the *field of forces* which is the healthcare services. The latter example identifies that some clinicians have difficulty changing their behaviour in response. The *reproduced* behaviours of their professions are durable and are often unable to change to meet patients' needs.

Democratisation of healthcare

The DHB includes members elected from the community. Notwithstanding the limited decision-making they have within the legislation as outlined in Chapter 3, DHBs are charged with making rationing decisions on behalf of their communities. However, they are constrained by directives from the Minister and Ministry of Health.

Chair 1: And it's like the "F" service which is a good example, we made a pragmatic decision that there is a whole lot of criteria that the shareholder gives you with priority observed "F" comes down at the bottom. Is it something the public system should be providing? I don't think it is, if you are short of the money and have an endless supply of money it does not matter. That costs us nearly $2 million a year and by default they are white middle class two income people it only costs $3000.

As shown in the example above participants indicated that there were funding constraints which impeded the democratic process of rationing services and that in some cases, mental health for example, Ministry directives ring-fenced funds. This meant that the DHB was limited in its spending in the most cost effective manner. The result was conflict because of the Ministerial control.

CEO 2: I think there is a conflict in current setting that the whole population based funding environment is creating a more autonomous setting for boards around how they should plan and prioritise health services for their region and I guess the reality of how much scope boards have to do that is still quite constrained you know I think everyone acknowledges that there are funding restrictions, they're not saying you know by and large health has done well compared to any other state sector in the recent years but you know when you look below the settings and you find you've got you know significant demands around elective services there's a requirement to protect the mental health blueprint. You've got continued growth in acute services and you know implementing the primary care strategy controls around co-pays and so on, that your ability to then actually look at what is left and the flexibility around that is quite difficult. And if you are going to bring about service change including the service coverage framework which is reducing services or choosing not to purchase some services and leave something out, you still require Ministerial signoff. So there are quite strong controls and sanctions on board so how much autonomy do you really have in the current settings even though the funding environment has become quite autonomous. So…

Researcher: It's a bit of a mismatch…

The Ministry's role in governance, or not, was described by several participants. They indicated that the DHBs should have an autonomous role in decision-making but that was not possible in the current legal and political circumstances.

CEO 2: I think there are tensions around Ministry's expectations on boards and the reality of what that means at a local level but I still very much hold that the Ministry doesn't have a role in governance they do have a role in policy development and that needs to be reflected in the Minister's expectations on boards around what our service priorities and plans actually are.

Researcher: Does the Minister have a role in governance?

CEO 2: Well ultimately the Minister would have a role in governance because boards are directly accountable to the Minister at the end of the day under the current legislation they're not, boards first and foremost are required to deliver on the Minister's expectations and the requirements of the New Zealand public health and disability legislation, they are not first and foremost as individuals there to represent their community. So the Minister does ultimately have a role around…

As indicated by this CEO, the current legislation hinders the DHBs' ability to be autonomous entities making decisions in their own right. As previously identified the legislation (NZPHD Act,2000) itself impedes the democratic process espoused through the elected DHBs. All participants made some reference to the frustration of decision-making by the "democratisation" process. For example:

CEO 3: It is my responsibility to make sure they are implemented and that I report back on the progress of implementation and I have a degree of responsibility to help the board get to that level as well because if I don't, they will not get there and it is helping vs. leading the board with an elected board. Managing up in elected boards is quite a hard process and I spend a lot of time whereas previously under the old commercial model 10-15% of my time was managing up and it would be more than 50% now, but it does depend on the skill of the chair.

For this CEO the workload had focus on keeping the board educated and informed. The DHB elected members, in particular, did not come with the requisite *cultural capital*.

Collective decision-making, collective responsibility

All participants alluded to changes in more recent times that had enabled better communications within decision-making groups. This was applicable to the inter-professional relations and those relations between those making corporate decisions and those making clinical decisions. The medical specialist below identified that familiarity with people in their roles as clinicians and managers facilitated communication.

Medical specialist 2: (in relation to involvement in corporate governance) Yes, one of my perspectives and one of the successes of xxDHB and the hospital is that there are opportunities for clinicians and managers to work together and get to know each other as people in the same room and on first-name basis so they learn from each other and I have learnt a lot about the difficulties in issues facing corporate and financial. I think they have learnt a lot about the clinical difficulties and issues, the fact that we are in the same room and address those and have to work a way through is far more powerful than some organisations where an angry letter or email is sent back and forwards without them really exploring what the issues and what the concerns of all parties.

Participants gave examples of the class and group *habitus* which they brought to decision-making. The group *habitus* develops without conscious effort (Bourdieu, 1977a). Learning is by exposure to other people and situations and listening to their perspective. The structure that allows that to happen in an organised environment is formalised so that the perspectives of others will not be excluded if they are not able to represent themselves. The structure of the group itself (in this case the professions represented) structures the structures of the group *habitus*. Bourdieu describes *structuring structures*, "circular relations that unite structures and practices" (1977b, p. 203). The group itself provides rules and formats for decision-making.

Several participants identified that one of the challenges in their work was getting people engaged in the process of making a decision. This frustration was seen as being because those others lacked an understanding of the healthcare services environment and its subtleties.

Medical Specialist 1: It is more than that. It is getting people to be engaged in the process. If you say there is problem X here, can you not see there is a problem?

…..I have no problem about not making decisions; it is the inability to address problems concerns me, sometimes.

Medical Specialist 3: … so I personally don't understand why people are so reluctant to engage, I think they don't know how to engage.

However all participants identified efforts made to be inclusive of stakeholders in decision-making whether that was the community, staff or the shareholder. All participants demonstrated an awareness of requirements for transparency, honesty and an underlying probity to their governance.

CEO 1: The other set of things that I spend a lot of energy on now, which is equally important, that a lot of our leadership needs to be able to deal with some of the emotional intelligence issues. Essentially a lot of the leading is about how you interact and control yourself and how you persuade people and what is the legitimate way to involve people and try to get them on board and have that debate. We are quite strong on values, behaviour and the way people behave to each other and the influence type stuff, from my understanding it is important there seems to be a lot of leadership evidence that those sort of things are probably key to an organization's ability to deal with change and to actually be able to attract people that can work together and deal with change.

Medical Specialist 3: Absolutely and the community said they wanted openness and transparency and our first community engagement workshops and the board picked that up that's in our strategic plan and all of the work as soon as it goes to the board it is open to everybody and we don't put it in PDF framework we just give it to people, do what you want with it so I personally don't understand why people are so reluctant to engage, I think they don't know how to engage.

Chair 1: I do think I have a responsibility to ensure that the shareholders strategy is implemented whether I am chairing or not. I've had a lot of political experience and I know how to do a resolution and get it out. I don't often do that because I think it is better to do it with consensus but at the end of the day if everyone else is going to fluff it out I am going to do it. The biggest responsibility I have is for everyone to walk out of that room feeling they have had a chance to have their say and that whatever the collective decision was we are not going to go out there and bad mouth the staff or each other. And I think we have been very successful at that and I feel good about that of course there have been decisions that some of us

disagreed with or not but at the end of the day we all felt I had my say. Collectively we have decided this…

Collective decision-making, for the last participant above means consensus; individual contributions may be listened to but not used to influence the decision necessarily. Collective decision-making incorporates the opinions of all those participating in the decision. This becomes decision-making through compromise.

Collective decision-making was perceived as important in getting others to accept decisions. For these participants these underlying values form the basis for offering a quality healthcare service. However, in clinical practice collective decision-making remains disconnected, especially between the medical staff and other health professionals.

Researcher: Do you think collective responsibility is a nursing thing?

CNM: I think it is, but in saying that it is getting more multi disciplinary like the Physiotherapist's and the OTs have far more input now than they used to. So we keep ward meeting and mention every patient and they will ask the question why is that been done for that patient and its up to me after they have had their say to take it to the medical people.…..…

Researcher: Does that lead to collective decision-making about the patient or are your nursing decisions and the allied health staff decisions have got closer together, but are the medical staff included in there is there a collective decision making there

CNM: No, I think the medical care is still isolated from the nursing care. Not so much for the consultants, but from the registrar.

For example, in the case above the nursing team made peer assessed decisions, involving the paramedical staff and then took decisions to the medical staff in an isolated manner based on arbitrarily set historical rules.

Summary

The healthcare services *field* is structured by the legal context and rules and the chosen organisational structure of the government placed in time. Time includes history, context and tempo. All activity happens in time.

The data highlights the influence on decision-making of the legal frameworks and frameworks assuring quality and safety in healthcare governance decisions. These include audit of both clinical and financial activity, guidelines for clinical decision-making and the

influence of the individual professional thesis, the collective institutional memory and the rules of the game in health sector decision-making.

Also highlighted is the impact of tension and power created by the *structure of the field* of healthcare services. This includes the impact of the democratisation of healthcare services process especially in creating conflicts of interest and the assault that the legislation makes on the fiduciary duty to the healthcare service organisations. The current democratized structure includes DHB members appointed by the Minister, some of whom have been elected by their communities. Balancing the professional duty of care with the duty of utility to the organisation generates conflicts of interest which may include fiduciary duty to the organisation balanced with obligations of self-interest and commoditization versus patient care. The data also identified that the formal governance decision-making framework defined by the legislation demands collective decision-making which is impeded by the lack of knowledge and understanding of the healthcare services system which some board members bring to the organisation. The processes, which those with authority from *cultural, political* and *symbolic power* put in place to counter the above deficiencies, can limit transparency in the decision-making process.

Conclusion to Analysis

Chapters 6, 7 and 8 have shown how healthcare services provide a complex environment in which the multifaceted character of the subject was reflected in the data collected from participants with different experiences in healthcare services. Using Bourdieu's process of research (Bourdieu *et al*., 1991), analysis of the *field of practices* identified the attributes of individuals within particular groups which participants indicated shaped their decision-making in governance in healthcare *practice*. Developing a *social topology*, a map of the power and tension within the *field of healthcare services practice,* from the data illustrated the key attributes required to balance that power and tension. And lastly, investigating the *structure of the field* of healthcare services practice and its influence on the shaping of decision-making in governance in healthcare services identified the supporting and inhibiting structures which influence governance decision-making.

Analysis of the data revealed 22 determinants common to participants as shaping decision-making in governance in their healthcare services practice. From ongoing reflection and

immersion in the data the researcher was able to distinguish six key themes from the data which embody groups of the determinants identified in the data. The determinants are not exclusively assigned to each concept group as, as indicated by participants, decision-making in governance is multifaceted. The concepts are:

- **Professional maturity**, in the context of the study, encompassed life experience, education, leadership, technical and professional skill, which culminate in *metaliteracy*.

- **Duty of care balanced with the duty of utility**; both have ideologies and philosophies influencing decision-making. These include personal and professional culture, including profession-hood, represented in *cultural power* and which may lead to conflicts of interest. Also included is the ability to act with economic rationality

- **Quality and safety** of organisational activity which includes professional morality, professional thesis, institutional memory, rules, the role of clinical guidelines and audit of clinical activity and clinical governance.

- **Power and tension** which includes the role and use of *symbolic and social power*, the democratization of healthcare, collective responsibility, and trust.

- The context of decision-making in **time** and the healthcare **organisational structure** shapes the decision-making in healthcare service governance. The context provides support for decision-making in governance.

The analysis has been developed into a framework (Figure 2, page 209) that gives guidance, from the participants' perspective, to the governance decision-making processes in the New Zealand public healthcare services. The determinants are the specific attributes and tools explicitly used in decision-making in governance in healthcare services identified from the data. The determinants are grouped by dominant theme to give dimension to and facilitate understanding of those processes.

The themes named by the participants and the researcher reflect the nature of the healthcare services sector/ industry to which they are being applied. The dominant themes within

decision-making in governance are supported by the organisational and legal structures pertaining to the healthcare services sector within the context of time. Through examples given by the participants relating to accountability, transparency, probity and fiduciary duty, the data demonstrated that generic principles can be applied to healthcare service organisations and in any organisational function, such as clinical decision-making, in which governance decisions are made.

Chapter 9

The shaping of decision-making in governance

This study explored and analysed the experience of participants in the shaping of decision-making in governance in New Zealand's public healthcare services. The analysis provided the way to develop a framework which could facilitate decision-making in governance in healthcare services through using the 22 determinants and themes to guide decision-making.

This study, underpinned by Bourdieu's (1993a) *Economy of Power,* identified the *cultural, social, symbolic* and *political capital* all stakeholders used in balancing the tensions and meeting the desired outcomes of healthcare services.

Specifically, the data showed that the rules for clinical and corporate governance are the same (page 168) and evidence from the literature (Chapter 4) found that two aspects to governance can be distinguished which facilitate the transferability of generic principles of governance to New Zealand healthcare services. Firstly, governance is the making of decisions in good faith (Farrar, 2005; Finn, 1977), with independence of mind (Garratt, 2005) and with the appropriate skills, diligence and care taken on behalf of others (M. King, 2002a; Tricker, 1984). Secondly, the structures of governance are audit (Power, 1997), laws (Finn, 1977; Health Practitioners' Competency Assurance Act," 2003), guidelines, codes (Cadbury, 1992) and principles (New Zealand Securities Commission, 2004) which support decision-making on behalf of others.

The impact of *cultural power* was recognised through the analysis of the *field of practice,* that is, governance in public healthcare services. Analysis of the data suggested that governance in healthcare services is driven by the *cultural power* of professional maturity which is determined by experience, education, skills, credibility, leadership and *metaliteracy*. These are the attributes required to be accountable for ones decision-making. Nevertheless each professional group has its own particular culture and tensions which arise from the tribal and traditional behaviour of health professionals. Their ideologies and beliefs create conflicts of interest and test the moral and ethical convictions of individuals and the need to balance the duty of care to patients with the duty of utility required by the organisation.

Similarly, for transparency to be maintained the *symbolic power* used in balancing power and tension through the use of *symbolic* and *social power*, creating trust, enabling democracy and promoting collective responsibility for decision-making. Fiduciary duty drives the balancing between duty of care and duty of utility to the organisation driven by the personal and professional *cultural power* and recognising the influence of ideologies and philosophies, conflicts of interest and the need for economic rationality. In achieving probity, identified within the data were clinical guidelines, audit, institutional memory, professional morality and professional thesis and the rules which bind together as the dimensions of quality and safety.

Analysis of the power interplay within the *field of practice* demonstrated how decision-makers use their types of power to influence the decisions of others through the leadership of people and the management of change. From the data the need for shared leadership and collective responsibility for decisions emerged, especially within a context of scarce resources that is evident in New Zealand healthcare services.

