CORPORATE GOVERNANCE IN THE VICTORIAN PUBLIC HEALTH SECTOR

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ABSTRACT

This thesis sets out to investigate the meaning, understanding and application of corporate governance in a public sector health service provider in Victoria, Australia. The methodological and analytical approach is based on an adaptation of the Glaser and Strauss' grounded theory, using ethnographic and survey techniques to collect and describe data so as to capture a broad interpretation of how governance as a process is interpreted, understood and practiced in this organisation.

Most studies of governance focus on economic compliance and performance, and questions concerning less obvious human elements of governance involving decision-making are left largely unaddressed and unresolved. In this thesis, these less tangible elements of governance are explored. The perspective presented here is that corporate governance is a socio-cultural phenomenon that requires not only an examination of the governance structures and processes in place, but also the direct observations of social and cultural elements including individual and organisational decision-making.

There is a dearth of corporate governance research in the public sector, which has in the past decade adopted a system of governance more aligned to a private sector model. This thesis starts to address this lack. It combines a study of the Board and its accountabilities in the face of rapid change (analogous to the private sector model) with evidence from stakeholders to assess the impact of the governance in the public sector.

From the analysis of the data collected and from the researcher's observations, the health provider studied here can be described as having an effective Board. It appears to have integrated decision-making, with the Board strategically setting the direction of the service and supporting the actions of management to meet the key performance targets and measures as prescribed by the Department of Human Services (DHS).

This research explores how governance as a process is interpreted, understood and practiced in the context of a public sector organisation. It offers a unique insight into the complex concept of corporate governance and offers a constructionist conceptual paradigm for further governance inquiry.

DECLARATION

"I Maree Fitzparick, declare that the PhD thesis entitled *Corporate Governance in the Victorian Public Health Sector* is no more than 100,000 words in length, exclusive of tables, figures, appendices, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work".

Signature Date

ACKNOWLEDGEMENTS

This thesis is dedicated in memory of my parents *Margaret Elizabeth* and *Louis Fitzpatrick.*

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To Leon, my family and friends for their belief and support.

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CHAPTER 1 INTRODUCING THE STUDY

1.1 INTRODUCTION

This thesis sets out to investigate the meaning, understanding and application of corporate governance in a public sector agency in Australia - more specifically a Victorian metropolitan health service provider. The research explores how governance as a process is interpreted, understood and practiced in this organisation. The methodological approach is based on an adaptation of the Glaser and Strauss' (1967) grounded theory, using predominantly ethnographic techniques of prolonged engagement, systematic observations and interviews to collect and describe the data. The study incorporates a survey and several questionnaires to capture a broader interpretation of governance in this organisation.

This study is based on an assumption that in practice, the focus of governance is on economic compliance and performance and that given this focus, there are a range of largely unresolved and unaddressed questions to be explored concerning what may be considered the human elements of governance involving decision-making. This aligns with the view that:

> …the fundamental problems in corporate governance… stem not from power imbalances but from failures in the corporate decision-making process (Pound, 1995:85).

The hypothesis presented in this thesis is that corporate governance is a socio-cultural phenomenon that requires not only an examination of the governance structures and processes in place, but also the inclusion of direct observations of individual and organisational decision-making.

1.2 BACKGROUND

An overview of the literature indicates that research on corporate governance is predominantly in the private sector and on organisational economic performance. There is a dearth of corporate governance research in the public sector, which has in the past decade adopted a system of governance more aligned to a private sector model. More detailed engagement, sustained observation and interaction with the key stakeholders such as staff and those citizens in receipt of the essential services provided by public organisations may provide a greater insight into the impact of the changes in governance processes in this sector.

The complexity of governance and the identification of stakeholders in the public sector are acknowledged by the *Chartered Professional Accountants of Australia*

> …the public sector has responsibilities and accountabilities to numerous and more diverse stakeholders and greater demand for openness and transparency (CPA, 2000:5).

The intensity of interest and concern about corporate governance has been fuelled by the increasing incidence of global, national and local corporate collapse. The

emphasis of the debate on why this is so seems to have moved from a business issue or its economic ramifications, to the broader social implications of governance inadequacies or failures. Answers and solutions regarding accountability and responsibility by key decision-makers are more frequent, as the lives of more individuals are touched by corporate impropriety on a daily basis (McGregor 2000). Equally, the place and rights of stakeholders in governance processes has become prominent.

Corporate governance failure has far reaching consequences and often the focus is on the economic costs when governance goes wrong. It seems that the reason for this narrow focus is due to the contention that the dominant concern of business is for the generation of profits to shareholders (Friedman, 1962). The separation of ownership and management performance in large organisations has been discussed for over seventy years (Berle and Means, 1932). This has driven the contemporary research agenda and has accounted for the dominance of economic models as the theoretical frameworks for measuring governance performance. A discussion on the range of theoretical frameworks including economic models is presented in Chapter 2.

Shareholder profit returns are the pivotal measurement or evaluation of governance and leadership performance in private enterprise. That is, when profit returns are high it is assumed by shareholders that good governance reigns and there is little need for scrutiny. When shareholders fail to receive profit returns from their investments, accountability is demanded. However, in the public sector there are no shareholders or profits to be dispersed, rather programs and services to be delivered. The governance success of a public entity is measured in terms of its ability to 'cost-

effectively implement programs in accordance with government legislation and policies' (*Australian National Audit Office* (ANAO), 2000:2). The Australian public health sector is further complicated in terms of accountability because of the shared funding from both the federal and state governments (Capp, 2001).

There are clear distinctions between the governance operations and ownership in the private and public sectors. Hodges, Wright and Keasey (1996:7) claimed it was the 'diversity of objectives and management structures' that distinguished public from private sector governance. Although there are differences in the corporate governance frameworks in these two sectors, the fundamental principles of a governing body of directors guiding the organisation can be considered similar (Armstrong and Sweeney, 2001; Canada, 1999). The key similarity is that of accountability by the governing body of any organisation. The Board is given fiduciary power to make decisions on behalf of those who may have a direct or indirect stake in the organisation. Fiduciary power is given on the basis of trust in each director's capacity to steer and guide the organisation for which they serve.

The push for efficiency, productivity and cost-effectiveness in both private and public organisations, can be attributed to the impact of the 'profound', 'rapid' and 'dramatic' changes that have occurred in Australian workplaces over the past two decades, with the public sector leading its private counterpart in most areas of organisational change (*Australian Centre for Industrial Relations Research and Training* (ACIRRT), 1999).

This change and organisational restructure has also:

> …produced a fundamental and continuing debate over corporate governance… some critics are calling for a fundamental change in the governance process (Donaldson, 1994: 10).

This thesis acknowledges the rapid workplace change over the past two decades and the impact of this change on management and governance practices to meet the bottom line. Driving the majority of organisational change in the Australian public sector has been government reform. Reform 'has been a dominant theme in government and business in OECD (*Organisation for Economic Cooperation and Development*) countries during the last 20 years' (Ahn, Halligan and Wilks, 2002:1). Such reform has seen a change in organisational structures that are based on 'more flexibility, less hierarchy and greater devolution of authority' (ANAO, 2000:3). The major focus of reform in Victoria has been the creation of a more efficient, accountable and transparent public sector (CPA Australia, 2000). This has seen a shift in orientation and a drive for public organisations to become more entrepreneurial and attract financial support from private sources with an ultimate aim of less reliance on government funding.

The industrial employment make-up of many public sector agencies can be described as more complex than most privately run organisations, with its diversity of employment types, modes and relationships. The public sector workforce comprises of a mix of full-time tenured positions, part-time and casual staff, and often contractors and consultants. This is especially evident in the health sector, which has

numerous levels and categories of both medical and non-medical staff, with an amalgamation of employment arrangements in place. This mixed workforce represents ‘the new work order’ as labelled by Lankshear (1994:105). It is a workforce based on less middle management and the expectation of a more adaptable, flexible and autonomous workforce.

Despite the structural differences between the two sectors, the core and central element of corporate governance is based on human decision-making by a collective group of individuals referred to as a Board and that it is this human element that may render 'governance issues around the world… more similar than different,' (Demb and Neubauer, 1992: 9). The governance make-up of any organisation is based on collective decision-making. This research looks at the collective-decision making processes and structures in a Victorian public sector health Board.