Finally, there was recognition of the importance of the legal frameworks, the foundations of public policy and organisational structures in *structuring the field* of governance decision-making. These structures include the impact of quality assurance, audit and guidelines and the memory as *structuring structures* (Bourdieu, 1993a) within the institution. Within the *structures of the field* are included the moral and ethical practice of professionals and the rules which are established to facilitate *practice*. The data highlighted the conflicts of interest arising from the democratisation of healthcare services process and the commoditization introduced out of the economic necessity to understand what happens in healthcare services. The analysis of the structure of governance in New Zealand healthcare services also demonstrated the importance of collective decision-making and collective accountability in current *practice*.

The study has identified 22 determinants which were revealed from the rich data gathered from the interviews, focus groups and observations as shaping decision-making in governance in healthcare services. These determinants were organised according to themes related to decision-making in governance in healthcare services. Secondly, the study, supported by historical case law ("Marquis of Bute," 1892; Romer J. in Re City Equitable [1925] Ch 407) ") and literature (Farrar, 2005; Finn, 1977) identified that decision-making in governance is dependent on and shaped by the context in which decisions are made. That is, governance within the area of clinical

practice is similar to governance within management and corporate practice in healthcare services. The data from analysis of the *field of practices* demonstrated that governance in both contexts is underpinned by the same principles and themes.

Farrar (2005), Garratt (2003) and Leblanc & Gillies (2005) support a similar view of governance in the corporate context but it has not previously been explored in a public healthcare system such as that of New Zealand. While the level of commitment to the generic principles of governance was recognised by all participants in this study as an underpinning shaper of decisions in healthcare services, most participants also recognised that the generic principles are not commonly recognised or applied to governance decision-making by all stakeholders or across all functions of healthcare service organisations.

The *reflexive* process in exploring the *field of practices*, developing the *social topology* and exploring the *structure of the field*, according to Bourdieu's research process, was apparent in the three levels of analysis. Firstly, the 22 attributes which determined the shape of decision-making identified in analysis of the *field* were grouped by dominant theme. The themes of quality and safety, duty of care versus duty of utility and conflict and tension were offered from the data and professional maturity was the product of researcher reflexivity. The themes reflect the operational dimensions of decision-making in governance in healthcare services and reflect the relationship of their characteristics to the generic principles of governance as identified by the participants and on the reflection of the researcher.

Framework for understanding decision-making in governance

The framework, figure 2, page 209, locates the determinants which were revealed from the data. They are the abstracts, tools and structures which demonstrate the operationalisation of decision-making in governance in healthcare services in *practice* settings. They are grouped by a dominant theme. Themes revealed in this study customise governance decision-making principles to the context of public healthcare services and reflect the generic principles of governance. The generic principles of governance are placed in the diagram to indicate the influence on the grouping of the data and the outcome of interpretation which is that to make governance decisions an individual needs the attributes of each of the themes.

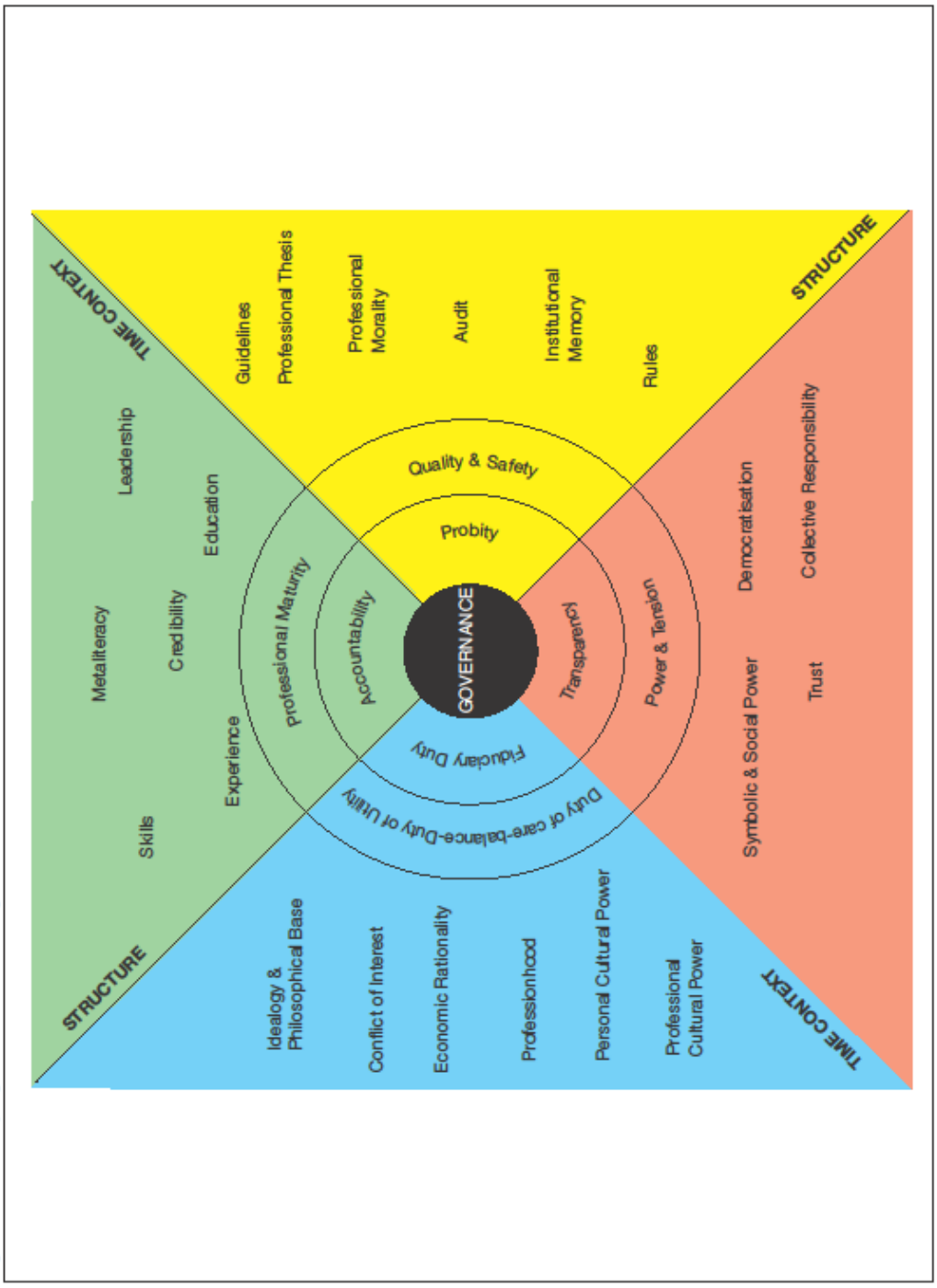


Figure 2. The Shaping of Decision-making in Governance in Healthcare Services

In the next section each concept group of determinants will be discussed.

Professional Maturity

Professional maturity was identified in the data as a prerequisite for the ability to be accountable for one's decision-making in governance. Professional maturity was revealed as a dimension of decision-making in governance based on life experience, professional experience, education and technical skills. The data indicated that those who are professionally mature demonstrate leadership in that their credibility is recognised by others. While this concept may be compared with Senge's (1990) "personal mastery" discussed in Chapter 6, these participants have reached a turning point with self-recognition of confidence in their own competence to make decisions in their *practice* and recognise the views of others which is expressed as *metaliteracy* by Webb *et al.* (2002). As reported by the participants, the increase in the *cultural power* of those who are professionally mature is recognised by others through the consistency observed in decision-making. The participants confirmed their professional maturity by stating that they know when not to proceed but also when to *practice* outside of the established processes using knowledge based on qualification and experience.

Education and credibility

Health professionals are required to have a tertiary qualification and be recognised as good citizens to register as health professionals ("Health Practitioners' Competency Assurance Act," 2003). The HPCA Act (2003), through the statutory councils, aims to assure for the consumers of healthcare services, the currency of *practice* of registered health professionals and the maintenance of standards of *practice* for each professional and for each profession. All participants in this study described currency in *practice* as an important aspect to professional maturity. Currency for health professionals is maintained through ongoing education programme requirements of the registering professional councils and offered, and sometimes funded, by public healthcare service employers, publicly funded education institutions and private organisations e.g. DHBs, Universities, the Order of St John.

The requirement by professional governance organisations for directors and board members to have gained qualifications and ongoing education in governance to maintain currency has been interpreted from the data as being very important and is

supported by Leblanc (2003), Garratt (2003) and the Institute of Directors in New Zealand (IOD) as discussed in Chapter 4. In contrast while there is an expectation that DHB members will maintain currency in their knowledge of governance in the healthcare services context (NZPHD Act, sch 3, cl.5) the requirement is only to the "extent practicable" and therefore not mandatory. And while the minister is obligated to appoint suitably qualified persons there is no stated defined level of education for elected members prior to their appointment to a DHB.

All participants talked about the importance of tertiary and post-graduate management qualifications in supporting basic educational preparation and maintaining currency of practice. These qualifications gave credibility to their practice as board members, chief executives and clinicians.

Experience and credibility

In a similar way to education requirements, managers in the healthcare services are required by employers to have a variety of experience and qualifications depending on the area in which they work. Most entry level managers have attained a minimum bachelor level degree in management, humanities, commerce or an area specific to clinical practice. Membership of professional organisations which offer programmes to assure currency is encouraged and in some cases mandatory, for example in accounting. In this study the chief executives, in particular, emphasised the requirement by their boards that they have a thorough understanding of the healthcare services for which they take responsibility. The data suggests that those who are health professionals and who use their clinical experience to inform their management decisions, not to limit them, are justifiably confident in the quality of their decisions and the ability to be accountable for those decisions. The data also suggests that those chief executives who are not qualified as health professionals should have experience in health services in order to understand the complexities of the provision of care and the multi-faceted nature of the healthcare system. Therefore having the *cultural capital* through qualification and understanding the culture, *the doxa*, of healthcare organisations is seen by participants as influencing the shaping of decisions in governance of those organisations.

Leadership

Experience allows the individual habitus to accumulate *cultural, social* and *symbolic capital* (Bourdieu, 1986) to balance tensions in the *field* and participants called this leadership. Participants recognised the importance of leaders having attributes of being able to set direction, establish standards and integrate the agreed values of the organisation including setting ethical boundaries. However, in a similar manner to the leadership role discussed by Hayes (2007), participants highlighted the role of the leader as change agent as being the key function of leadership. For most participants leadership included both recognising the abilities of others in being accountable in their positions and sharing or delegating the leadership function as the way to get commitment from teams to work together. In support of this notion, Schwartz & Tumblin (2002) claim that service industries are transformational and situational with servant leadership styles which recognise the values of others are most successful in energizing human resources within an organisation and that this optimizes human *capital*. Similarly, Hesselbein's (2004) concept of the sharing of leadership was considered by participants as being integral to establishing trust throughout the healthcare organisations. Participants identified the expectation of leadership as a concept embedded in the organisational culture, the *doxa*, of healthcare service organisations. Participants identified that having the skills to lead was an obligation of leadership in public healthcare organisations in assuring that the public had confidence in healthcare services.

Skills

Ideally, appointed DHB members are chosen because of their skills in order to complement those skills of elected board members for each DHB (NZPHD Act, 2000, s.29 (5)). While the Minister publishes a general set of desirable attributes (Ministry of Health, 2007a) of DHB members, there is no published job description or list of experience and skills required for either appointed or elected members of the Boards. However, the Minister is required to appoint people appropriate to the position (NZPHD Act, 2000, s.29). The data indicated that in some cases an appropriate skill mix was still not available following the choice of appointed members to DHBs. The *ad hoc* membership to at least one board was required indicating that the appointment process was flawed in providing the mix of expertise for that region. This particularly related to

the lack of financial, accounting and commercial skills identified as being crucial to effective DHB governance and the maintenance of financial disciplines.

In contrast to the above, elected DHB members have no requirement for demonstrated skills, experience or even understanding of the healthcare sector. They self-select through accepting nomination from their communities and are elected on the notion of merit. Elected members therefore require a presence in their community but that presence may be limited to one special interest, a specific local constituency or just a recognised name. Participants emphasized that there are occasions when elected board members are the least qualified to be making decisions on behalf of the organisation especially with regard to making allocation decisions concerning millions of dollars of public funding. While participants did not suggest ways to test credibility of elected members, they accepted that some board members' credibility may never arise formally as it may only be tested when in office. This is a risk which the researcher believes that the public should not be exposed to and board appointments based on qualification, experience and skill can mitigate that risk as suggested in this study and supported in the literature (Leblanc, 2005).

Metaliteracy

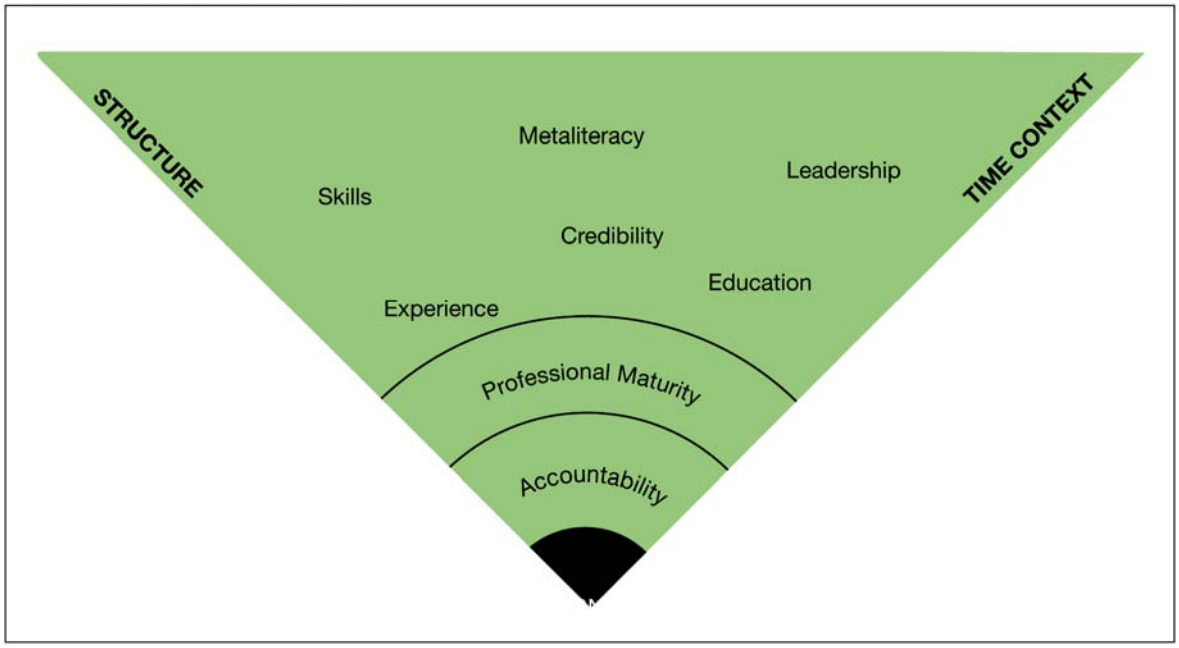
All participants identified a period in their professional lives when their confidence in their own competence reached a peak. There is not a specific point in time rather a maturing of their *habitus* that is reflected in their professional *practice*. The turning point is measured through *metaliteracy,* as described by Webb *et al*. (2002) and discussed on page 127. It is the ability to receive and consider the opinions of others and choose to use those opinions or not based on one's own professional thesis. For participants, recognising the turning point was also characterised by the realisation that aging impacts on the scope of *practice* possible. Participants also explained the turning point was reached with the recognition of "what one doesn't know" the result of reflection on one's *practice.*

Accountability

Accountability for professional *practice* arises from professional maturity as identified in the data in Chapter 6, with credibility arising from education from experience skills, and leadership and the recognition of a turning point in the personal *habitus* which culminates in *metaliteracy*. Each governance decision requires some element of each

determinant of accountability. However, as the data indicates, professional accountability within clinical governance is regarded as a separate concept from the accountabilities of the healthcare service organizations, and this is supported by Deighan (2006). Professional accountability relates to the decisions made by autonomous health professionals, especially in their role as practicing clinicians and involves accountability to patients.

Figure 2a. Accountability



Accountability has been identified as a generic principle of governance (Cadbury, 1992; Charkham, 1994; Farrar, 2005). In contrast to the generic governance literature clinician participants in the study identified personal accountability of patients and communities as important to decision-making in *practice*. This exemplifies the *symbolic power* of patients in action. Choice of care and treatment is maintained through informed consent ("Health and Disabilities Commissioner Act," 1996) and the ability to formally withdraw from treatment programmes. Being accountable allows patients to influence the tension and balance in the *field* of clinical practice.

Clinicians are held accountable for their practice through the Health Practitioners' Competency Assurance Act (2004)) and their professions are held accountable within the framework of the law. DHBs, on the other hand, are accountable to the Minister to provide systems, processes and resources to enable clinicians to make clinical decisions with confidence and to provide services to the public (NZPHD Act, 2000 s.37). While these organizations are not legally accountable to their communities the data suggested that elected board members, in particular, perceive accountability to their electorates

and this is supported by Ashton *et al.* (2005) who identified three levels of accountability, to the electorate (perceived), the board as an organisation and the Minister.

Much of the relevant governance literature (Charkham, 2005; Garratt, 2005; Leblanc, 2003) suggests that to be accountable directors must be professionally qualified and have sector experience to gain competence as public company directors. This study has identified experience and professional qualification, education and professional maturity as being important to decision-making in governance in healthcare services. Chief executives in this study indicated that up to 50% of their time is spent "managing up" i.e. up-skilling and coaching board members to a level where they are have the knowledge and skills to make the complex decisions required. The data and the literature (Mays *et al*., 2007) also suggest that the success of a DHB is dependent on the ability of the Chairman in leading their board because the board members may not offer the required level or range of skills to ensure good governance.

In summary, professional maturity is reflected in leadership of organisations and recognition that there is a turning point in becoming professionally mature which results in *metaliteracy*, demonstrated by the ability to recognise the value of others and to have confidence in one's own decisions. Also, individuals, across the functional divisions of healthcare services, are accountable for their own credibility demonstrated through education, experience and skill and the credibility of colleagues and subordinates through providing opportunities for education experience and skill attainment. Professional maturity illustrates the principle of accountability in governance decision-making in healthcare services.

Quality and safety

Healthcare consumers, the public of New Zealand, have an expectation that the publicly funded healthcare services being offered will be of the best quality and available when they are required at the price funded. The participants in this study stated that those services are underpinned by the professional morality of the healthcare service providers as organisations and individuals. Participants suggested that clinical governance in current *practice*, that is, with the focus on quality and audit, has obscured the other dimensions of governance and their application to governance decision-

making in clinical activity. Issues of duty, power and tension and professional maturity in clinical activity are not recognised as issues requiring governance decision-making.

In healthcare services, probity is operationalised through the structure of the quality and safety programmes in all functional areas, including the professional requirements for currency in practice ("Health Practitioners' Competency Assurance Act," 2003), the maintenance of professional autonomy and institutional memory.

Quality and safety in decision-making in governance is based on guidelines, rules, audit, the professional thesis and morality of the clinician and the memory of the institutions in healthcare services.

Professional morality and professional thesis

Professional morality defines “doing what is right” and is enshrined in the pledges and oaths of health professions (Dock & Stewart, 1938; Edelstein, 1943). The ethical boundaries are set by the health professions and their legislated councils and operationalised for their members in publicised scopes of professional practice ("Health Practitioners' Competency Assurance Act," 2003). Participants who were health professionals gave examples from their clinical practice e.g. page 170, indicating that professionally mature health professionals are exercised and practised in the application of ethics to their decision-making. When this *practice* is combined with clinical knowledge gained from education and experience it is “professional thesis” as named by one participant. Professional thesis was considered by the participants as the collection of the knowledge and experience that health professionals, or other participant’s professions such as law, have on which they base a decision. Sometimes this may appear intuitive, spontaneous and immediate like the concepts in “Blink” (Gladwell, 2006) but on other occasions the process of decision-making may be consciously rational.

The chief executives in this study identified the importance of consistent values being apparent in the leadership of their organisations and appointed board member participants highlighted that “doing the right thing” was an important consideration in their decision-making. One appointed chairman had specific experience in the monitoring of professional ethics. Seedhouse (2005) also recognises the importance of accounting for values in decision-making recognising the contribution from different value bases. The maintenance of healthy and robust questioning of the ethical and moral

basis for decision-making, i.e. the process of making decisions, was seen to be as important as the decisions themselves.

Rules and guidelines

The demand for effective and efficient allocation and use of resources requires the establishment of rules, as named by several participants. From the data it emerged that the health professionals recognised the need to have some rules for *practice*, both administrative and clinical, for reasons of expediency and in order to anticipate the actions of others. For example, clinical guidelines have a place when patients have needs which can be met by a standard pattern of treatment and care and only exceptions need an individual treatment regime; an example is the care of primary maternity clients. However, at other times the guidelines are set at a level which confines the independent decision-making of the health professional based on professional thesis and/or the clinical team. This was identified by one participant and is discussed by Harrison & Lim (2003). An example is limiting drug compendiums and clinical pathways which corral the health professional's decisions.

Similarly, as Ashton *et al.* (2005) found, DHBs were restricted by the rules set by the Minister and the Ministry of Health. Chief executives and managers in the study indicated that the rules were inconsistently applied by the Ministry of Health personnel because of different experience and skill of Ministry personnel to those in DHBs. The ambiguity of rule application bounded the strategic thinking as described by Bazerman & Chugh (2005) and action of the DHBs, their managers and clinicians. The data in this study indicated that boards, managers and clinicians need the space not only to make decisions according to the situation and the available resource, but also in relation to other priorities of that district, and the time available. The researcher suggests that rules for healthcare services operations are better set in legislation, gazetted as regulations, published as policy and limited to *extraordinary* ministerial directive only. Crown agency, as classified in the NZPHD Act (2000), limits the independent decision-making of DHBs which participants indicated was necessary for decision-making related to efficient use of resources. Participants suggested it would be beneficial to be able to work within a known policy framework, without the operational involvement of the Ministry of Health personnel, at arms length from the Ministry in the manner of Autonomous Crown Entities ("Crown Entities Act," 2004) as discussed on page 41.

Institutional memory

The *habitus* of healthcare service organisations is shaped by their experiences as institutions. One way this is demonstrated is by the maintenance of institutional memory. Clinician participants, in particular, were frustrated at the loss of intellectual *capital*, as described by Becker (1976), over time and the perceived imbalances in *political* and *symbolic capital* created through the loss. Intellectual *capital* is lost when individuals leave organisations through social and structural change, including when health professionals cannot practice in a manner with which they feel safe to practice. The latter, which leads to what is popularly called "burnout", is a challenge to their professional thesis. Intellectual *capital* is also lost when the timeliness of projects results in actions not undertaken or projects not undertaken because of financial limitations. The value of maintaining institutional memory was highlighted by all participants but formal strategies are not often put in place to maintain institutional memory, as noted in the data. Institutional memory can be maintained through organisational structures in which all functions of the organisation are included and which are durable across political change. Examples include accessible archives of records of evaluation of projects as part of the management of change.

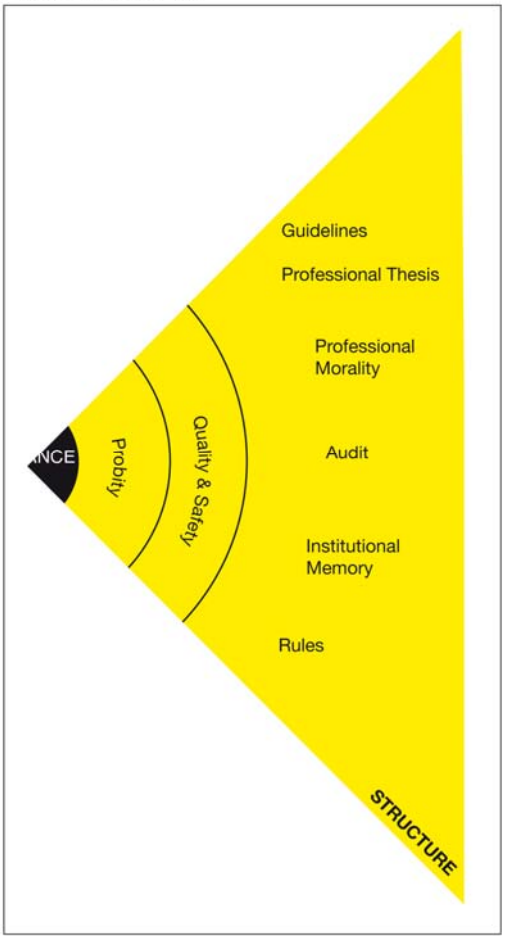
Audit

Audit programmes, including those standards required by the New Zealand Ministry of Health for the certification of services, are based on minimum standard sets. While audit is recognised as an integral part of probity it has, as evidenced in the data and supported by the literature, been the driver of change for quality rather than a tool for the monitoring of quality and performance (Power, 1997). O'Neill (2000) says that this has at times undermined the trust in professional decision-making. While audit should be maintained as a monitoring tool, the data suggested that clinical guidelines and measures set by recognised peer-reviewed international standards should drive all practice in healthcare organisations. Clinical decisions should be supported and not limited by historically established practice. Although the role of research was not canvassed explicitly, the data indicated the reluctance, particularly of clinicians, to be restricted in their decision-making by edict.

Probity

Probity is the formalisation of the honesty and integrity of the organisation, its people, processes and systems. Probity is underpinned by and a reflection of the quality of care and safe practice clinically, administratively, in management and within the DHB. While all participants' DHBs identified practice and professional qualification, audit and rules which guided practice, none identified ongoing evaluation of the basis or the values on which *practice* decision-making was founded. Few examples of the maintenance of institutional memory within DHBs were identified. Although, as indicated in the data, participants emphasised its relevance to establishing and maintaining robust systems and process in the organisation e.g. project archives

Figure 2b. Probity



Maintenance of quality and safety assures probity. The process includes public certification of services and clinical guidelines which allow decision-making based on autonomous professional thesis and professional morality. Administrative, financial and clinical audit should be used as monitoring tools and not to drive of the incorporation of standard practice into organisations. Best practice should be the set standard in contrast to the minimum standard sets currently in use. Institutional memory should be maintained through managed change evaluations and within hubs of clinical activity. These would be available to any health professional or healthcare services manager to access.

Power and tension

Maintaining healthy tensions between stakeholders through robust debate, recognition of competence in others and confidence in their opinions ensures transparency in organisations. Tensions which are the result of an imbalance in the *symbolic power* between individuals and/or groups in the particular healthcare service are unhealthy. As

expressed in the data, negative tension costs time and money and is a distraction from the governance of healthcare organisations.

Social and Symbolic power

Analysis of the data showed that s*ocial power* in healthcare services is established through shared leadership, which is supported in the literature by Hesselbein (2004). *Social power* is also attained through managing people by defining roles, credibility and using one's *power* to balance tension within the *field of practice*.

Symbolic power is only recognised by others when sufficient *cultural* and *social capital* are accumulated and demonstrated by people in positions of authority or organisations or groups which have shown their ability to lead (Bourdieu, 2005). *Cultural capital* is obtained through qualification and experience and *social capital* through the membership of relevant social groups such as families and professions and the *power* that emanates from them. The data indicated that decision-makers in governance require *symbolic power* in order that they may enjoy the confidence of the public through trust in their experience, skill and qualification. Those decision-makers include DHBs, managers and clinicians and the maintenance of their credibility forms part of plays for power in the *field* of governance within the healthcare service organisation.

Trust

The participants indicated that some clinicians did not feel valued or that they were not trusted to make appropriate decisions for their organisations or individual patients. The data indicated that for some groups, nurses in particular, this was considered a violation of the validity of their professional *practice.* As they sought to validate their *practice* the *symbolic violence* experienced was real, e.g. as described by the clinical nurse director on page 155.

The data also alluded to patients and the community not always having confidence in or trust of the healthcare services. From a macro perspective, chief executives and chairmen indicated that there were times when they felt that they were not trusted, by either the Minister or the Ministry of Health officials, to get on with their jobs. For example the public nature of board meetings has created a paradox as communities should have better access to boards but boards feel exposed to the risk of making mistakes when decision-making in public. Trust, as discussed by O'Neill (2002), is in

crisis because of the highly complex environments we find ourselves in and which we cannot control. This results in the underutilization of human capacity in our organizations, especially that of professionals. Trust is required for the success of all organisations but particularly in the steward role when directors are entrusted with the interests of the public (Muth & Donaldson, 1998). Chief executives and chairmen all stated that having trust in one's staff or colleagues was integral to success in the organisation. Trust is the key attribute of relationships in which tension is positive and in turn can allow successful achievements of projects and management of the organisation.