The thesis considers that, in order to understand governance as a practice, it is necessary to examine all of the elements of governance. By investigating the governance processes in any organisation, we are better able to understand the complexity of governing. This in turn will assist us in challenging existing models or methods that may no longer be appropriate in order to improve our governance systems so that organisational failure may be reduced.

1.3 DEFINING GOVERNANCE

Corporate governance can be described as, ‘the system by which companies are directed and controlled’ (Cadbury, 2002:1). This same definition can be found in the

literature on public sector governance however, the terms 'organisations' or 'agencies' replaces the term 'companies'. Much has been written and debated on what corporate governance actually is or involves and why it is important (Cameron, 2003). Kooiman (1999) argues that the use of the term 'governance' in the literature is disparate in meaning and application.

The concept, and in turn corporate governance structures (the accountabilities of Boards of directors) has become a topical subject that has and continues to generate much academic and public debate (Pettigrew, 1992; Francis, 2000), and 'as a term has progressed from obscurity to widespread usage' (Graham, Amos and Plumptre, 2003:1). It has even been labelled as fashionable (Farrar, 2001; Garrat, 2003). A more detailed discussion of this debate on governance is presented in Chapter 2.

Despite having long-standing and historic origins, it would seem that our governance systems have problems and are in need of improvement. Examples of some of the many questions appearing in the growing body of literature concerning corporate governance include: Why is the incidence of corporate failure and collapse continuing? Are the economic pressures on public agencies related to governance practices? What are the skills and expertise needed to be a director? Are the voices and hence the issues of key stakeholders heard and addressed in public organisations alike? Is it important to include a range of stakeholders in corporate governance? This research explores these and emerging questions using a grounded theoretical method.

1.4 GOVERNANCE STRUCTURES

Corporate governance is a global concept with a variety of configurations across countries, cultures, industry sectors or types, such as private, public, non-government and not for profit organisations (Turnbull, 1997). Demb and Neubauer claimed that 'the essential purpose and basic mechanisms of governance are the same in every country' (1992:9). The dominant or typical governance organisational structure in Australian corporations is usually depicted and described as the organisational chart that maps out the divisions of power and the lines of accountability from the various departments or areas of the organisation. Standard organisational charts show the hierarchical division of power and have the Board placed at the top of the apex with the Chief Executive Officer on the next level.

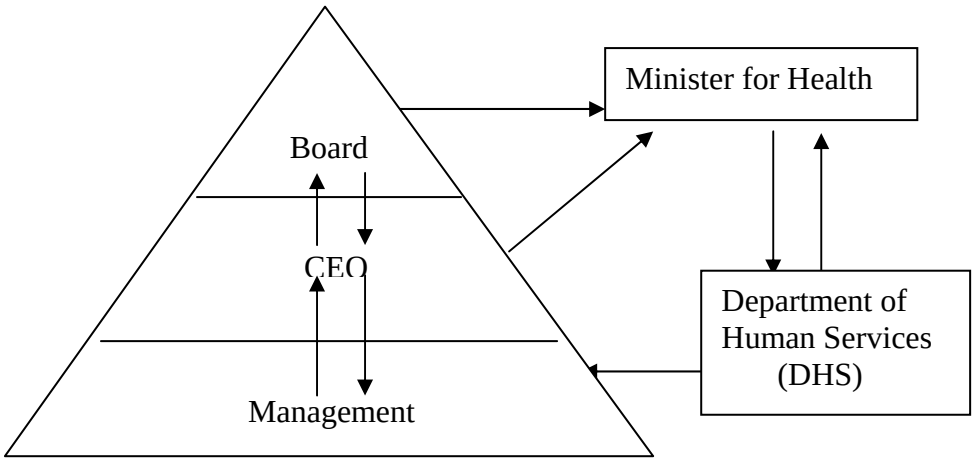


Figure 1.1 Organisational structural apex

Figure 1.1 shows the organisational structure and governance hierarchy for a public sector health agency. Decisions and reporting of management is passed up and strategic decision-making passed down from the Board.

The *Health Services Act 1988*, (refer Appendix 7) governs the delivery of both private and public health service Boards in Victoria, with the Minister for Health having ultimate power. The Governor in Council appoints both the Chair and individual directors to each of the Victorian Health Services on the recommendation of the Minister. The Governor in Council (on the recommendation of the Minister) also has the power to terminate a director from office. Appointments of directors and the Chair for each health service are made on the basis of the skills and the expertise required for each Board (refer: Appendix 1: *Selection Criteria*). Each director is remunerated in exchange for his/her expertise and time. Together with the Chief Executive Officer (CEO), the governing body or Board of directors are allocated the responsibility for the strategic orientation and direction of the organisation. They are deemed accountable and ultimately responsible to the key stakeholders of their organisation. The stakeholders in this instance include staff, patients and their families and the broader community. This includes all Australian citizens, who have the right of access to medical treatment at any public hospital (The Australian Health Commission, 2001).

The governance responsibilities to these groups is stipulated in the contracts of employment and codes of conduct for staff, the *Public Hospital Patient Charter* (2002) for patients and their families, and, the local government and the statutory authorities regarding utilities and services, such as the supply of water, power and road access. The identification of stakeholders in the public sector is vast. A full discussion of the identification and definition of stakeholders can be found in Chapter 2.

The evolutionary shape of our contemporary governance systems is said to be in response to corporate failure (Iskander and Chamlou 2000). Responses include the establishment of committees to investigate and recommend better practice principles of corporate governance practice and tighter regulation and reporting mechanisms. In the private sector, since July 1996, under listing Rule 4.10.3 of the Australian Stock Exchange (ASX), listed companies are required to include detailed information concerning their corporate governance practices in their annual reports. This information includes remuneration of directors, attendance at meetings, and identification of risk management.

Public sector agencies have followed this and also report on the corporate governance of the organisation listing the profile of the Board and senior managers, with the details of attendance and composition of sub-committees published in Annual Reports. However, it would appear that such initiatives are not adequate in terms of ultimate shareholder and stakeholder protection. Whilst this provides a level of information on the activities of directors, it provides little substance of the governance processes and may, in some cases, be regarded as inadequate. Such information may be considered as window dressing or as an exercise in public relations rather than as an accurate demonstration of the accountability of directors in terms of governance reporting mechanisms.

> The corporate collapses of recent times, culminating with massive collapse such as those of *Enron* in the United States and *HIH* in Australia, have suggested to many that there are systematic problems facing the way in which corporations and corporate governance operate (Tomasic, 2002:1).

Such collapses and their predecessors of the 1980s have seen numerous calls for tighter regulation, reform and penalty for directors failing to meet their fiduciary duty. There have been multiple local, national and international inquiries of corporate governance practice and these have become published as; guidelines, codes or best practice. They are also industry specific. Major inquiries and reports include: *The Financial Aspects of Corporate Governance (Cadbury Code)*, U.K. (1992), *Committee on Corporate Governance (Hampel Report)*, U.K. (1998), *Committee on Corporate Governance (Combined Code)*, U.K. (1998), *Corporate Governance Forum Principles*, Japan (1998), *Corporate Governance – Core Principles and Guidelines* (1998), *Organisation for Economic Co-Operation and Development (OECD) Principles of Corporate Governance* (1999) and *Standards Australia International Companion Guides to the Standards for Corporate Governance - HB 400-2004 and HB401-2004*(2004).

This is not an extensive list of all of the guidelines, codes and reports that can be used to identify the governance strengths and weaknesses in organisations. They provide the link between regulation and compliance with the ethical ideals of how organisations should be governed. They are not mandatory and are best described as descriptive rather than prescriptive or 'aspirational' (Harrison, 2001) models of governance.

Pound (1995) acknowledged that contemporary debate on corporate governance has centered on power. However, he argued that rather than the misuse of power, governance failures were the result of poor decision-making processes by Boards and managers. Cadbury (2002) supported the notion that power and accountability are the

fundamental governance issues in terms of the identification of where and how power is used and the accountability relative to this power.

Tricker posited that governance is about power and responsibility:

> Corporate governance is about the exercise of power over corporate entities…but how is power over the enterprise exercised and legitimised? To whom is a company accountable and, ultimately responsible (2000:*xiii-xiv*)?

Rather than focus on the 'exercise of power', in line with Pound's argument this research identifies the key people and processes involved in the corporate governance processes in a public sector entity and demonstrates how the power is exercised and legitimised by an actual account of the daily governance practices.