In order to trust, people must have confidence in what others do and they must know what others do. Transparency facilitates that understanding and therefore trust. Organisational structures should facilitate familiarity within the healthcare service professional teams and their support services colleagues. The role of managers and board members is to support and ensure that clinical activity can take place in the best way available and they need to have the confidence to trust clinicians to perform the tasks as required. As one chief executive, a health professional, indicated, decisions can be informed by historical professional practice but historical practice should not be used explicitly as the basis for decision-making.

Collective Responsibility

For the majority of services discussed by the participants, collective responsibility, that is each professional taking responsibility for their *practice* in clinical decision-making, has overtaken the autonomy of the independent health practitioner. Collective responsibility contrasts with inter-professional accountability in which decisions are made between professionals and all practitioners share the collective responsibility for care (Ovretveit, Mathias, & Thompson, 1997). As indicated in the data, this emerges as a result of the complexity of clinical decisions. In the case of corporate and management decisions, it arises from the multifaceted nature of healthcare services. The data suggested that collectivity in decision-making is a desired attribute of healthcare services. However, participants also suggested that the *habitus*, described as cultural histories of the professions and healthcare organisations and the *doxa* or the 'way things are done' in some clinical areas, impede both the collective decision-making and responsibility taken for decision-making. Organisational structures and the expectations of behaviour within them need to be explicit to patients, health professionals,

management and those responsible for governance decisions in any context in healthcare services. This would have an outcome where the concept of collective accountability would not preclude the accountability of the individual healthcare service professional.

There was little evidence in the data of inter-professional accountability or inter-professional *practice* as discussed by Jones (2000). Ovretveit *et al*. suggest that it is through common accountabilities that healthcare decisions will become connected and will move in the same dynamic *field*, and that the patient and/or community will be included in that *field*. In contrast participants suggested that managing the conflict and tensions between health professions and the imbalances in *cultural power*, between health professionals and managers and the DHBs was a challenge. Given the lack of inter-professional accountability, the collective decision-making is one way to achieve common accountability. However, while this was recognised by participants, especially in relation to the role of the board, it was identified as being not evident across healthcare organisations. Formal clinical networks, supported in service specifications, can ensure that there is a structure for collective decision-making for clinical practice and that can be inclusive of the patient or community.

Democratisation

Political power is based on the democratisation of healthcare services which at present is focused on the process of appointment by the minister or electing members of the public to DHBs and the statutory committees, which is defined in the legislation (NZPHD Act, 2000). *Symbolic power* is gained through membership of the health professions by qualification and experience which is supported by the concepts of Bourdieu (1989b, 1977a).

Through reform, the democratisation of the healthcare services was an attempt to engage the public in the decisions made about healthcare services, to provide a community voice as stated in s.3 (1) (c) of the NZPHD Act (2000) and to reinstate the public's confidence in the public healthcare services. Democratisation involved the inclusion of seven DHB members elected by their local constituencies and the establishment of statutory advisory committees to provide for public input on particular subjects. In practice the process resulted in the transfer to the community of the responsibilities for rationing healthcare services. Analysis of participant responses,

supported by the literature of Feek (1999), suggested that rationing decisions require sophisticated and informed professional analysis. While the professional skills of some elected board members are recognised, skills in making rationing decisions are not readily identifiable in New Zealand's lay communities because of the primacy of self-interest either personal or group, as described by Bazerman and Chugh (2006). Legislation precludes these board members from being answerable to their constituents and it has been suggested that there are doubts that democratisation has occurred since the model commenced (Gauld, 2005; Mays *et al.*, 2007) identifying a need to review how the public is engaged in decision-making in healthcare services. The researcher's proposals for pubic engagement are on page 224.

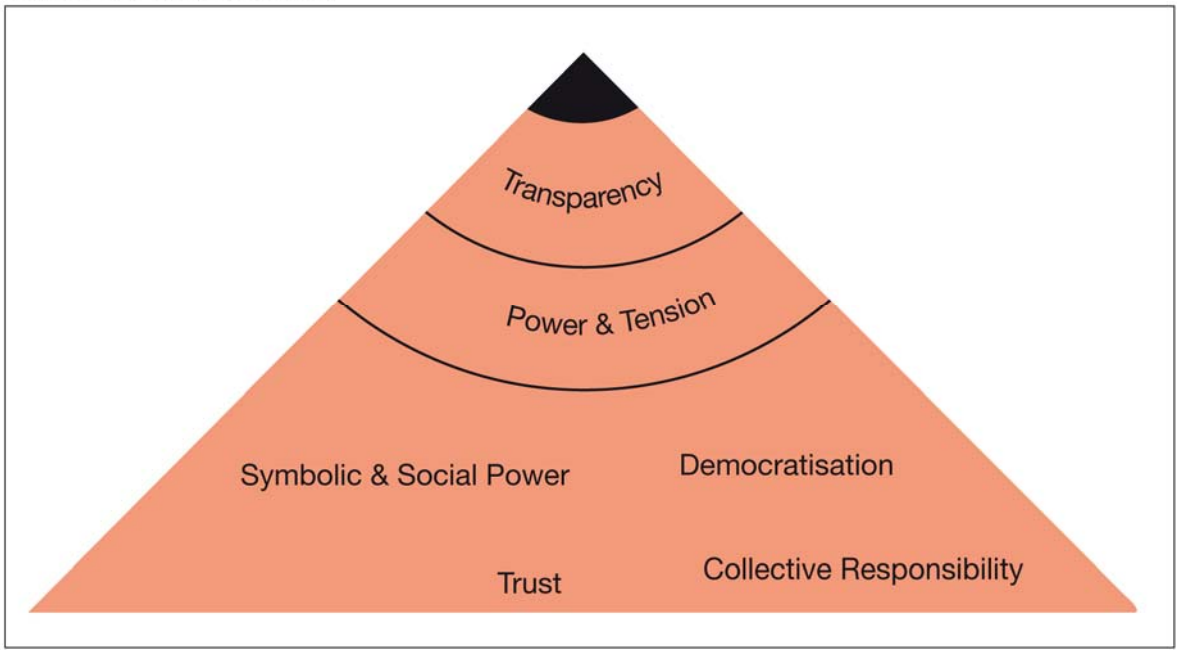
Transparency is also designed to be achieved through board meetings being open to the public, but in practice few attend. As the data indicated, many discussions and some decisions are planned prior to the formal board meetings. Therefore transparency is obfuscated. While some participation from the statutory committees is warranted and reported by participants as worthy, they also suggested that statutory committees are not only another level of bureaucracy but that single issues risk dominating their activity. A further failure of the system was identified in the data which showed that the outcomes of the committees can be in conflict with decisions of the board. While committee decisions are not binding, chairmen and chief executives would like the opportunity to decide what committee support, or other form of stakeholder feedback, their organisations require. This issue was also highlighted by Mays *et a*l. (2007).The tension which arises is that boards, driven by the expediency of decision-making, are in conflict with the intent of the democratisation process to restore public confidence in public healthcare services through participation and transparency.

Transparency

Transparency lies within the framework of formal reporting requirements. Examples are the New Zealand Public Health and Disability Act (2000) and the Public Finance Act (1989). For the healthcare services organisations, the formality of informed consent, availability of options for care and the sharing of knowledge in clinical practice enhance transparency. However, transparency has not always been evident, for example the waiting time programmes (Ministry of Health, 2007b) have been described by a participant in this study as "rationing in drag" indicating that the public have not been openly informed of the mechanisms of that programme. Using Bourdieu's analysis this

is an example of *symbolic violence;* that is, limiting the resources available while suggesting that that is an appropriate strategy in resource management. A further example expressed by participants is the propensity of DHBs to deal with contentious topics in camera, in workshops or meetings prior to being open to the public. The reasons suggested by participants included the contentious nature of some issues and the need to be clear about the issues prior to an open meeting. The political interests therefore are served before interests of transparency, including the obligation not to deceive.

Figure 2c. Transparency



In assuring transparency the appropriate avenue for inclusion of the democratic process in healthcare governance is through government and ongoing community and specific issue consultation for which legislation may be required. An example would be the introduction of a health tribunal as previously described by Smith (1999) on page 189. Transparency could be exercised through ongoing public consultation, including stakeholder reference groups for special interests, ensuring a democratic approach to decision-making in governance through which *political* and *symbolic capital* is used to balance tensions in the governance *field*.

Duty of care balanced with the duty of utility

The primary purpose of governance in healthcare services is to balance the tension between the duty of utility, as one participant described the efficient and effective use of

resources, with the duty of care demanded by both professional *practice* and the legislation in relation to DHBs ("Crown Entities Act," 2004) which are required to take due care.

For the purposes of this study the duty of care as enshrined in common law and codified in the Companies Act (2003) does not remove, override or pre-empt the concept of duty of care of heath professionals who are bound by oath or pledge. The health professionals' duty of care is now formalised in the Code of Patient Rights of the Health and Disabilities Commissioner Act (1996). Any case arising under that code would be dealt with on merit of the particular case[6]. As participants in the study discussed, the duty of care is the same in both the corporate and patient care contexts demonstrating the same characteristics of trust and accepted authority to care on behalf of others. They are enacted differently because of different contexts – in different *field*s - but the underlying principles are the same. The point is important as the outcome of the study shows that decision-making in governance is the same no matter within which context they are applied, that is corporate, management or clinical. It is recognised however that all decision-making in public healthcare services is complex as it is limited by economic rationality.

Economic rationality

Tension occurs when the duty of care to patients is in peril of being compromised by the need to stay within budgets and/or to conform to models of care which may not be the optimum choice for a particular patient or community. Ensuring those tensions are positive and facilitate activity within the healthcare services is key to the successful provision of care within the boundaries of the funds available. Participants in this study illustrated the impact of funding limitations or rationing on decision-making in governance and several indicated that providers could be efficient if the rationing function was separate from the provision of services in contrast to both functions being located in DHBs to reduce transaction costs.

Funding is a function of affordability and, as discussed in the review of the literature (Chapter 3), the level of affordability is decided by central government. Economic rationality will only exist if a model based on the most efficient and effective use of

[6] Advice from the Office of the Health & Disabilities Commissioner 19.12.07.

funds is applied contrary to the "needs first" model as described by the Ministry of Health in the Elective Services document (2007) reinforcing the government policy (A. King, 2000b). This model results in those with greater need being treated/cared for first, rather than funds being spent in the most economically efficient manner. Some participants accepted the challenge with one participant stating that "people do die".

Bamford & Porter-O'Grady (2000) and Malcolm (2000) have identified that health professionals have also experienced some difficulty in responding to the fiscal restraints demanded from all the reformation processes no matter what their ideological basis. As Malcolm (2000, p. 5) says, "A critical problem with health systems is the reluctance or even rejection by clinicians of accountability for resource use and even, in the past, collective accountability for quality of care." The inference is that if clinicians do not have the power in decision-making in resource allocation, they will not be accountable for their *practice*. The conclusion is that there is tension in the healthcare services *field* between the *economic power* of management and the *cultural power* of the health professions. Organisational structures in DHBs, discussed on pages 54/55, place the authority of managers over funding allocation and operational management decisions above the professional decision-making authority of health professionals. Balancing this tension is the fundamental purpose of healthcare services governance decision-making, that is, to meet the demands of economic rationality, simultaneously meeting the healthcare service demands of individuals and their communities.

Ideologies and philosophies

Through professional maturity, as described in this thesis (page 209) leaders manage tensions in the *field* of duty through recognising the ideologies and philosophical bases of other stakeholders. Creating recognised healthcare service values within the organisations was considered by the chief executives in this study to be an important part of their role in that decision-making would therefore be drawn from common values. I propose a Code of Practice which encompasses those values as representing those of the New Zealand healthcare services and that they be published to allow common knowledge and understanding in the same manner as the Securities Commission Guidelines (2004) and the Principles of Best Practice for New Zealand Directors (Institute of Directors in New Zealand, 2007). In such a Code of Practice for Healthcare Services values would be underpinned by the concept groups and the inter-relationship with the generic principles of governance. The determinants show

practitioners the links to decision-making in clinical activity and how governance is embedded in *practice* and in so doing shapes the decision-making of all healthcare service practitioners. For example a description of probity in *practice* would demonstrate for decision-makers what they needed to consider when making governance decisions.

Cultural Power

Cultural power is the product of history and ongoing interplays between the *habitus* and the *capital* present in the *field of power. Cultural power* shapes the society through the representations created and chosen by the players in the *field*. The data suggests that *cultural power* is gained through personal and professional experience and qualification. It involves people with governance responsibilities having the professional maturity to reflect on their *practice.* As the data showed, importance is placed on the personal and professional *cultures* of the participants in that participants did not separate the influence of their personal histories from their professional experience. Recognising the idiosyncrasies of different *cultures,* as diverse as those of the professions, class and ethnic groups, facilitates decisions in management and in clinical *practice*. As described by one participant in the study, making people comfortable in the healthcare services environment eases their participation in both governance decisions or in receipt of care and treatment. The governance determinant of *cultural power* is based on the ability of decision-makers, through education and experience, to balance their duty of care with the duty of utility.

As all participants in the study illustrated, professional cultures impact on both decision-making and decision-making processes. The myth of medical knowledge superiority was identified in the data and medical specialists who were professionally mature readily identified the attributes of other health professions but admitted that some of their colleagues did not which resulted in tension in the healthcare services *field.*

Professionhood

Professionhood, the collective membership of a professional group with whom individual health professionals identify, allows the application of *sens practique* as described by Bourdieu (1977a) and is a reflection of the professional maturity of the *habitus* of the profession. Familiarity with role responsibility allows anticipation of action and dissipates tensions between stakeholders in the healthcare services.

Participants identified that a sense of belonging to a profession or team was important especially in collective decision-making. Health professional participants considered that chief executives and managers lacked understanding of the health professionals roles along with board members which impacted on decision-making in governance in healthcare services. The result was that too much time and experience was needed to manage the resulting conflicts especially between the interests of individual patients, the duty of care and the interests of the organisation, the duty of utility. The power imbalances and tensions which arise are the impetus for inter-professional working in order to gain balance between the professions.

Conflicts of Interest

Conflicts of interest and power struggles within DHBs were identified by participants as a key challenge from the inception of the model and the existence of this tension was confirmed by the literature (Ashton, Tenbensel *et al*., 2005; Mays *et al*., 2007). There have been significant instances of litigation arising from poor management of conflicts of interest since the data was collected (Ashton, Tenbensel *et al.*, 2005; DML v ARDHBs and Labtests," CIV 2006-404-4724; Sage, Pocknall, & Sugrue, 2007). General practitioners as board members, in particular, have ongoing conflicts with their authority in decision-making concerning allocation of funds to Primary Healthcare Organisations (PHO).