1.5 RESEARCH RATIONALE AND OVERVIEW OF METHODOLOGY

The theoretical rationale for this study is in response to claims that corporate governance is lacking in any empirical, methodological and theoretical coherence (Pettigrew, 1992: Tricker, 2000) and that the problem is that the governing role is "one of the least studied in the entire spectrum of argued industrial activities" (Juran and Louden 1966:7). This research examines the role of governing in the industrial context of a large public acute health provider by providing insights about governance from directors, managers and staff. The researcher acknowledges that the design of the study presents a range of challenges, but it is the nature of these

challenges that demonstrate that the study meets the criteria of offering a unique contribution to knowledge.

> Because research on Boards and directors is still in its infancy, there are few theoretical, empirical, or methodological guideposts to assist the optimistic yet wary researcher through the prescriptive minefield (Pettigrew, 1992:169).

The study was also in response to scrutiny of governance processes and practices in all organisations generated by recent major corporate failures, such as, *Enron, HIH Insurance* and *One Tel*. The focus of this research is on the governance practices in the public health sector which has limited resources and has been put under increased pressures during an intense period of reform (Ahn, Halligan & Wilks, 2002). Given the rapidly changed multiple economies and work practices that have impacted on both private and public sector organisations, demands on the public sector for improved efficiency and effectiveness have intensified and created the need to examine all operations within organisations, especially governance. As published by the *Australian National Audit Office* (ANAO):

> In an environment which will become increasingly competitive and contestable with additional demands being placed on scarce resources, Boards will need to examine continually ways to innovate, adapt and strengthen those structures and processes within their organisations which support their leadership and decision-making and ensure sound and effective governance (2000:5).

This empirical research is responsive to the call for a greater understanding of the diverse pressures placed on members of a corporate Board. Rather than a measurement of performance, the research, in recognition of governance's complexity and diversity examines the critical components of governance and the interplay of the many variables that contribute to strategic decision-making processes. It does this by direct observation of how the key figures of governance in one agency perceive and execute their roles and responsibilities.

The limited number of observational and ethnographic studies of Boards include: Brannen (1987), Winkler, (1987) Samra-Fredericks (2000), Stiles and Taylor (2002). Ferlie, Ashburner and Fitzgerald (1995) included observation and attendance at several Board meetings as part of their study of corporate governance in the United Kingdom's *National Health Scheme* (NHS). This thesis incorporates a range of techniques including detailed and prolonged observations of *HealthCo's* governance processes, personnel and procedures. It responds to the need for a closer examination of corporate governance principles and accountability and the development of models of good corporate governance (Tomasic and Bottomley 1993; ANAO, 2000) and the need for a model of corporate governance focussing on decision-making rather than monitoring managers (Pound, 1995).

Hilmer (1998:3) identified three key questions concerning corporate governance:

- What is the principal contemporary concern about the roles of the Board, directors, management and auditors?
- What are the key functions of a Board that require greater emphasis if this concern is to be addressed?

- To carry out these functions, what should be the responsibilities of directors and other parties involved in corporate governance and what other changes are needed in Board composition and processes?

Rather than shape the study, these questions formed a general basis of inquiry to initiate the research.

There appears to be a dearth of research into the procedural and ethical underpinnings of day-to-day corporate governance. Equally, there is no universal or 'one size fits all' model for good corporate governance (OECD 1999). There is also a pronounced lack of information on corporate governance available to public sector organisations. It is in response to this gap in the knowledge of the practical workings of governance in a public entity that this research tackles governance from both practical and theoretical orientations. The researcher, as an ethnographer, describes the legislative structures and the professional and social characteristics of a Board, monitors its development and progress and finally analyses the impact of the inquiry internally (within the organisation) and externally (how the organisation is perceived by the broader community or stakeholders).

The thesis argues that there is no singular conceptual framework that can be used to test assumptions that the degree of interest and concerns raised about governance are being actively undertaken by organisations to construct good models of corporate governance. The researcher explores the meaning and function of governance in an actual organisation. It is not a study undertaken at arm's length, rather a 'lived experience' (Denzin, 1989) of governance processes and practice.

1.6 RESEARCH SETTING/CONTEXT

The research setting for the study is primarily in a large acute metropolitan health service (comprising of several hospitals or campuses in one region), which are part of Victoria's public health system. Capp defined this system as:

> …in its simplest form, includes all those services funded by Commonwealth and State Governments. Services regarded as public sector services include public hospital and emergency care, community health services, dental services, aged care, home and community care, district nursing, mental health, immunisation, maternal and child health and other public health services (2001:7).

As part of the ethical agreement, a pseudonym *HealthCo* is used. The names of participants and the actual health service are not named for the purposes of confidentiality and anonymity. Like other Victorian public sector counterparts, *HealthCo* has recently undergone a government initiated restructure. This has impacted on all areas of the organisation, and the roles of Board members have become more onerous with a need for tighter scrutiny of resource allocations concerning both medical and business imperatives. The interplay of these factors has created some dilemmas that must be addressed at Board level for the service delivery to be both efficient and harmonious.

This research recognises that a 'collective' public health service comprising of more than one hospital faces an array of complex governance issues. Not only must the governing body ensure that the bottom line is met, they must also make diverse and

difficult ethical decisions regarding the allocation of scarce resources and ultimately control the scope of clinical and medical procedures. Organisational decision making can therefore be described as critical and in some cases, the difference between life and death.

The current impetus for critical debate and scientific exploration of corporate governance is not only being driven by economic imperatives, but rather, fuelled by public demands for tighter enforcement of social and cultural business fiduciary accountability and responsibility. As stated earlier, the issue of poor corporate governance should not be measured in terms of economic loss, but rather in terms of the less obvious social and personal impacts common to all members of society regardless of wealth, creed or status. For example, does the current corporate governance framework adopted in the public health sector ensure equity in the access and delivery of essential services? As stated by Carver:

> Hospitals literally hold the power of life and death over most of us at some point in our lives. The Boards that govern these complex organisations… face staggering fiscal, political, and liability issues (2002:293).

In acknowledging that *HealthCo* has a definable purpose to provide acute healthcare and treatment, this thesis explores how those involved in governance decision-making interpret their roles, responsibilities and accountability.

1.7 DATA SOURCES AND OUTLINE OF METHODS USED

This thesis uses a combination of original empirical research to explore and investigate the meaning and application of corporate governance in a large public sector health agency. The research uses a grounded theoretical orientation based on the emerging themes found in the data over the course of the study. Each of the data sources, including observations, interviews, questionnaires and organisational artefacts were categorised and analysed based on the principles of theory building (Glaser and Strauss, 1967).

Literature on corporate governance was also used as a data source and unlike traditional research methods; the majority was consulted at the end of the data collection rather than before. This approach is recommended by the originators of grounded theory to allow for fresh and original 'discovery' within an area of concern or interest. However, it was necessary for the researcher to provide a brief overview of the areas of the literature she intended to consult prior to the commencement of the study to satisfy the candidature requirements. There were also specific instances when the researcher was asked to provide a background on particular aspects of governance in relation to emerging areas. For example, to provide evidence of a possible link between governance and staff satisfaction or to answer a director's question on the history of governance and to do so, the researcher needed to have some knowledge of the literature.

1.7.1 Observation

The prolonged observation of the Board and the organisation itself was a primary data source. The ethnographic fieldwork included observation of Board meetings, sub-committee meetings, attendance at 'retreats' and strategic planning days, and senior management meetings, over an eighteen-month period. It also included observation and participation in organisational activities with the researcher based on site for two days per week (June 2001- December 2002). This activity was concurrent in that the researcher predominantly observed a range of organisational activities during standard hours of operation eight-thirty am to five-thirty pm.

Observations of Board and committee meetings were usually conducted after standard working hours. For example, monthly Board meetings usually commenced at five pm and finished at eight pm, followed by an evening meal. The researcher also attended bimonthly sub-committee meetings of the Board. These were generally held in the evenings. Retreats and strategic planning were conducted during the day and were followed by an evening meal. These were held off site to minimise interruptions. The researcher was also invited and asked to participate in several workshops including one on clinical governance. The purpose of the workshops was to assist in the drafting of guidelines and policies.

1.7.2 External interviews

One of the initial data sources was a series of eight personal interviews. These interviews are labelled 'external interviews' and were conducted with individuals identified as being prominent in the field of corporate governance, including senior

policy makers and/or managers in a governance role and academics. All were currently in or had previously held Board appointments.

The interviews were conducted between July 2001 and May 2003 and lasted approximately forty-five minutes. All of the interviews were transcribed and returned to the interviewees prior to analysis for confirmation of accuracy. Full details of the processes and use of the material is presented in Chapter 6. A copy of the final interview schedule is presented as Appendix 2. It is referred to as a final schedule as the researcher built on each interview and allowed subsequent questions to emerge in the traditions of grounded theory.

1.7.3 General interviews

Over the course of the study, the researcher conducted a series of personal or face-to-face interviews with various participants. They included: the CEO, Chair and other stakeholders. The purpose of the interviews was to further explore emerging issues from the observations and external interviews. The researcher also conducted several telephone and or electronic interviews to accommodate those participants who were unable to meet with the researcher in person.

1.7.4 Board questionnaire and appraisals

The researcher administered three separate questionnaire instruments: a *Board Self-Appraisal Questionnaire* (Appendix 3). This questionnaire was adapted from the *Corporate Governance in Health Better Practice Guide* (1999), Board self-appraisal.

The questionnaire was given to Board members in July 2001. The questionnaire provided base line data in terms of the Board members knowledge and understanding of corporate governance and their roles as directors.

Toward the conclusion of the research and as a part of a Board Governance Workshop, directors were given two other questionnaires; a self-performance evaluation (Appendix 4) and, a Board performance evaluation questionnaire (Appendix 5). Both of these were adapted from *Building a Better Hospital Board*, (Witt, 1987). These were analysed in conjunction with the Self-Appraisal Questionnaire to see if there had been any changes in relation to knowledge, understanding and performance in their roles as directors and as a Board.

1.7.5 Staff satisfaction survey

A staff satisfaction and governance survey (Appendix 6) was administered to 3,762 staff. The survey contained 31 questions in relation to work satisfaction and knowledge of the organisational governance at a fundamental level, for example: *The practices and decisions made by the Board and management match the mission and values statements?* A total of 825 responses were returned. The survey had two purposes, the first being to provide information to senior managers and the Board regarding staff perceptions of the organisation, and their job satisfaction. The researcher also used this survey to canvass staff opinions regarding their understanding of the more visible components of governance.

1.8 OUTLINE OF THESIS

This thesis consists of ten chapters, a bibliography and appendices. Chapter 2 provides an overview of the major conceptual frameworks that have been used in corporate governance research. The argument constructed in this chapter concerns the limitations and inadequacies of analysing governance from only an agency or economic perspective and offers an interpretive approach – grounded theory (Glaser and Strauss, 1967), in response to the call for a multi-disciplinary or more holistic examination of corporate governance

Chapter 3 presents the history of the current configuration of governance in the Victorian public health sector and how this was shaped by the national health policy *Medicare* that was conceived and developed to ensure the equitable access to health care for all Australian residents (Scotton, 2000). The structural differences in governance between the private and public sectors are also discussed. The chapter concludes by introducing and defining 'clinical governance' and the significance of clinical governance within the overall governance framework at *HealthCo.*

The rationale for a grounded theoretical methodology is presented in Chapter 4 along with its origins examples of contemporary applications in organisational and management research. The key elements of naturalistic inquiry and ethnography are also outlined.

In Chapter 5, the context and setting for the study are presented. Details of the fieldwork and the key data sources are also given, along with the processes used by the researcher to demonstrate the trustworthiness and reliability of the data.

In Chapter 6 the data is reported and interpreted by the researcher. It also includes 'thick description' of the narrative based on the researcher's observations. Governance in a public sector agency is explored using a grounded theoretical approach.

An analysis of emergent theory on corporate governance practice at *HealthCo,* is presented in Chapter 7. This is based on the actual data combined with the literature in relation to the various key aspects of governance.

The conclusions, discussion and recommendations are reported in Chapter 8 along with an acknowledgement of the limitations of the study and recommendations for future research.

1.9 SUMMARY

This introductory chapter sets the foundation of the thesis and provides an overview of the background to the research, the research questions driving the study and an outline of the proposed methodology. The aims and objectives of the thesis along with a rationale for the need for empirical research on corporate governance in the public sector are discussed, in terms of the 'theoretical exploration' on the topic (Tricker, 2000). A synopsis of each of the chapters is also presented.

In the next chapter, the major theoretical constructs that have been used to examine corporate governance are presented, together with the varied definitions provided by key governance commentators. The chapter concludes with a discussion of the strengths in a multi-theoretical perspective and outlines the value of a grounded theory approach in organisational studies.

CHAPTER 2 CONCEPTUALISING CORPORATE GOVERNANCE

2.1 INTRODUCTION

This chapter provides an overview of the major theoretical frameworks that have dominated corporate governance research. A synopsis of the dominant theories found in the literature is presented. Each of the substantive theories is discussed in terms of its relevance or appropriateness as a conceptual model for the context and setting of this empirical research – namely a state legislated public sector entity. The chapter also explores the variety of definitions attached to the term *corporate governance* found throughout the literature and suggests that there are perhaps definitional discrepancies regarding the actuality of what corporate governance may mean in different contextual settings.

As argued in Chapter 1, governance is a diverse concept and, as such, the interpretation of what are deemed appropriate governance processes and applications may vary according to organisational context. This research directly examines the processes and procedures of governance and how those involved in governance at *HealthCo* perceive their roles and responsibilities. The chapter then moves from a broader discussion of governance and presents a discussion of the five dominant theoretical models that have been used in research on corporate governance. The chapter concludes with the argument for the use of a multi-theoretical perspective and presents a grounded theoretical approach to build on the existing knowledge base on governance.

2.2 GOVERNANCE: A MULTI-DISCIPLINARY CONCEPT

As has been argued in Chapter 1, the issue of corporate governance is problematic because of its multi-disciplinary nature, or as stated by Fannon:

> The term corporate governance clearly is multi-faceted and indeed the debate has raised more issues than have been resolved (2003:3).

The introductory chapter highlighted the multi-disciplinary nature and the variety of questions surrounding the 'unresolved issues' of governance. In acknowledging that governance is both diverse in meaning and disciplinary study, how then do we best examine or conceptualise it? Turnbull stated that there has been a 'diversity in corporate governance analysis and concerns' (1997:185) undertaken by academics from a range of fields. He further contended that:

> No one theory or model of society is likely to be sufficient for understanding, evaluating or designing governance structures. There are many pieces to the puzzle …An interdisciplinary holistic approach is required (1997: 200).

This study reveals both the governance structures at *HealthCo* and the processes and procedures undertaken by the directors and senior managers. The thesis contends that the processes and procedures of governance are vital components in the puzzle and that in order to enhance governance structures, it is necessary to undertake such a study.

Cornforth (2003) also argued the need for a 'multi-paradigm perspective' of governance.

This thesis supports the calls of both Turnbull (1997) and Cornforth (2003) for a holistic approach. It recognises that there is no one unitary or definitive theoretical approach to conceptualise corporate governance due to the great diversity in the perceptions and variety of governance structures and settings. For example, the governance structures may be described as the same in the public health system, however, how the success of the organisation may be due to how the governance processes and procedures are followed.

The rationale for this argument is based on the idea that every organisation can be described as unique and despite what may be deemed as prescriptive governance arrangements and requirements, such as those ordained by legislation and/or law, there may be similarities and differences, but no two circumstances the same. In addition, as with the different types of organisation, there are various governance approaches according to the organisational make-up. This includes the selection, appointment and or co-option of directors as deemed by the organisation's legal, legislative or constitutional charter. Each member of the governing body brings their own values, ethics and judgements to the organisation or agency they represent. Given this possible diversity of the human elements of governance, this thesis contends that governance is best examined using a methodological approach that allows us to view governance through the various lenses and disciplines from which a contemporary notion of governance has been shaped.

Demb and Neubauer (1992) however, offered a different perspective and argued that governance on a global level has more similarities than differences and that the key elements of governance are essentially the same. As previously stated, this thesis recognises that many governance structures may be deemed as the same, but it is the human elements of governance that may differ.

Ashburner (2003) suggested that the appropriateness of a conceptual model of governance is better analysed by an examination of the range of roles and the appropriateness for different contexts of Boards rather than the specific role of each Board. It may be argued that there may be a range of roles for each Board and that this may vary greatly between the private and public sectors. For example, the literature indicates that the primary or dominant role of the Board in the private sector is based on economics - to generate profit (Friedman, 1962). Rather than an emphasis on the 'bottom line' one of the roles of the public sector health director may be considered more social in application. For example, one of their major roles may be to develop strategies and policy for staff recruitment and staff satisfaction during such times as a global shortage of medical staff (Gough and Fitzpatrick, 2004).