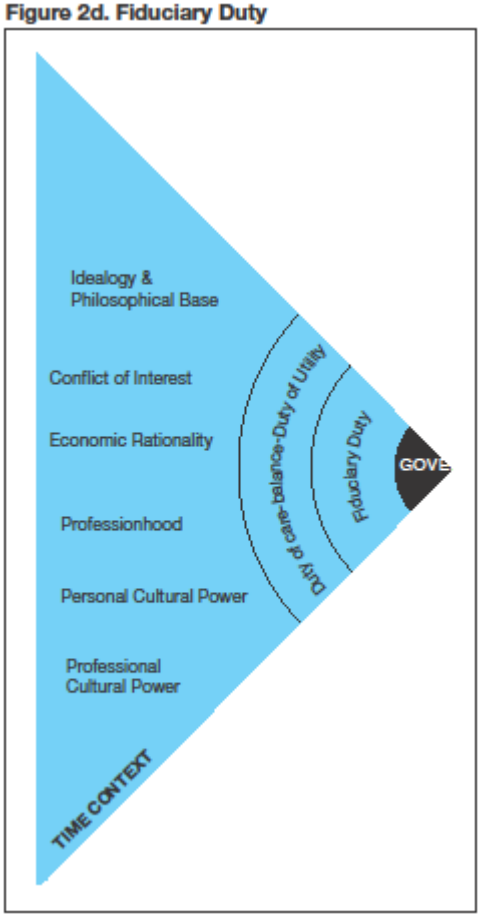
The management of conflicts of interest is described in the legislation (NZPHD Act, 2000) however, that detail has proven to be inadequate in the management of some examples as cited by the Auditor General (Brady, 2007). Although independence of mind as described by Garratt (2005) is an ideal attribute of board decision-makers the opportunities for conflict are insurmountable in light of the inherent self-interest described in the literature (Bazerman & Chugh, 2006; Jenkins, 1992) and the challenges in managing those conflicts within the ambiguous direction in the legislation. The researcher contends that only through an independent appointment process undertaken by the Crown Companies Monitoring and Advisory Unit or similar body, and not directly by the Minister, can those conflicts be mitigated for DHBs. Appointment of directors would be contingent on their not having conflicts of interest of an existing or ongoing nature with that board. For example, clinician membership could be attained without material conflict through having membership from outside of the DHB constituency. Intermittent conflicts of interest would be managed through removal of

the board member with an interest from any discussion and decision-making on the topic in contrast to the current legislation (NZPHD Act 2000, Sch 3 cl. 34).

Conflicts were also identified between health professionals and DHBs and management. The data suggested that, when health professionals felt in control of their decision-making, they would not put energy into creating those tensions between DHBs and themselves. The conflicts of interest which reportedly arose were overtly about the opportunity to provide best care available i.e. professional standards demanding actions which are in conflict with the interests of the organisation or even public policy. In reality they are about the use of *cultural and symbolic capital* to maintain positions of power. Therefore organisational structures should allow for health professionals to manage their own destiny, maintaining their independent mind as discussed by Garratt (2005) and including their clinical decision-making within the interdisciplinary team. Support for financial management, which participants recognised as a reality, and to manage change and create incentives, is the role of management.

Fiduciary Duty

Figure 2d. Fiduciary Duty



As discussed in Chapter 4, fiduciary duty to the entity, the trust authorised by others and accepted by directors, takes precedence over all other duties and responsibilities including that duty to the shareholder (Hinnant, 1988). In contrast, the legislation relevant to DHBs (Crown Entities Act, 2004; NZPHD Act, 2000) specifically ensures that primary accountability of board members is to the Minister of Health prior to any accountability to the organisation. As demonstrated in the data, DHBs cannot make independent decisions in the best interests of the organisation, with the confidence that those decisions will not be overturned by the Minister. The Minister is vulnerable to decision-making in response to political pressure and the government's broader situation and not primarily in the interests of the DHB as shareholder. Others describe this problematic situation as a dual accountability (Mays *et al*., 2007) i.e. duty to the Minister and the organisation. It becomes problematic when the Minister's decision impacts on the strategic and operational decision-making of the DHB.

Therefore, attaining the balance between duty to the organisation and duty of care to the patient or community recognises that there will be conflicts of interest which require management. However, the participants in this study indicated that self-interest is very difficult to manage and in some cases cannot be managed. The participants' responses are confirmed by the findings of Bazerman & Chugh (2005) as discussed in Chapter 4. Therefore DHB members should be appointed without ongoing conflicts of interest. While board members are drawn from the local communities, maintaining the original intent of the legislation, the wider public voice could be provided for through participation in a health tribunal using the model of Smith (1999) as previously discussed.

Structure

All participants in this study stated that the organisational structure of healthcare services influenced both the way decisions were made and where they were made. All participants had been involved the New Zealand healthcare services for a long time and particularly during the period of reformation from 1989 to 2000. The impact of change in the funding model from one funder (Health Funding Authority) to 21 DHBs with a combined funding and providing role was shown to have spread the decision-making capacity within DHBs thinly (Tenbensel 2002). The lack of qualification and skill of some board members, who were appointed through the electoral process, was confirmed in the data (page 174) which suggested that not only were boards reliant on the skills of chairmen but that CEOs spent a lot of their time in "managing up" (page 199).

As discussed in Chapter 4, organisational structure must incorporate disciplines which ensure adherence to the primary principles of governance. A traditional example is the separation of the audit function from management and representation independent of the board on the audit committee. Governance disciplines should also include personal accountability for and transparency in *practice* in all parts of the healthcare services.

For the determinants of decision-making in governance revealed in this thesis to influence decision-making in healthcare services a political structure is required which does not impede the decision-making within those services. As discussed in Chapter 3, page 41, the Crown Entities Act (2004) was created in order to establish definition of the roles of Crown Entities (State Services Commission, 1999, 2000a, 2000b, 2000c). A consequence has been easy access by Ministers to interfere with the decision-making of DHBs. This means that the best interests of the healthcare service organisations are not the primary interest of the Minister or board members. Economic logic can be thwarted too easily. DHBs should be defined as Autonomous Crown Entities (ACE) which are not subject to the impulse of Ministers or the vagaries of political tensions. One participant suggested that decision-making independent of government influence outside of published policy will allow publicly funded healthcare services to allocate funds in the most cost-effective and efficient manner for their communities. Solutions will be offered later in the chapter where a new framework for decision-making in governance in healthcare services is advocated.

Time

Our histories and our presence in the *field* of *time* shape decisions of the moment. Recognising *time* in context and managing tempo were identified in the data as a role of those making decisions in governance and are supported by Bourdieu (2000) as impacting on the present, future and how we make *time* in order to have activity in a *field*. Managing *time* and timeliness of decision-making was identified by participants as a requirement of the leadership of efficient healthcare services. Similarly participants indicated that the context of *time* in history or the present influenced governance decisions through institutional memory, the changes in the *cultures* of healthcare service professions and currency in *practice*.

Promoting a framework for governance in healthcare services in New Zealand

The shaping of decision-making in governance in the New Zealand public healthcare services – a framework for decision-making in governance in public healthcare services

The purpose of healthcare services is to provide education, treatment and care to individuals and their communities and to achieve positive health outcomes. The purpose of decision-making in governance in healthcare services is to enable clinical *practice* which incorporates inclusion of the patient or community in decision-making. Ideally, all healthcare services governance should be directed at supporting clinical *practice* and providing the resources and environments in which *practice* can be carried out.

The understanding of the shaping of decision-making in governance enables a framework for governance practice to be used in all areas of governance in New Zealand's public healthcare services. The implications of the framework include:

- Making **transparent** the characteristics of personal and group experience which influence the shaping of decision-making in governance.

- The framework is suitable as the basis for a **code of healthcare services governance** which would demonstrate, for all stakeholders, a set of common values to be used in governance decision-making in New Zealand public healthcare services. Those values would emanate from the dimensions of

governance which shape decision-making of professional maturity, quality and safety, power and tension and fiduciary duty.

- The inculcation of a common **definition of governance** and its operationalisation in New Zealand healthcare services, recognising the patient and the community role in decision-making as centre of the governance process in healthcare services. A proposed definition is:

Governance is the decision made on behalf of others within a given and accepted relationship of trust. Decision-making in governance in healthcare services is firstly characterised by professional maturity which enables accountability, quality and safety which assures probity, power and tension which supports transparency and balancing the duty of utility and the duty of care which compliment fiduciary duty. Secondly, governance decisions are supported by the structures of law and policy and within the context of time.

Considering the impact in law

- DHBs, so that they may act within government policy but independent of shareholder involvement in decision-making, would be re-classified as **Autonomous Crown Entities** as defined in the Crown Entities Act (2004). While still having regard for government policy, autonomy would support decisions related to economic rationality in the provision of services, and ease the tensions caused by perceived multiple accountabilities.

- DHB members would be appointed, by the Minister as shareholder, based on their experience, qualification and skill in healthcare services governance in a similar manner that health professionals are appointed to positions based on qualification, skill and experience. The **balanced board** would include qualified members from the community and health professionals who do not benefit or are not at risk of benefiting personally from the decisions of the board.

Considering the impact on process

- **DHB clinician engagement** would be established through the board committee and advisory process including the clinical advice function. Each board would have at least one clinician without personal interests as a member.

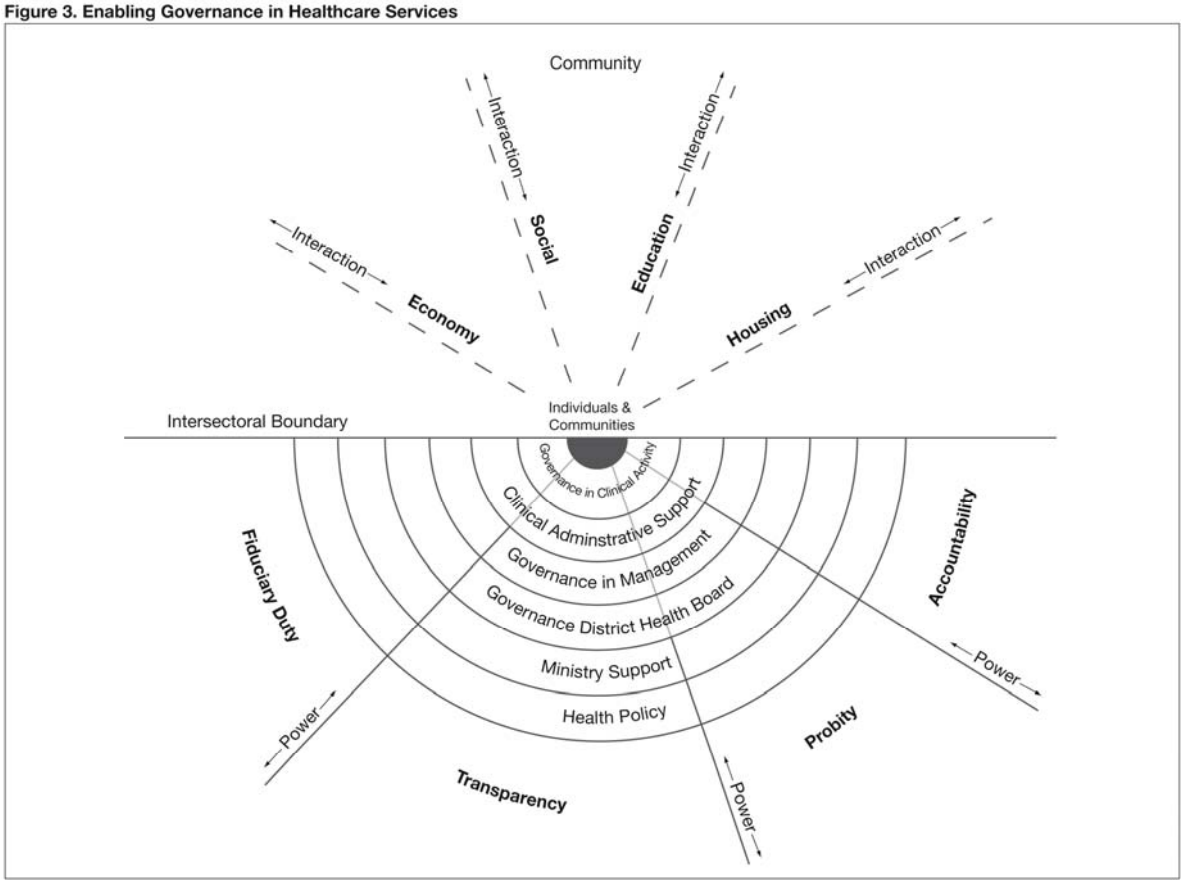
- Service specifications will require inclusion of modules which support interdisciplinary practice. For example, in maternity services an antenatal service module which allows the lead maternity carer and general practitioner to coordinate care, and similarly between them and the well child provider during the post natal period, would encourage **clinical networks**. Both modules could be added to the existing section 88 notice (NZPHD Act, 2000) which covers the provision of care and payment.

- Community engagement and the function of community consultation are combined with the function of the National Health Committee in the **New Zealand Health Tribunal.** The Tribunal, based on the ideas of Smith (1999) would be open to any member or group of the public. It would hear the views of the people in locations throughout the country ongoing and throughout the years. The DHB statutory committees would cease as their contribution has varied across DHBs (Mays *et al*., 2007), but public providers would attend the Tribunal when held in their district and hear the views of the public directly.

- **Intersectoral engagement**, that is, between health and other social agencies, would be formalised at Ministry and District levels with governance recognising a similar model for decision-making in social services governance.

Applying Bourdieu's concepts the *cultural, social, political and symbolic power* brought through *capital* to healthcare services provides the vehicle to explore the tensions and work to maintain balance in the *field* of governance. Changes are designed to maintain balance in the *field* of healthcare services governance and allow the focus to be on care of patients and communities, as shown in figure 3, which demonstrates the enabling of governance across healthcare services and the intersectoral relationship of healthcare services governance with other sectors in our community. The figure, underpinned by the generic principles of governance, focuses on the recipient of care and the interacting decision-making between them and clinical *practice*. All other *practice* in the healthcare services organisation supports clinical *practice*; including those support functions with governance responsibilities such as management which interprets the direction and strategy and monitoring of the board. *Cultural, social and symbolic power* are tensile across the organisation.