Hung (1998) argued that it is the role of the Board that determines the conceptual theory. He identified six Board roles and then classified the relationship between the roles undertaken by the Boards and the theory to which each of the roles is related. He described this as a 'typological approach' to conceptualising governance. He also advocated that there is no unitary model of governance. He stated:

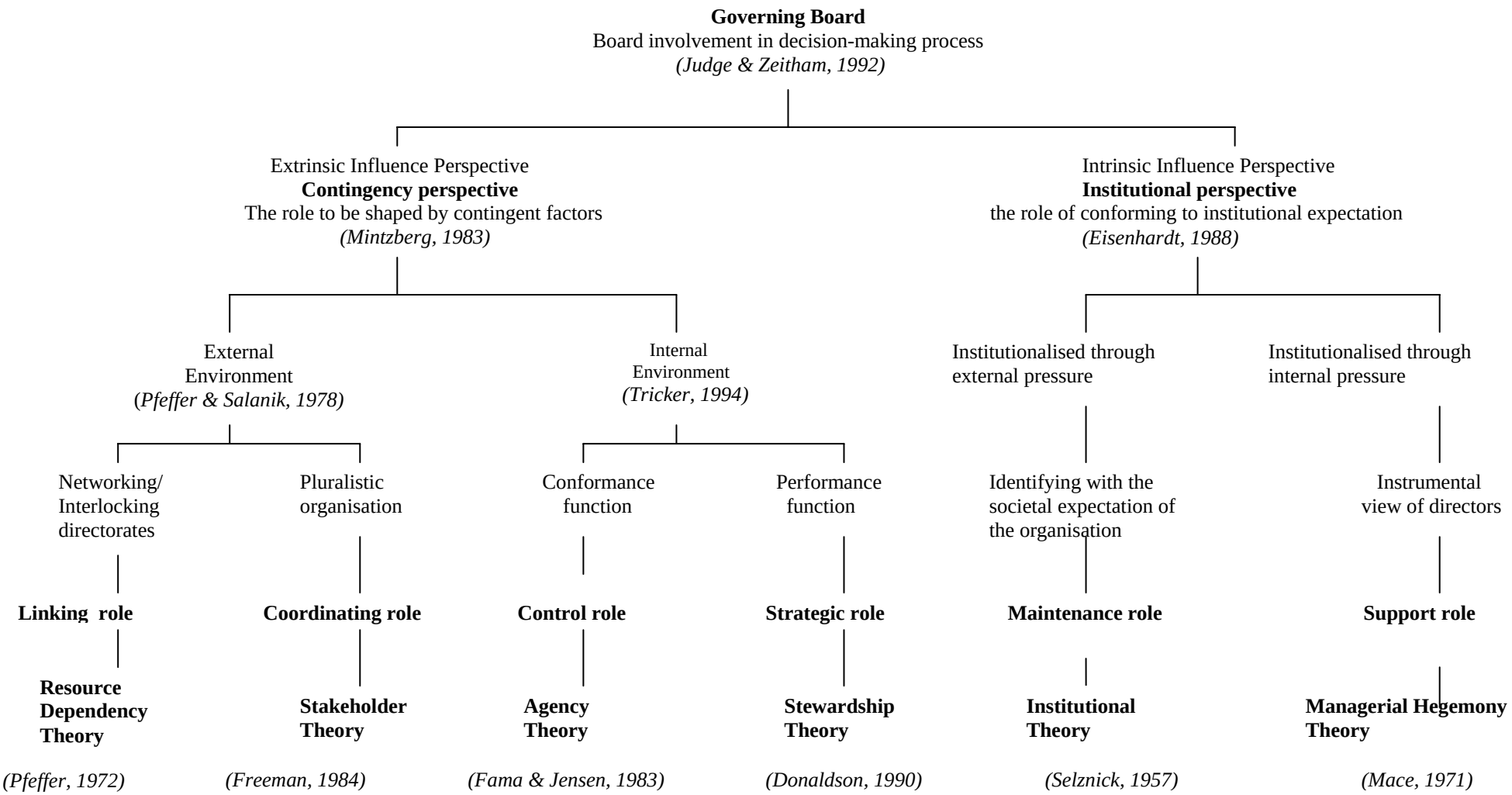
> Since Board involvement is such a complex phenomenon, it is commonly suspected that no single theoretical perspective could adequately capture the entire process (1998:102).

Hung's 'typology' is presented as Figure 2.1. In this, Hung argued that it is the role of the Board that determines the applicable theory. For example, according to Hung, a Board whose role is said to be that of co-ordination could be described as following a stakeholder

model or theory of governance. If the Board were said to have a strategic role, a stewardship theory or model could be applied. Hung's 'typology' provides a useful starting point for conceptualising the theoretical models used to analyse corporate governance. However, what happens when the role of the Board is pluralistic? Is it possible for a governing body to have more than one role and if so, what is the most appropriate theoretical framework to follow? Also, in terms of understanding a Board's role, it is necessary to look at the contextual definition attached to corporate governance. This includes, the hierarchy, devolution of power and accountability to whom the Board is most answerable.

This thesis supports the contentions' of Turnbull (1997), Hung (1998), Fannon, (2003) and Cornforth (2003) that there is need for a new and or pluralistic theory required in corporate governance research. It also argues that the existing knowledge base on corporate governance is framed from a diverse range of academic disciplines. Each of these disciplines brings a different analytical perspective. However, there is a lack of articulation, recognition or sharing of these perspectives. The strength in organisational research is in the many theories from which it is studied (Hirsch, Michaels and Friedman 1987). To this end, a discussion of the major various conceptual models of governance that have framed a small, but interdisciplinary diverse base of empirical research follows.

Figure 2.1 A typology of the theories relating to roles of governing boards



Source: adapted from Hung, H., 1988, 'A typology of the theories of the roles of governing Boards', Corporate Governance: An International Review, 6:2, pp 907.

2.2.1 Agency theory

In organisational studies, agency theory is said to be the dominant theoretical framework on governance research (Davis, Schoorman and Donaldson, 1997; Cornforth, 2003). It is considered to be both an important and controversial theory (Eisenhardt, 1989). Ross claimed:

> The relationship of agency is one of the oldest and commonest codified modes of social interaction…essentially all contractual arrangements, as between employer and employee or the state and the governed…contain important elements of agency (1973:134).

Agency theory can be described as an economic approach to governance and is based on the relationship between the shareholders or owners, described as the 'principals', and the managers of the organisation as described as ‘agents'. As such, in agency theory, corporate governance or organisational control is clearly divided from the contract between the ‘principal’ and ‘agent’ determined by financial remuneration (Eisenhardt, 1985). Jensen and Meckling (1976) advocated that managerial interests may not be aligned with the ‘principals’ but rather concerned with the maximisation of their own monetary rewards. Agency theory is based on an ‘economic’ model of man in which both the principal and agent is interested in their own financial gain. Davis, Schoorman and Donaldson (1997:27) stated that, 'According to agency theory, man is rooted in economic rationality’.

Agency theory has a narrow focus reliant on the examination of shareholder returns and management control (Allen and Gale, 2000), and presents only a partial view of the world

(Eisenhardt, 1989). Stiles and Taylor (2002:130) claimed that agency and economic theory has dominated empirical studies on corporate governance, with the emphasis of research on the 'link between Board composition and financial performance'. Ryan (1994) advocated that agency theory's economic focus is limited and devoid of a sociological perspective, particularly in relation to studies in healthcare. According to Stiles and Taylor agency theory:

> …highlights the role of the Board as a monitor of management activities in order to minimise agency costs and thereby protect shareholder interests…It is clear that reducing agency costs and maximising shareholder wealth are key roles of the Board according to the theory (2002:14).

Hence, it may appear that agency theory is limited to governance research in private sector industries with shareholders. However, the micro-economic reform of the Victorian public sector introduced by the Liberal Government revealed an agency orientation via the adoption of public organisations administered and governed by contracts. Placed within a public sector context:

> Agency theory conceives of social relationships as ones between principals on the one hand and agents on the other. The principal specifies what is required, and engages and pays or otherwise rewards an agent to produce it. Thus, a principal–agent relationship can exist between a buyer and a seller, between an employer and employee, between voters and politicians and public servants … it is assumed in each case that people maximise their self-interest and therefore that principals and agents have conflicting interests (Alford and O'Neil, 1994:15).

This raises numerous issues for those in governance roles in the public sector in relation to the 'maximisation of self-interest'. Muetzelfeldt (1994) described the notion of self-interest as 'misplaced' within a public sector context that is founded on the promotion of common or communal interest and 'the common good'.

This thesis acknowledges that the impact of neo-liberalism on Victorian public sector agencies has seen some dramatic changes and an emphasis on organisational productivity, efficiency and economic success that has created pressures and dilemmas for governing bodies. Such dilemmas may include the reduction in staff to meet the bottom line and in the case of a public health service, possible services reductions or reconfigurations. The study seeks to examine how those in governing roles are best able to meet the economic goals and the social needs of their stakeholders. The thesis argues that in both the private and public sectors, the social or human elements of governance are as important as the economic or business imperatives of the organisation and they should not be understated or ignored (McGregor, 2000; Garrat, 2003). As stated by Tricker:

> Critics of agency theory argue that the reality of governance involves interpersonal and political relationships that are just not reflected in a two-person contract (2000:*xxii*).

Given the context of the setting of this study, a large public health provider, agency theory was not considered as the most appropriate given that a public sector entity is not privately owned and accountable to shareholders, despite the push for agency principles via the creation of the 'Contract State' (Alford and O'Neil, 1994). *HealthCo* can be described as an organisational melange of both traditional and contractual arrangements and

accountable to its 'principal owners' that include the community and the government. The rationale posited by Cornforth best accounts for inappropriateness of agency theory for this study:

> One difficulty in applying an agency perspective to public and non-profit organisations is that there is much more potential ambiguity over who the principal owners are…in the case of public organisations, it is the general public, service users, taxpayers or the government itself (2003:7).

A discussion of the other major theoretical perspectives on governance is now presented.

2.2.2 Stewardship

A steward is defined as a: 'person entrusted with management of another's property…a paid manager' Sykes, (1982:1043). The notion of stewardship has historic and religious roots in Western society (Saltman and Ferroussier-Davis 2000). Davis, Schoorman and Donaldson (1997) presented stewardship as an alternative to agency theory in researching corporate governance. Rather than an alternative, Cornforth argued that stewardship theory 'starts from opposite assumptions to agency theory' (2003:8). Stewardship theory incorporates the sociological and psychological rather than purely economic approaches. Davis et al argued the strengths of this model because:

> …organisational relationships may be more complex than those analyzed through agency theory. The propositions of agency theory may not apply in all situations (1997: 43).

The key distinction between agency and stewardship theories is that of managerial motivation. The individualistic and self-interested 'model of man' who acts rationally to secure financial gain is the core of agency theory (Jensen and Meckling, 1976). Whereas, the stewardship model of man presented by Davis, Schoorman and Donaldson:

> is based on a steward whose behavior is ordered such that pro-organisational, collectivistic behaviors have a higher utility than individualistic, self-serving behaviors (1997:24).

Stewardship appears to present a more positive picture of managers than does agency theory, in that it presents a concept of a manager who is motivated by doing a good job rather than seeking economic gain. The main function of the Board in stewardship theory is to add value to management decisions, rather than a concentration on compliance. It is also distinguished from agency theory in that it argues that the role of the CEO and the Chair should be held by the same person. The combination of the Chair and CEO is the American model of governance. Donaldson and Davis (1991) argued that CEO and Chair duality is vital for shareholder success and hence better governance. The choice between an agency or stewardship approach is best summarised by Donaldson and Davis:

> Ultimately, the question might not be whether agency theory or stewardship theory is more valid. Each might be valid for some phenomena but not for others (1991: 60)…The most valid theory of corporate governance may lie in between the two extremes of stewardship and agency theory (1993: 222).

The term ‘stewardship’ is most appropriate as a description of the delegation of responsibilities and accountabilities in *HealthCo*. That is, the roles of the Board and CEO are to direct and steer the organisation. They operate as stewards or caretakers on behalf of the government. Ultimate accountability is to the Minister for Health. The organisation’s governance framework is stipulated in legislation, specifically the *Health Services Act* 1988. The positions of Chair and CEO are legislated as separate and independent, with the Chair being appointed by the Minister and the CEO employed by the Board. Given the legislative framework, the roles cannot be shared and are purposefully separate, rendering the Donaldson and Davis (1991) stewardship model of governance as inapplicable in this context.

2.2.3 Stakeholder theory

Stakeholder theory could be described as a sharp contrast to Friedman’s (1962) postulation that the primary purpose of business is shareholder profit. Freeman (1984) offered an alternative way to look at the theory of the firm with the protection of the rights and interests of stakeholders in organisational management. Rather than a solitary focus on shareholder wealth, stakeholder theory introduces the concept that there is a broader institutional and external range of actors and interests to consider in regard to the obligations and performance of any organisation. Each of these actors has a 'stake' in the organisation. It can be described as a more collaborative approach to business between the organisation and its broader constituents, including employees, government, suppliers and the community (McAlister, Ferrell and Ferrell 2003).

The link and significance of stakeholders, social responsibility and citizenship has been identified by Glazebrook (2000), Birch (2001), Sweeney et al (2001) and others. Demonstrable corporate social responsibility is considered as a vital component of good corporate governance. As a contemporary issue in the governance debate, the participatory rights of stakeholders has become acknowledged Fannon (2003), with the role of stakeholders listed in the OECD *Principles of Corporate Governance* (1999) and a call for a more inclusive model of governance (Tomasic 2002). According to Greenwood:

> Stakeholder theory is based on the notion that organisations consist of various stakeholders and that they should be managed with these stakeholders in mind (2001:32).

Clarkson (1995), Donaldson and Preston (1995), Greenwood (2001) and others agreed with the need to include a range of stakeholders in the governance of an organisation. Freeman (1984) identified two categories of stakeholders – narrow and wide. This has lead to more comprehensive definitions of stakeholders being provided (see: Watts and Holme, 1999; Estes, 1999; Davenport, 2000; Post, Preston and Sachs, 2002). What can be described as a wide or comprehensive definition of who stakeholders are was offered by Clarkson:

> *Stakeholders* are persons or groups that have, or claim, ownership, rights, or interests in a corporation and its activities, past, present, or future. Such claimed rights or interests are the result of transactions with, or actions taken by, the corporation, and may be legal or moral, individual or collective. Stakeholders with

> similar interests, claims, or rights can be classified as belonging to the same group: employees, shareholders, customers, and so on (1995:106).

Dean (2001: 93) posited that within a corporate context, stake holding as a theory requires that all of those who are engaged with the company, 'merit consideration and involvement in its decision-making - they have a stake in it'.

Despite their recognition, stakeholders fail to be awarded formal definition in the *OECD Principles* (Post, Preston and Sachs, 2002) and their identification can prove complex (Mitchell et al. 1997). This complexity is demonstrated by the definitions offered by Clarkson (1995) and Dean (2001) that appear very broad and may be difficult to identify, especially in the context of a public health system that every Australian has equal access to. In relation to the setting of this research, the following definition provided by the *Baldrige National Quality Program* 2001 in Health Care was considered to be more contextually relevant:

> The term "stakeholders" refers to all groups that are or might be affected by an organisation's actions and success. Examples of key stakeholders include patients and other customers (e.g., patents' families, insurers/third-party payors, employers, health care providers, patient advocacy groups, Departments of Health, and students), staff, partners, investors, and local/professional communities (2001:33).

This definition illustrates the broad and diverse parties that may be deemed as stakeholders in the governance debate. The representation and equity of stakeholders in public sector governance is equally complex.

Attempts to include stakeholder voices in the public health sector are evident in the *Health Services (Governance) Act 2000* (see Sections: 65A and 65B). This section stipulates the make-up of the mandatory sub-committees of the Board that include what can clearly be defined as stakeholders as they are, practitioners, staff and members of the community.

This research acknowledged the difficulty in the identification and inclusion of the diverse range of who can be deemed as stakeholders in any public system or organisation. However, this study made a genuine attempt to include a broad range of stakeholders in this Victorian public sector health agency.