Figure 3. Enabling Governance in Healthcare Services



Healthcare services interface with other social services which determine health and the figure demonstrates the interaction with those services.

The shaping of decision-making in governance in New Zealand public healthcare services has been explored, analysed and a framework has been proposed. The outcome is a framework, figure 2, which shows how governance practice is shaped within the *field* of healthcare services. The framework offers practical examples of governance decision-making. It recognises those determinants in the shaping of decision-making which are less easily identified but which have equal importance in the decision-making process. Each healthcare services governance decision requires an aspect of each of the concept groups of governance identified in this study. All dimensions of governance are supported by economic, cultural, political and organisational power and structures and are located in time. Governance in healthcare services interacts with the decision-making in other social sectors influencing the decisions of individuals and their communities.

Limitations to this study

The DHBs are accountable to the Minister of Health and report to officers in the Ministry of Health; in contrast to the separate Crown Companies Monitoring and Advisory Unit, which monitored Hospital and Health Services between 1996 and 2000 at “arms length” from the Minister. The primary limitation of this study is that it does not include data from the Minister at the time of data collection, or the Ministry. While Ministerial boundaries on DHBs are identified in the legislation and literature considered there is no assessment of what shapes the Minister’s decisions in relation to the governance of healthcare services. The researcher chose not to include the Minister or Ministry officials for the following reasons:

- The study was focused on the public healthcare service organisations which fund and provide services. The Minister of Health has changed three times during the course of this study and while several participants have changed their positions all but one are still involved in the provision of public healthcare services.

- Ministry officials are driven by the policy of the government. Their role is to provide impartial advice based on published evidence and best practice and they determine much about the interpretation of government policy. Their duty is to the government and not to organisations which are removed from government through legislation, no matter how close their relationships may be. The date identified that the relationship with the Ministry officials and the DHBs is multifaceted and would offer further complexity to the study. That relationship and its influence on DHB decision-making would be an important subject for further study.

Another limitation was the decision to exclude a detailed discussion on rationing but rather to focus on the influence of resource availability on decision-making in governance in healthcare services. Rationing is a complex issue with facets including funds, human resources, technology, ethics and policy. The influence of rationing on decision-making could be a study in itself and would not be done justice within the body of this study.

A further limitation of the study is the purposive selection of participants who may or may not be typical examples of chairpersons, chief executives and senior clinicians.

Although all participants could be considered experts in their *field* it is recognised that experts can be, and often are, wrong (Morse *et al.*, 2002). However, for the purposes of this study the individual idiosyncratic behaviour of the participants was of interest as well as their professional technical expertise. Morse *et al*. (2002) also identify that purposive sampling may also miss important views, for example those expressed by Ministry of Health officials, and the researcher cannot gauge how representative the participants are of the wider group of chairmen, chief executives and senior clinicians in New Zealand healthcare services. There is also the risk that more weight may be given to the opinions of the participants than is warranted and in that respect confirmation of opinions from the literature was important in mitigating that risk.

However, notwithstanding the limitations of purposive sampling the results can be disseminated to others and may be transferable to other public healthcare services as discussed in Chapter 5 and the intent of the study was to explore the New Zealand public healthcare services from a generic perspective. It was important that participants were accessible; enthusiastic about their roles in healthcare services and that they had given time through experience to reflect on what the influences on their decision-making behaviour might be. The process of the study was to explore, not to quantify, the shaping of decision-making; therefore both quality and depth of understanding through using a small sample size gave rich data.

All responses from participants in this study were given equal weight recognising the value of all participants in governance in healthcare services. In particular there was no differentiation between board members who were elected and those who were appointed. A limitation of the study is that, although identified, insufficient focus, during data collection, was placed on the individual's perspective as a board member appointed after election or appointed by the Minister. Similarly, there was no differentiation between those participants who were or had been health professionals and those who came from another profession. A limitation was that professional distinctions were given insufficient focus.

A further limitation is the limited demonstration of the influence of the differentiation between organisations and individuals on shaping decisions in governance. That includes data which was not common to all participants but which shapes individual decision-making. The unique, one-off responses from individuals are included in the analysis where they exemplify a prominent theme. Some themes identified in the data,

but not directly related to the decision-making process, were identified for further investigation and not part of this study. They include inter-professional and vertical *symbolic violence*, qualification and experience of non-health professional managers, the notion of critical friend and the valuing of and trust in professional capability.

Impact on policy

The findings of this study reflect directly on the policy of community inclusion in decision-making by electing the majority of DHB members and the statutory committees and the difficulty in managing the conflicts of interest which arise. Community inclusion was designed to regain pubic confidence in and understanding of New Zealand healthcare services (A. King, 2000b). This study found that the education and qualifications and appropriate experience were paramount to the success of Boards as perceived by the participants. Their opinions were supported by Leblanc & Gillies (2005). Therefore Boards will have a greater chance of success in adding value to their organisations if their members are appointed based on qualification, experience and demonstrated skill. Alternatives such as elected or appointed from employees risk ongoing conflicts of interest which are difficult to manage.

Secondly, as previously discussed, the structure of DHBs needs a level of independence, offered in the current legislation ("Crown Entities Act," 2004) as Autonomous Crown Entities (ACE), which would allow incorporation of government policy but an arm's length relationship with the Minister and Ministry of Health. ACEs are sufficiently independent to make decisions but not isolated from the control of taxpayer funds. Therefore the Ministry of Health's function would revert to one of policy and regulation and the administration of bulk funding based on population.

It is recommended that public participation should be through the general electoral system with consultation on specific issues required by legislation. A previously discussed, suitable processes should include the tribunal system described by Smith (1999) which is applicable to all New Zealand peoples. This would be a major change in policy relating to the engagement of the public in healthcare service decisions.

Notwithstanding the impact on policy discussed above, professional maturity, quality and safety, power and tension and the efforts to balance the duty of utility with the duty of care will continue to influence decision-making in governance. The framework

produced facilitates practitioners' understanding of governance decision-making in pubic healthcare services.

Conclusions of the study

Decision-making in governance in the New Zealand healthcare services is shaped by 22 determinants grouped into four themes within the context of structure and *time*. These are the dimensions of governance which allow the balancing of power within the *field* of governance decision-making. They reflect the generic principles identified in the literature and common to governance in all organisations in all contexts: accountability, probity, transparency and fiduciary duty. The concept groups are specific to the context in which governance is occurring, such as healthcare services. Through reflexivity, they are, in turn, interpreted from and into the governance decision-making activities of the healthcare services through the determinants of decision-making in governance which were identified in the data.

The literature highlighted the influence on decision-making of government policy, the experience of history and the boundaries set by the law and its associated structures within the context of public healthcare services. The impact of self-interest and the opportunities provided or limitations placed on an individual's decision-making by the pressure of the group was also identified in the literature. Other boundaries identified in the literature as influencing decision-making were funding structures and the impact of rationing prerogatives coupled with the experience, skill and educational preparedness of individuals as directors, DHB members and/or health professionals.

In healthcare services decision-making is shaped by:

- Professional maturity characterised by experience, education, credibility, leadership, technical skill and recognition of *metaliteracy* of the maturing professional. Professional maturity effects the principle of accountability.

- Quality and safety which are characterised by guidelines and professional thesis, professional morality, audit, institutional memory and rules. Quality and safety operationalise probity.

- Power and tension which are characterised by the interplay of *cultural, social, political* and *symbolic power*, trust, democratisation and collective

responsibility. Power and tension reflect the degree of transparency present in a *field.*

- Duty of care balanced with the duty of utility is shaped by the ideological and philosophical base to practice, recognition of conflicts of interest and *cultural power*, economic rationalisation, professionhood and personal and professional cultures. The balance between the duty of care and the duty of utility gives support to the trust implied in fiduciary duty.

The scope of decision-making in governance in healthcare services includes the political, economic, organisational and clinical structures of healthcare services. Structures facilitate or impede decision- making (Drucker, 1999). The study offers a dimensional base which interprets those concepts for all governance decisions within healthcare services.

The study further found that the nature of governance is the governance decision which is taken on behalf of and with the authority to make decisions for others. It embodies trust between the parties. Fiduciary duty arises out of the trust given by one to another to act in their interests. The decision-makers are accountable for those decisions which should be taken in a transparent manner and with probity. Governance is governance. However, while the context in which governance decisions occur may differ, the principles which underpin and the determinants which shape decisions are the same. The duties of care, skill, diligence and good faith are the same whether making decisions in clinical or corporate environments. By defining governance by the context in which decisions are made such as corporate or clinical contexts, the whole of the scope of governance is obscured.

The study contributes to the understanding of decision-making in governance through bringing together the determinants which shape decision-making in governance into concept groups within the context of structure and time. The framework (Figure 2, p.209) aims to facilitate the choice of people as directors, managers and clinicians who understand the accountabilities, duties, transparency and probity required to make governance decisions in New Zealand’s public healthcare services and to give them guidance in their decision-making.

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Appendices

Appendix 1 Participant information sheet

Participant Information Sheet

Project Title: The shaping of decision making within governance in healthcare service

Invitation from Lee Mathias: You are invited to join me in my study to understand more about what influences the decision-making in corporate and clinical governance in our health services.

What is the purpose of the study? Through identifying why and what underpins governance decision making for both board directors and clinicians I hope to stimulate further understanding of the roles and responsibilities of people who provide effective health services. The thesis will fulfill part of the requirements for my Doctor in Health Science qualification.

How was a person chosen to be asked to be part of the study? I am inviting people in both corporate and clinical governance roles in their respective organisations. I am including those from three DHBs.

What happens in the study? There will be an individual interview, lasting approximately one hour. The interviews will be taped and then transcribed. The transcripts will be returned to you for confirmation that you are willing for all data to be included for the analysis and form part of any publication or presentation. The participants from each organisation will be invited to attend a later focus group in which responses to each other's thoughts will be taped and recorded. The third part of the process is to observe your interaction in a governance situation, a board meeting, clinical group meeting or similar during which interactions with others are recorded.

What are the discomforts and risks? Your participation is purely voluntary. Sometimes talking about how we make decisions may cause discomfort as we stretch our minds to reach for new understandings and we may not have recognised some of the influences on our past decision making processes or those of others. Participants have the right to withdraw at any time without any

negative consequences and request the return or destruction of any interview material.

What are the benefits? To participate is to engage in a self-reflective process of the experience of decision-making within your experience of governance, either corporate or clinical. Such insights could be valuable in bringing fresh understanding to how individual professional and life experiences shape governance decision-making.

How is my privacy protected? Anonymity will be protected through not naming any of the DHBs participating or individual participants. Your identity will be known to other focus group members and those present during the observation of board and clinical meetings. In that respect confidentiality may be in question. All data will be on computer disk and stored within a secure area at AUT.

Opportunity to consider invitation: I will contact you, per phone, within two weeks of your receiving this invitation to confirm your participation or not.

Participant Concerns: Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor (Dr Marion Jones, 917 9999 ext 7871). Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, madeline.banda@aut.ac.nz ,917 9999 ext 8044.

Thank you for considering this invitation.

Lee Mathias

Approved by the AUTEC on 30.06.04

Reference number :04/110

Appendix 2 Consent to participation in research

Consent to Participation in Research

Title of Project: The shaping of decision making within governance in healthcare service

Project Supervisor: Dr Marion Jones

Researcher: Lee Mathias

- I have read and understood the information provided about this research project.
- I have had an opportunity to ask questions and to have them answered.
- I understand that the interview will be audio-taped and will be transcribed.
- I understand that I may withdraw myself, or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way. If I withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed
- I agree that my identity will not be revealed unless I give permission for that to happen
- I agree to take part in this research.

Participant signature: .....

Participant name:

Date:

Project Supervisor Contact Details: Dr Marion Jones, 917 9999 ext. 7871

Approved by the Auckland University of Technology Ethics Committee on 30.06.04

Reference number: 04/110

Appendix 3 Application for Ethics Approval

Auckland University of Technology Ethics Committee (AUTEC)

FORM EA1

APPLICATION FOR ETHICS APPROVAL FOR RESEARCH PROJECTS

A. GENERAL INFORMATION

A.1 Project Title

The shaping of decision-making within governance in public healthcare service.

A.2 Applicant Name/Qualifications ***(If the researcher is a student (including staff who are AUT students), applicant is the principal supervisor. If the researcher is an AUT staff member undertaking research as part of employment, applicant is the staff member. If the researcher is a staff member undertaking research as part of an external qualification, applicant is the staff member.)***

Name: Dr Marion Jones Qualifications/registration: BA, MEd Admin (Hons) PhD, RGON

A.3 School/Department/Academic Group/Centre

Associate Dean - Post Graduate, Office of the Dean

A.4 Faculty

Health

A.5 Complete this section only if the researcher is a student

A.5.1 Student Name(s): Lee Mathias

Number(s): 0297920

Qualification(s) BA, MBA, Cert. Health Econ., RGON

E-mail address: lee@birthcare.co.nz

A.5.2 School/Department/Academic Group/Centre

Faculty of Health - Post Graduate

A.5.3 Faculty

Health

A.5.4 Name of Degree **Research Paper** **(delete as appropriate)**

Doctor of Health Science Thesis

A.6 Complete this section only if other investigators are involved in the project

A.6.1 Investigator Name(s)

N/A

A.6.2 Investigator Organisations

N/A

A.7 Are you applying concurrently to another ethics committee? ***(delete as appropriate)***

No (as per agreement with REC)

If yes provide details including meeting date:

A.8 Declaration

The information supplied is, to the best of my knowledge and belief, accurate. I have read the ***current*** Guidelines, published by the Auckland University of Technology Ethics Committee, and clearly understand my obligations and the rights of the participant, particularly with regard to informed consent.

Signature of Applicant: ..... Date: / /

(*In the case of student applications the signature must be that of the Supervisor)*

Signature of Student: ..... Date: / /

(*If a student project, both the signature of the Supervisor, as the applicant, and the student are required)*

A.9 Authorising Signature

Name of HOD/AGL/School/Centre: Dr Marion Jones, Associate Dean – Post Graduate, Faculty of Health

Signature of HOD/AGL/School/Centre: ..... Date: / /

B. PROJECT GENERAL INFORMATION

B.1 Project Duration

B.1.1 Approximate Start Date of <u>Data Collection</u>

…20./…06./ 04….