The three theories presented above, agency, stewardship, and stakeholder can be described as being the major theoretical frameworks used for corporate governance research. They are by no means definitive in the study of governance, as governance has been viewed through a variety of lenses: economic, social and political. Hawley and Williams (1996) identified four models of corporate control as part of a literature review on corporate governance in America. The names of their models are: *The Simple Finance Model*, *The Stewardship Model*, *The Stakeholder Model* and *The Political Model*. These four models included the three major conceptual frameworks presented earlier. The 'Simple Finance Model' is an adaptation of Agency theory and also includes Transaction-cost economics (TCE). Transaction-cost economics was considered as similar to agency theory in the conceptualisation of Boards, with both theories seeing the primary function of the Board as one of control over management (Stiles and Taylor 2002). Both the stewardship and stakeholder models are consistent with the literature definitions.

Turnbull summarised the *political model*:

> The political model recognises that the allocation of corporate power, privileges and profits between owners, managers and other stakeholders is determined by how governments favour their various constituencies (1997: 191).

The *political model* cannot be discounted as a means of understanding the structural boundaries and influences that may impact on corporate governance in a public sector entity. Equally, a recognition is required that each political party may be more closely aligned to an agency or stewardship driven approach based on their views and expectations as to the place and input of various stakeholders. Legislation may certainly provide the mechanisms of appointment, but ultimately, Directors and Boards are chosen by the incumbent Minister of the particular party in question. However, the focus of this thesis is on governance processes and personnel rather than the influence of the different political parties.

2.2.4 Resource dependency theory

The focus of resource dependency theory is on the relationship between the environment, an organisation and other organisations (Pfeffer and Salancik 1978). As stated by Cornforth:

> Organisations depend crucially for their survival on other organisations and actors for resources (2003:8).

The main premise of resource dependency theory is that organisations must link and 'interlock' with both the external environment and other organisations as they are dependent upon them for survival. Hence, directors may sit on the Boards of other organisations for a range of purposes, including as a link between the community and the organisation, and or to enhance and protect the organisation from perceived environmental threats. The theory has both economic and sociological roots and has been concerned with the distribution of power within an organisation (Zahra and Pearce 1989). In Pfeffer 's 1973 study of the linkages between the organisation and its environment of fifty-seven hospitals in the United States, he concluded that:

> Organisations, as open social systems, are inextricably bound up with the conditions of their environments. Organisations must obtain support, both in the form of resources and in social legitimacy from their social context…It has been suggested that the Board of directors is one vehicle for coopting important segments of the environment (1973: 362).

The legitimacy of a public health service is crucial to its survival in a social context and as part of the public health charter, in non-life threatening cases, potential patients have a choice for treatment. As such, it is logical that directors foster and develop relationships with a variety of organisations within the same social context to assist in resource building. Within the Victorian public health sector, each organisation is reviewed according to the specified *Key Performance Indicators* (KPIs), most of which are based on its ability to meet the needs of the community or the social context it serves.

2.2.5 Managerial-hegemony theory

The origins of managerial-hegemony theory are linked to the work of Berle and Means' (1932) thesis of ownership and control of the firm. They observed that with the growth of modern corporations in the 1930s came a departure from the traditional model of ownership control to managerial control. That is, with organisational growth came greater numbers and dispersion of shareholders and diminished the voice or power of the individual investor. Corporate wealth remained with shareholders, whereas organisational control was in the hands of its managers. 'As a result, the power of large shareholders to control corporations was diluted' (Stiles and Taylor, 2002:18).

In managerial hegemony, the managers, and the Board hold dominance in decision-making reactive to the decisions made by management. Drucker (1974) dubbed the role of the Board in this model as a 'legal fiction', and Cornforth, 2003 described the role of the Board as a 'rubber stamp'. Within the boundaries of managerial-hegemony theory, Stiles and Taylor (2002:1) described non-executive directors as, 'poodles, pet rocks, or parsley on the fish'. In this model, the power and control of the organisation lays in the hands of its managers. The Board's function is thus symbolic to legitimise the actions of management (Cornforth, 2002:54). Mace (1971) and Lorsch and MacIver (1989) also questioned the role of Boards and supported the concept that Boards were ineffective monitors of management. Cornforth's interpretation of the both the role and make-up of the Board within the various models discussed is presented in Table 2.1.

It could be argued that on a practical level, major decision-making on a daily basis must rest with senior management, more specifically the CEO. This was observed at *HealthCo.* However, at *HealthCo* it appeared that decisions were based on the broader principles,

policies and recommendations of the Board. As such managerial-hegemony as an analytical model was not considered appropriate

Table 2.1 A comparison of theoretical perspectives on organisational governance

Theory	*Interests*	*Board members*	*Board role*	*Model*
Agency theory	Owners and managers have different interests	Owners' representatives	Compliance/conformance: safeguard owners' interests oversee management check compliance	Compliance model
Stewardship theory	Owners and managers share interests	Experts	Improve performance: add value to top decisions/strategy partner/support management	Partnership model
Democratic perspective	Members/the public contain different interests	Lay representatives	Political: represent constituents/ members reconcile conflicts make policy control executive	Democratic model
Stakeholder theory	Stakeholders have different interests	Stakeholder representatives: elected or appointed	Balancing stakeholder needs: balance stakeholder needs make policy/strategy control management	Stakeholder model
Resource dependency theory	Stakeholders and organisation have different interests	Chosen for influence with key stakeholders	Boundary spanning: secure resources maintain stakeholder relations being external perspective	Co-option model
Managerial hegemony theory	Owners and managers have different interests	Owners' representatives	Largely symbolic: ratify decisions give legitimacy managers have real power	'Rubber-stamp' model

Source: Adapted from Cornforth, C, 2003 p.12, 'The Governance of Public and Non-Profit Organisations: What do Boards Do?' Routledge, London.

2.2.6 Overview of the major theoretical debates used in governance research

As has been argued throughout this chapter, corporate governance presents both definitional and conceptual problems. It would appear that the majority of the research on corporate governance is on Board and organisational performance, and the economic models and theories have dominated in these areas. The five theoretical frameworks discussed earlier; *Agency, Stewardship, Stakeholder, Resource Dependency* and *Managerial Hegemony* have been shown to have either the possibility for application in this research and/or distinct limitations. Each of the theoretical models has been drawn from different academic disciplines. These include: economics and finance, management and sociology. Rather than rate each theoretical perspective, the hypothesis offered is that in the application of any study or research on corporate governance, a pluralistic theory is required in order to incorporate the many aspects of governance that may be under scrutiny. The researcher has adopted a grounded theoretical model to include those elements of governance not restricted to economics. This enables the features of all of the models to be seen, if indeed they are present and relevant. A detailed discussion of grounded theory is presented in Chapter 4.

Table 2.2 Five theoretical debates on governance roles

Dimension Theoretical Perspective

	Agency TCE	**Stewardship**	**Resource dependence**	**Class hegemony**	**Managerial hegemony**
Board role	Ensure the match with managers and owners	Ensure the stewardship of firm assets	Reduce environmental uncertainty, boundary spanning	Perpetuate ruling elite and class power	Board a 'legal fiction'
Theoretical origin	Economics and finance	Organization theory	Sociology	Sociology	Organization theory
Detail on Board activity	Low	Low	Low	Low	Moderate
Empirical support	Equivocal	Limited	Moderate	Moderate	Moderate
Limitations of theory	Assumptions too narrow, ignores the complexity of organisations	Largely untested	Focus on resource attainment, not resource use, interlocks not shown to influence behaviour	Partial view of Board motivation	Problems over definitions of 'control' owner networks under-estimated

Source: Adapted from Stiles and Taylor (2002), *Perspectives on Boards of directors*, p.11.

In Table 2.2, four of the theoretical perspectives of governance, discussed earlier, can be identified. The table also includes Class Hegemony theory that is derived from sociology and based on the notion of elitism – that is, Boards and hence the power of large organisations lies in the hands of the upper class.

According to Collier and Esteban (1999) a 'pragmatic' theoretical perspective of governance has been presented in the literature with the four types of research being limited to financial, stewardship, stakeholder and political models. They argue for a more participative or cybernetic model that values and encourages participation by all

organisational members. This model can be aligned to a stakeholder approach with an emphasis on trust and creativity. They claimed that:

> … governance becomes a question of choice of direction, of navigation in the face of competing and conflicting demands inside and outside the organisation. Effective governance relies on the ability of the organisation to trust freedom and to encourage and support the creativity of its members (1999:10).