B.1.2 Approximate Finish Date of Complete Project

…./06…./….05

B.2 Are funds being obtained specifically for this project? ***(delete as appropriate)***

NO

IF YES, YOU MUST COMPLETE SECTION G OF THIS FORM

B.3 Types of persons participating as participants

(Check as applicable)

B.3.1 Applicant's students ☐

B.3.2 Adults (20 years and above) ☑

B.3.3 Legal minors (16 to 20 years old) ☐

B.3.4 Legal minors (under 16 years old) ☐

B.3.5 Members of vulnerable groups (e.g. persons with ☐

disabilities, limited understanding, etc.)

IF DESCRIBE <Type here>YES,

B.3.6 Hospital patients ☐

B.3.7 Prisoners ☐

B.4 Does this research involve human remains, tissue or body fluids which does not require submission to a Regional Ethics Committee? (e.g. finger pricks, urine etc. Refer to Section 13 of the AUTEC Guidelines). ***(delete as appropriate)***

No

B.5 Does this research involve potentially hazardous substances, e.g. radioactive materials, (Refer to Section 15 of the Guidelines) ***(delete as appropriate)***

No

B.6 Does the research include the use of a questionnaire? ***(delete as appropriate)***

No

B.7 How will interviews be recorded? Indicate which apply:

Audiotape ☑

Videotape ☐

Note-taking ☑

IF INTERVIEWS ARE TO BE RECORDED, MAKE SURE THERE IS PROVISION FOR EXPLICIT CONSENT ON THE CONSENT FORM AND ATTACH EXAMPLES OF INDICATIVE QUESTIONS OR THE FULL INTERVIEW SCHEDULE TO THE APPLICATION.

B.8 Describe how the principles of the Treaty of Waitangi are being addressed and applied in this project. (Refer to Section 2.5 of the Guidelines and the HRC Guidelines for Researchers on Health Research on Maori (Appendix G). Consider who might be affected by the project, its possible consequences, consultation issues, partnership issues, etc.)

This research is for the benefit of all New Zealanders. It is envisaged that through establishing what shapes the decision-making in health care governance there will be the ability to identify why and where the corporate and clinical decision makers think differently, and the beginning of understanding of this difference, if one is established. Better understanding should lead to better relationships and organisational function within New Zealand's healthcare services.

The implications of the Treaty of Waitangi in relation to the perceived inconsistencies between it and the Health and Disabilities Services legislation will be raised to prompt discussion; as to whether the participants find this an inconsistency that is difficult to manage within the governance decisions they make.

The participants will also be prompted to look at the issue of representation and whether they are able to represent Maori, whether they feel that they are obligated to represent

Maori and whether that is contrary to the primary duty and obligations to the paramount position of the organisation and its needs.

The sampling provides no unreasonable barriers to participation and is non-gender, non-ethnic specific. All participants will be asked to consider how their ethnicity influences decision making within the requirements of the Treaty of Waitangi. Consultation has taken place with Dr Pare Keiha to assist should further issues arise.

C. PROJECT DETAILS

DESCRIBE IN LANGUAGE WHICH IS, AS FAR AS POSSIBLE, FREE FROM JARGON AND COMPREHENSIBLE TO LAY PEOPLE.

C.1 Aim of project: State concisely the aims and type of information sought. Give the specific hypothesis, if any, to be tested.

The specific aim of the study is to explore the influences that shape the decision making in governance, congruence between the corporate governors and clinicians – if any, and use that congruence to build a commonality in governance decisions.

The second aim is to clarify the principles underpinning governance and to provide a formula for health service governance that capitalises on the diversity offered by the individuals contributing to the service

The study also seeks understanding of effecting governance which is compatible with patients and communities making effective and efficient decisions about their health care. The method will use individual interviews, using a semi-structured format, focus groups and observation of public and clinical team meetings.

The study will use an ethnographic process underpinned by the philosophies and methodology of Bourdieu (Bourdieu, 1977a). The format will allow for exploration and clarification through a reflective, reciprocal dialogue underpinning the framework for the study.

C.2 Why are you proposing this research? (ie what are its potential benefits to participants, researcher, wider community etc?)

The uneasy relationships between the governors and clinicians within New Zealand's health service have been regularly reported in the popular media. This indicates that much energy is given to the resolution of difficulties caused by poor relationships rather than the efficient provision of healthcare services. It is envisaged that understanding the personal and social characteristics which influence and shape decision-making will facilitate the development of more efficient relationships and the creation of organisational structures which provide support for the client/patient and their families and/or whanau to make successful decisions about their health care.

Through understanding what shapes decision-making in health care service governance it is envisaged that consistent policy and procedures in organisations will evolve. This will allow the quality of health care decisions made by the client/patient to be optimised.

Further understanding of the influences on governance decision-making may facilitate seamless decision- making processes within our health system guided by a framework that will evolve from this research.

In making visible the distinctions between corporate and clinical governance, these may be decreased leading to a single seamless governance philosophy and structure in our health care organisations.

The research forms part of the requirements for the fulfillment of the Doctorate in Health Science.

C.3 Background: Provide sufficient information, including relevant references, to place the project in perspective and to allow the project's significance to be assessed. Wherever possible provide one or two references to the applicant's (or supervisor's) own published work in the relevant field.

The conflict between the governors and clinicians within New Zealand's health service is described in formal critiques of the health care system (Cumming *et al.*, 2003). Governors, in the context of this study, include Ministry of Health officials, board members of DHBs and any others who make governance decisions in the health sector. There appears to be a disparity between the understanding of the role of corporate governance by those in clinical governance and visa versa (Harrison & Lim, 2003). Rather than the efficient provision of healthcare services, these reports indicate that much energy is given to the resolution of imbalances that occur between the struggles and tensions of abusive power.

My progress has included a literature search and analysis to substantiate whether the decision-making within corporate and clinical governance has identified what the differences are and what might be the action taken that allows all governance decisions to primarily serve the patient/client interest.

C.4 Procedure:

a) Explain the philosophical approach taken to obtaining information and/or testing the hypothesis.

The study will use an ethnographic process underpinned by the philosophies and methodology of Pierre Bourdieu (Bourdieu, 1977a). This has been chosen because it has a strong sociological base, and it encompasses the power of groups of people, the tensions between them and their responses to each other. These responses influence their governance decision-making. The methodology allows for the identification of the cultural characteristics, of the individuals of each group, which influence those decisions. Bourdieu uses the dynamic dispositions within each of us (called habitus) within the demanding environment in which we live (the field) where the struggle for position in a particular environment takes place (Bourdieu, 1977a). Together, the individual's habitus, and the field in which it exists, are demonstrated in how people practice their craft or profession and it is this practice that is to be explored in the study.

The methodology will also allow the researcher to evaluate the participants' expression of their understanding of the value (capital) of their role to the organisation. Bourdieu extends the classical definition of capital as purported by Marx, to include power as having capital value and the value of intellectual, social, political and *cultural capital* within a particular society or community.

The methodology allows the researcher to explore the different types of power bases within our healthcare organizations. These power bases may impede or facilitate effective decision-making. Bourdieu's concepts will provide the framework for participants and the researcher to organise the data in a manner consistent with a healthcare organisation environment.

The critical ethnographic process seeks to not only identify, but to actively do something about both the issuing and distribution of power within a particular community (Grbich, 1999). Critical questioning by the researcher explores how decisions are made within the organization and find out what led to those decisions 'through deconstruction, the analysis of discourses, and a close examination of social class, ethnicity and gender' (Grbich, 1999) p158). The researcher adopts a decentred position and does not speak for others but displays their voices, as well as her own in exposing the settings multiple realities (Grbich, 1999).

b) State in practical terms what research procedures will be used.

Participants with the identified roles, chosen by purposive sampling, will be invited to participate. They will have the opportunity to clarify any points prior to giving consent to participate.

Each participant will have a background information sheet to the study prior to signing the consent form and interview.

The researcher will use a semi structured interview process informed by Bourdieu's framework as indicated in the interview guide. Participants will explore their perspective of their personal environment (field) within which they practice governance.

The researcher will be exploring the influences on decision-making as well as the structures and processes that may facilitate decision-making. It is envisaged that the semi-structured nature of the interview will elicit what it is about individual participants that influences that decision-making process within that environment and the researcher will guide the participants to explore how they came to those decisions. The individual interviews will be audio taped, transcribed and participants will have the opportunity to review them.

The participants from each organisation will be requested to participate in a focus group at a later date. The focus group will be guided by semi-structured questions, which have arisen from the initial interview analysis. The focus group allows further investigation of those questions and issues that arise from the personal interviews as well as allowing discussion about organisational and political influences on the shaping of decision-making. During the focus group interview a transcriber will be present to record who is participating at each time and draft the interactions of each participant. This will contribute to the transcription to be used in conjunction with the data available from the focus group tape recordings. The transcriber will sign a confidentiality declaration.

Each transcription will be analysed to identify patterns and themes that evolve in relation to each participants decision-making processes related to the governance aspects within each role. The researcher will make a taxonomic analysis of these themes and identify subsets should they exist; including the same or different ways people with similar or dissimilar dispositions and values interact with their environments.

The researcher will also observe governance in action at board meetings and clinical team meetings. Observation of participants in action provides the researcher with the opportunity to substantiate the personal and group impressions obtained from the interviews and focus groups and may inform the questions used in the focus groups. It allows the observation of governance in action, the process of decision-making happening in the corporate or clinical context.

c) State how information will be gathered and processed.

Each participant will be interviewed on a minimum of one occasion and invited to join a focus group on one occasion. The opportunity to follow up, as required, will be negotiated. Estimated time for each interview will be one hour. Participants will also be

requested to verify their personal interview transcripts and can add or delete "comments".

All interviews will be audio recorded and transcribed. Observations will be recorded with written notes and group interaction diagrams indicating both the number and the direction of interactions for each group member.

d) State how your data will be analysed.

The method of analysis is based on the three level analysis proposed by Bourdieu (Bourdieu & Wacquant, 1992b).

- Relate the dynamics, forces and tensions identified (from interviews) in health care service (corporate and clinical) governance to the field of power. That is the power relationship between health care services and the political and economic systems New Zealand society, what is expected of the health care services, how it is organised and to what ends, and what is valued and legitimate.

- Map out the objective structure of the relations between the opposing positions taken by those in governance roles (especially corporate and clinical roles), who compete for the authoritative positions in health care organisations. The different sectors, primary, secondary and tertiary, have particular areas of activity that can have specific legitimate terms of governance. Included in this step is the identification of the individuals, the agents of power, who may exist both across and within specific sectors.

- Analyse the personal attributes and dispositions (habitus) of the individuals involved which may be expressed in the organisational ethos of governors and senior managers who are attempting to apply national and organisational policies; or the professional activities, thoughts and beliefs of those being organised which will include the habitus of all clinicians (doctors, nurses and others).

Method triangulation will evolve through the individual and focus group interview recordings, observation of participants in their decision-making roles and evidence from other published sources.
Interview process guide is appended.

e) Provide a statistical justification where appropriate.

N/A

D. Participants

D.1 Who are the participants? What criteria are to be used for selecting them?

The participants will be governors that may include Chairs, board members and CEOs of DHBs, and senior clinicians and Ministry of Health officials. They will be invited to participate based on their role in or relationship with a particular DHB.

D.2 State whether the participants may perceive themselves to be in any dependent relationship to the researcher (for example, researcher's students).

No

D.3 Are there any potential participants who will be excluded? ***(delete as appropriate)***

Yes

D.3.1 If Yes, what are the criteria for exclusion?]

Those public health sector employees not involved in governance

D.4 How many participants will be selected?

A minimum of four from a minimum of three organisations

D.4.1 What is the reason for selecting this number?

Representation from each governance group i.e. Clinical and corporate

D.4.2 Provide a statistical justification if appropriate.

N/A

D.4.3 Is there a control group? If yes, describe and state how many are in the control group. **(delete as appropriate)**

No

D.5 Describe in detail the recruitment methods to be used.

Verbal invitation per phone, followed by information sheet and requirements of participation and request for consent, followed by completion of a consent form prior to data collection.

D.6 How will information about the project be given to participants (e.g. in writing, verbally)?

Verbal and written information about the project and its process and consent sought.

A COPY OF INFORMATION TO BE GIVEN TO PROSPECTIVE PARTICIPANTS SHOULD BE ATTACHED TO THIS APPLICATION.

D.7 Will the participants have difficulty giving informed consent on their own behalf? (Consider physical or mental condition, age, language, legal status, or other barriers.) ***(delete as appropriate)***

No

D.7.1 If participants are not competent to give fully informed consent, who will consent on their behalf?

N/A

D.7.2 Will these participants be asked to provide assent to participation? (delete as appropriate)

N/A

D.8 Will consent of participants be gained in writing? ***(delete as appropriate)***

Yes

IF YES, ATTACH A COPY OF THE CONSENT FORM WHICH WILL BE USED.

D.8.1 If No, give reasons for this

D.9 Will the participants remain anonymous to the researcher? (delete as appropriate)

No

D.9.1 If no, describe how participant privacy issues and confidentiality of information will be preserved.

Participants and their workplace remain anonymous in any reports of the research. All transcripts will have a code not the participant's name. Information will be stored as per the requirements of AUT policy.

D.10 In the final report will there be any possibility that individuals or groups could be identified? ***(delete as appropriate)***

No

D.10.1 If Yes, please explain.

D.11 Will feedback be disseminated to participants? ***(delete as appropriate)***

Yes

D.11.1 If Yes, please explain how this will occur.

Participants will be provided with a copy of the transcript of their interview for verification and correction should misinterpretation have taken place.

Participant groups will be provided with a copy of the transcript of the focus group for verification.

E. OTHER PROJECT DETAILS

E.1 Where will the project be conducted?

On site of the participants choice i.e. their place of work, office or AUT office etc.

E.2 Who will actually conduct the study?

Lee Mathias – the researcher

E.3 Who will interact with the participants?

Lee Mathias – the researcher

E.4 What are the ethical risks involved for participants in the proposed research? (Include moral, physical, psychological, etc. risks).

The publication of personal reflection, the risk of perception that their opinion or actions impede positive outcomes in governance may be construed as a risk for participants.

E.4.1 If there are risks, identify and describe how these will be mitigated?

The researcher is seeking to describe what shapes the decision making of individuals. The participants will be well prepared through written and verbal information. The participants will have the opportunity to review all material provided and change, alter or withdraw any comment, which may, in hindsight make them feel vulnerable.

If at any time any participant chooses to withdraw from the study they may do so without being disadvantaged in any way and all data collected from them would not be used.

E.5 Will there be any other physical hazards introduced to AUT staff and/or students through the duration of this project? (delete as appropriate)

No

E.5.1 If yes, provide details of management controls which will be in place to either eliminate or minimise harm from these hazards (i.e. a hazardous substance management plan).

N/A

E.6 Are the participants likely to experience any discomfort, embarrassment (physical, psychological, social) or incapacity as a result of the procedures? ***(delete as appropriate)***

It is expected that they will not experience any adverse consequences. All participants are professionals who will have consented to sharing their views and opinions. However, if any discomfort or any concern arises during the reflective process of this research, a note taker/transcriber will attend the focus groups to ensure that interactions not observed by the researcher are recorded. If any participant is considered at risk this can be managed through ceasing the focus group and debriefing either alone or with all parties. The researcher will offer and provide access to AUT Health Counselling Services (see below).

E.6.1 If Yes, have you approached AUT Health and Counseling to discuss suitable arrangements for provision of services to deal with adverse physical or psychological consequences (refer section 2.3 of the AUTEC Guidelines)? (delete as appropriate)

The Health and Counselling service has agreed to offer three free sessions to participants in AUT Ethics committee approved studies, which are being carried out under the supervision of AUT staff. The contact person is, Jan Wilson, phone 09 3079999 ext 7808, or e-mail jan.wilson@aut.ac.nz If a participant wants to use the AUT service they need to ring and make it known that they are a participant in an AUT research study. The service will work to support them, and/or to refer them on to other community agencies.

E.6.2 If No, explain the arrangements which have been made to have qualified personnel available to deal with unexpected adverse physical or psychological consequences?

E.7 Is deception of participants involved at any stage of the research? (Refer Section 2.4 of the AUTEC Guidelines). ***(delete as appropriate)***

No

E.7.1 If Yes, provide details and rationale.

N/A

E.8 How much time will participants have to give to the project?

One hour on two occasions plus time to verify transcripts

E.9 Will any information on the participants will be obtained from third parties?

No

E.10 Will any identifiable information on the participants be given to third parties? ***(delete as appropriate)***

No

E.10.1 If Yes, provide details.

N/A

E.11 Provide details of any payment, gift or koha and, where applicable, level of payment to be made to participants. (Refer Section 2.1 of the AUTEC Guidelines and Appendix A on Payment and Koha).

Small gift in respect of time given, no payment

F. DATA & CONSENT FORMS

F.1 Who will have access to the data?

Researcher and supervisors only

F.2 Are there plans for future use of the data beyond those already described?

THE APPLICANT'S ATTENTION IS DRAWN TO THE REQUIREMENTS OF THE PRIVACY ACT 1993

No

F.3 Provide the location and duration of final storage of data.

AUTEC REQUIRES THAT THE DATA BE STORED SECURELY ON AUT PREMISES FOR A MINIMUM OF SIX YEARS IN A LOCATION SEPARATE FROM THE CONSENT FORMS

Faculty of Health for six years

F.4 Will the data be destroyed? (delete as appropriate)

No

F.4.1 If Yes, how?

After 6 years all documentation will be destroyed through a confidential document destruction system. All tapes will be erased.

F.5 Who will have access to the Consent Forms?

Researcher and supervisors

F.6 Provide the location and duration of final storage of Consent Forms.

AUTEC REQUIRES THAT CONSENT FORMS BE STORED SECURELY ON AUT PREMISES FOR A MINIMUM OF SIX YEARS IN A LOCATION SEPARATE FROM THE DATA.

Faculty of Health – Post Graduate Office

F.7 Will the Consent Forms be destroyed? (delete as appropriate)

No

F.7.1 If Yes, how?

After 6 years documentation will be destroyed through confidential document destruction system.

G. MATERIAL RESOURCES

G.1 Has application for funds to support this project been (or will be) made to a source external to AUT? (delete as appropriate)

No

G.1.1 If Yes, state the name of the organisation(s).

N/A

G.2 Has the application been (or will it be) submitted to an AUT Faculty Research Grants Committee or other AUT funding entity? (delete as appropriate)

No

G.2.1 If yes, provide details.

N/A

G.3 Is funding already available, or is it awaiting decision? (Give details)

N/A

G.4 Explain the investigator's or co-investigator's financial interest, if any, in the outcome of the project.

NIL

H. OTHER INFORMATION

H.1 Have you ever made any other related applications? ***(delete as appropriate)***

No

H.1.1 If yes, give AUTEC application / approval number(s)

N/A

I. Checklist

Incomplete applications will not be considered by AUTEC.

A. General Information Completed ☑

Signatures/Declaration Completed ☑

B. Project General Information Completed ☑

C. Project Details Completed ☑

D. Participants Completed ☑

E. Other Project Details Completed ☑

F. Data & Consent Forms Completed ☑

G. Material Resources Completed ☑

H. Other Information Completed ☑

Spelling and Grammar Check ☑

Attached Documents (if applicable)

Participant Information Sheet(s) ☑

Consent Form(s) ☑

Questionnaire(s) ☑

Advertisement(s) ☐

Hazardous Substance Management Plan ☐

Other Documentation ☑

Send one (1) copy (single sided, clipped not stapled) of the application form with all attachments to Madeline Banda, Executive Secretary, AUTEC.

References:

Bourdieu, P. (1977) Outline of a Theory of Practice. Cambridge, The Press Syndicate of the University of Cambridge

Bourdieu, P. & Wacquant (1992b) An Invitation to Reflexive Sociology. Oxford, Polity Press

Grbich, C. (1999) Qualitative Research in Health: An Introduction. London, Sage Publications

Harrison, S.& Lim, J.N.W. (2003) The Frontier of Control: Doctors and managers in the NHS 1966 to 1997. Clinical Governance 8 (1): 13

Health Reforms 2001 Research Team (2003) Interim Report on the Health Reforms 2001 Research Project. Wellington, Victoria, University of Wellington

Appendix 4 Ethics Approval

MEMORANDUM

Student Services Group - Academic Services

To: **Marion Jones**

From: Madeline Banda

Date: **30 June 2004**

Subject: **04/110 The shaping of decision-making within governance in public healthcare service**

Dear Marion

Thank you for providing amendment and clarification of your ethics application as requested by AUTEC.

Your application was approved for a period of two years until 30 June 2006.

You are required to submit the following to AUTEC:

- **A brief annual progress report indicating compliance with the ethical approval given.**
- **A brief statement on the status of the project at the end of the period of approval or on completion of the project, whichever comes sooner.**
- **A request for renewal of approval if the project has not been completed by the end of the period of approval.**

Please note that the Committee grants ethical approval only. If management approval from an institution/organisation is required, it is your responsibility to obtain this.

The Committee wishes you well with your research.

Please include the application number and study title in <u>all</u> correspondence and telephone queries.

Yours sincerely

Madeline Banda

Executive Secretary

AUTEC

CC: 0297920 Lee Mathias

Appendix 5 Interview Guide

Interview Guide 01.07.04

The shaping of decision making in healthcare governance

Introduction of participant – background, professional, experience relevant to governance position, this organisation

How do you make decisions on governance issues in your role ? Why do you work this way? What influence does this have on the team, organisation etc. How has this occurred? How do you think in terms of collective responsibility?

Tell me what you understand about the term governance. What does it mean to you? Why do you think that? (Fiduciary duty, probity, solvency, policies, clinical resource management)

Where do you see yourself in the governance role?……tell me more

Do you distinguish between corporate and clinical governance that is, the way decisions are made and how that process happens? How did you get to those definitions? Why?

Where do you think that governance occurs?

What personal/professional attributes do you think influences your decision-making?

Why do you think that? Are there any others?

On what do you base most / many decisions? What influences you? Why?

Do you feel confined in any way (in decision making)? Do you think that the governance process conflicts with the way you think and do/or do things in any way? Are you familiar with …OSH, Financial reporting , Public Finance Act etc

Do you experience any conflicts with the process in decision making? How do you respond to that?

How do you think others see you in a specific role in governance? On what do you base that? How do you see yourself contributing? Do you have specific skills? Do you think that the way others see you influences decisions? How do others see you?

How does governance work in this organisation? Is this your experience? Whose responsibility is the role of governance? How did you get to that conclusion? Is there anything that you would like to see different?

Other follow up questions could include:

What does decision making mean in the context of your practice?

What does governance mean in the context of your practice?

How do you prepare for governance decisions? Do you use a process, if yes what is it? What considerations do you give to an issue …how are you influenced…prior to formalising a position.

Having made that decision how do you argue that position; What would influence you to change?

Exploring questions could include:

Can you explain further?

What does that mean to you? Why?

How do you feel about this?

What influences that?

Light italics indicate examples of my further questioning

Focus Group Guide

This guide will be developed following the initial personal interviews and will be submitted for Ethics Committee approval at that time.

Appendix 6 Confidentiality Agreement

Interviewer/ Transcriber/Project

Manager/Consultant/Translator

Confidentiality Agreement

Project Title: The shaping of decision making in public healthcare service governance.

Research Team: Lee Mathias

I _____ (Full name) agree to carry out my part in the research being conducted by the above research team in a confidential manner. I will not discuss identifiable information about the participants with anyone.

I _____ (Full name) agree to maintain the confidentiality of any material with which I come in contact as interviewer or consultant.

Signature: _____

Date: _____

Appendix 7 A comparison of policies and structure between two recent periods in the New Zealand healthcare services

Table 1:

1996-1999 National: NZ First Coalition	**Labour led Alliances 2000-2007**	**Comparison**
Policy to modify changes prior to 1996- coalition agreement; commercial, collaboration and break even status	Government ideologies remove health from the market, need first, public providers to be foremost in any policy	Economic rationality v. Service provision based on need first
Data and information based policy documents "Your Health and the Public Health" "The Social, Cultural and Economic Determinants of Health in NZ"	A series of health sector strategies – e.g. Public Health, Primary Health – 28 separate documents, services detailed to topic e.g. smoking cessation; similar to Area Health Board 10 point Charter	Broad based principles from the centre v. Centralised prescriptive direction
Use of the National Health Committee	National Health Committee role reduced	Centralised policy to rationing v. devolvement of rationing function to districts
Policy – Towards Health, A series of cross sector projects commenced	Cross sector projects continued. No real change in the goals of healthcare services	Similar goals for healthcare in New Zealand

Purchaser (HFA) provider (HHS) split maintained; market model facilitated use of private sector providers. Population based funding formula (PBFF) work commenced	Purchaser and provider role blurred into each DHB based on decentralization of decision-making policy, PBFF	Single v. multiple public sector purchasers.
National prices	District specific prices for most contracts	Standard v. inconsistent prices
National contracts	District specific contracts	Standard v. various contracts
Consistency in service specifications from HFA	Service specifications varied per DHB inconsistent especially for national organisations	Consistent access v. inconsistent access across the country
Funding per contract/ service – cross subsidization reduced Appropriation per region or service; allowed for well defined ring fencing of vulnerable services	Bulk funding of DHBs- Population Based Funding formula by July 2003 Cross subsidization of some services (WDHB, Mental health)	Disciplined financial model v. some cross subsidization within bulk funding
Reduction in transfer costs – one HFA	Increase in transfer costs x 22 DHBs	Single v. multiple funder costs

Significant investment in Information technology enabled explicit relationship between funders, purchasers and providers (Ryall, 2007)	Deconstruction of national information systems; little relationship between Ministry and providers. Policy of decentralization of decision-making	Standardisation of IT systems v. district choice to meet local need
Collaboration, contestability met Commerce Act requirements for anti competitive activity	Collaboration but public provider to be first choice all "things being equal"	Best provider choice v. public provider first
Consultation embedded at all levels, HFA, H&HS and legislated	Consultation has (unpublished) threshold. Perceived lack of consultation with public and stakeholders. Statutory committees	General public and stakeholder v. limited membership of statutory committees
Economic reality of rationing- National Health Committee, national Guidelines projects	Rationing decisions decentralized to each DHB; inconsistencies throughout the country	Centralised underpinning rationing principles v. Decision-making for local need
H&HS as Crown companies subject to all reporting disciplines and compliance of Companies Act 1993	Public Health & Disabilities Act (2000) and Crown Entities Act (2004) do not require personal accountability	

Growth based on recognised standards and business principles and practice	Growth based on published Strategies and on central decision-making	Growth influenced by the market v. growth managed from the centre
H&HS accountable for own decisions within policy. Company autonomy	Minister maintains right of veto Crown agent class	Company autonomy v. Crown agent
Primary duty to company and single accountability to Minister as shareholder	Legislated accountability to Minister but elected board members have triple agency, electorate, organisation and Minister	Clear accountabilities v. multiple perceived accountabilities
Personal director accountability as per Companies Act (1993). Concept embraced as traditional company director role understood by many; appointments by Minister as shareholder following independent nomination via CCMAU	No personal financial accountability; subtleties of board member role not grasped by some (Ashton 2005) in relation to conflicts of interest	Defined rules v. rules not as perceived by electorate
External financing by Hospitals & Health Services	Central financing and therefore control Crown funding agency, no	Market driven growth v. central

(H&HS) carried risk away from central government	private (public) sector borrowing; growth restriction	control of growth
Health Funding Authority Crown entity separate from Policy and Regulation function of Ministry of Health	Ministry has mixed function, both funding and policy/regulation functions	Discipline of single function v. compromises of mixed function
H&HS s created own organisation structure to meet local needs of the H&HS	DHBs have prescribed legislated structure including Community and Primary Care and Hospital committees s. 34,35,36 ("New Zealand Public Health and Disability Act," 2000). Legislated to prevent hospital requirements dominating resources	
Hospital function as provider separated from funder role	Hospital function, as provider embedded in structure	Competitive provider market v. public provider first choice
H&HS required to be consistent with umbrella agreements	DHB requirement to be consistent with other government requirements and to effect government policy part 1, s.7("Crown Entities Act," 2004)	Market and local need driven v. central policy driven

The table of comparisons is drawn from material from a number of sources including Ashton (2000), Boston, Dalziel & St John (2003), Barnett *et al*..(2000), Cumming (1999),

Cumming *et al*.(2005), Davis & Ashton (2000), Feek (1996), Gauld (2002b), Perkins *et al.* (2002), Perkins & Salmon (1996), political party policy - New Zealand Labour Party (1999), Shipley (1995);Upton (1991), government policy (Ministry of Health, Various years) and legislation ("Companies Act," 1993; Crown Entities Act," 2004; Health and Disabilities Commissioner Act," 1996; Health and Disability Services Act," 1993; Health Practitioners' Competency Assurance Act," 2003) ministry directives (Ministry of Health, 2007b), Hospital and Health Services and DHB process, personal experience and observation.