Given the 'multi-disciplinary' and complex nature of corporate governance, it is not surprising to find debates within the research base. The theories used to analyse governance tend to be dominated by the function, nature and role of the organisation's governing body. For example, an agency approach is often adopted by those examining the private sector and financial accountability and performance of the directors as the key variables. It would seem that our own cultural, contextual and academic disciplinary background determines the orientation and analysis taken on governance research. It should not be limited to one theoretical perspective but include the insights from a range of disciplines. Rather than an examination of organisational performance, this research is based on the how and who of governance. As such, it requires a framework that allows a degree of flexibility for the researcher to pursue emerging issues.

This thesis argues there are a diverse range and number of stakeholders to be considered in the governance debate. The identification and inclusion or representation of all stakeholders may be difficult and at times impossible, however, attempts to include and supports a range of stakeholders voices is vital, especially in the context of this research,

with a large public sector agency responsible for the provision of vital and essential public service as well as a large employer and community institution.

The research acknowledges the notion of stewardship in this context where the role of the Board can be described as taking care and guiding a vital public commodity and as such, must demonstrate decision making on merit and equity. This research supports Turnbull's (1997) call for a new approach to researching governance and suggests that it may be time for changes in our existing governance models (Tomasic 2002). It presents a grounded theoretical construction as an alternative approach to broaden the existing knowledge on organisational governance.

The conceptional framework for the research can therefore be said to include a 'melange of different perspectives' (Pettigrew, 1992) of theories or models used to examine governance. The argument for a multi-theoretical approach is based upon a lack of consensus on a unitary theoretical perspective on corporate governance to be found in the literature. A variety of disciplinary orientations have shaped a range of perceptions on the concept of corporate governance. As proffered by Turnbull (1997:180) there is a need to intersect the many disciplines and theories that shape, ' …the conceptual, cultural, contextual and disciplinary scope of the rapidly evolving topic of corporate governance'.

Given the evolutionary nature of governance, rather than attempt to overlay a conceptual framework, this study uses a grounded theoretical approach (Glaser and Strauss, 1967). It uses a naturalistic inquiry exploring the governance operations in the context of a large Victorian public health sector organisation. It is an emergent study (Dick, 2002) and as such the research is not hypothesis testing; rather, it is inductive and theory building based

on an ethnographic framework and the 'lived experience' of corporate governance (Denzin, 1989).

2.3 FRAMING A GROUNDED THEORETICAL MODEL OF GOVERNANCE IN THE PUBLIC SECTOR

In Chapter 1, it was argued that despite key structural differences in the corporate governance frameworks of the private and public sectors, the fundamental principles of directing an organisation are the same (Armstrong and Sweeney 2001). Further, this chapter has also argued that because of the complex and diverse nature of what can be deemed the public sector (Horrigan, 2001), it is better to use a theory building framework than overlay a conceptual framework on governance.

Coghill (2003) labelled governance in the public sector as 'public governance'. Whilst acknowledging the complexity of governance relationships in the public sector; such as the overlay of governmental control via legislation and funding, the diverse array of employment professions and modes along with a demonstrable accountability to a multitude of stakeholders, it is also argued that in terms of functionality and adherence to legal and ethical principles, the nature and practical application of governance remains the same. Based on the premise that while the functions of governance in any organisation in any given sector may be considered to be fundamentally the same, the notion of accountability and ownership may have considerable differences. Coghill stated:

> Governance is shared between three clearly identifiable sectors - public, corporate and civil society…The sectors are interconnected, interdependent and interact as parts of a complex evolving system (2003:2).

The 'complex evolving system' known as corporate governance continues to be under scrutiny regardless of the sector. As argued by Horrigan, Edwards et al:

> Corporate governance is in a state of transition both public and private. There is a need to clarify language and to develop a conceptual framework for corporations in an environment that is demanding more accountability, transparency, ethical behaviour, a triple bottom line as well as increased participation as stakeholders (2003: 43).

This thesis examines both the perceptions as well as the daily realities of the governance processes in a large health care provider in the state public sector. This grounded theory (Glasser and Strauss 1967) endorses the calls of Turnbull (1997), Horrigan (2001) and others for the need to clarify the discourse on governance and develop a conceptual framework that acknowledges the diverse fields and disciplines from which the literature and research on corporate governance is drawn. The researcher was mindful that:

> Models and frameworks are helpful for clarifying theories and abstract concepts or constructs. But to be useful in practice, a model or framework must be applicable to the conditions that it is attempting to describe, analyze, or predict (Clarkson, 1995: 94).

Given that the context of this study is an examination of the governance practices on a daily basis and as viewed by a range of actors, a naturalistic inquiry was deemed most appropriate because it allowed for a comprehensive examination of governance rather than a partial view of governance as delineated by existing governance models.

2.4 SUMMARY

This chapter presented the dominant theoretical constructs used to research corporate governance. It argued for and supported the postulation by Turnbull (1997) and others that governance has 'many pieces to its puzzle' and hence required a holistic and interdisciplinary conceptual framework. As such, this study used inductive theory 'building' rather than 'testing' as it was considered by the researcher more 'applicable to the conditions' of this study.

A discussion of the major theoretical debates on governance in the literature was provided to support the call for a 'multi-disciplinary' approach given the diverse and complex puzzle that is deemed corporate governance. The theoretical literature on corporate governance revealed that no-one unitary definitive model is adequate and as such, this research is a contribution to the developing knowledge on such a broad and complex topic.

In Chapter 3, the history and the legislative framework of governance in the Victorian public health sector is presented. The term 'clinical governance' is defined in relation to its place in corporate governance decision-making. The chapter concludes with an outline of the framework for clinical governance reporting at *HealthCo*.

CHAPTER 3 THE HISTORY AND ROLE OF CORPORATE GOVERNANCE IN THE VICTORIAN PUBLIC HEALTH SECTOR

3.1 INTRODUCTION

In the two preceding chapters, the concept of corporate governance was presented from both practical and theoretical perspectives. In their analysis of health care and public policy, Palmer and Short (1999) provide a comprehensive outline of health services and health care policy in Australia and the reform that has driven both the economic outcomes and personal impact on all Australians. They highlight the 'shortcomings' in the literature on health policy in Australia and the lack of a 'multidisciplinary framework' to analyse public health. The researcher acknowledges not only these shortcomings and provides a map of the historical profile of the reformed acute health services in Victoria.

This chapter also outlines the Australian public health system, and what the objectives of this system may mean to health service directors in terms of the rights and expectations of the public for access to and the provision of and delivery of health care services. This is followed by an historical overview of the Victorian government rationale for the current model of governance in the public health sector, along with the details of the legislative framework in place for governing bodies and Boards.

The chapter reveals a dramatic change in governance from individual Committees of Management for each hospital to the establishment of Health Service Boards, responsible for one or more grouped hospitals and in turn more staff, resources and patients. The origins of and a definition of 'clinical governance' is introduced, along

with a discussion of its relationship to corporate governance, more specifically in terms of the ultimate accountability and the consequences of decision-making resting with Health Service Boards under the auspices of the Minister for Health.

3.2 ACCESS TO PUBLIC HEALTH CARE IN AUSTRALIA

Rawls (1972) developed the concept of accessible health for all as a right not a privilege and the social reform introduced by the Labor government in the 1970s saw the introduction of the then National Health Insurance scheme *Medibank* in 1975. *Medibank* was introduced as a health policy to ensure equitable access to health care for all Australian residents (Scotton, 2000). The scheme was abolished and then reintroduced as *Medicare* in 1984. According to Scotton (1977: 5), 'It differed from the original *Medibank* program only in matters of detail'. As outlined by the *Australian Health Insurance Commission* (2001), the objectives of *Medicare* were:

- to make health care affordable for all Australians;
- to give all Australians access to health care services with priority according to clinical need;
- to provide a high quality care.

Medicare provides access to:

- free treatment as a public (*Medicare*) patient in a public hospital;
- free or subsidised treatment by practitioners such as doctors, including specialists, participating optometrists or dentists, for specified services only.

All Australian residents are still guaranteed access to public health through the *Medicare* system, however, as has been discussed in Chapter 1, economic

rationalism and cost cutting has created pressure on the public system and the incentive for faster and better access to treatment based on fee for service. Based on clinical need, the public are triaged or prioritised for access to treatment. Medical staff make the initial decisions of prioritisation. However, the consequences or outcomes of these clinical decisions become the responsibility of the Board in terms of accountability.

Duckett (2007) describes the impact of reform has changed the focus of Boards in public health organisations adopting a 'more business-orientated approaches to determining the services to be provided by institutions within their control and for decision making generally p.177.' His review of the Victorian public health system in 1999 outlined the complexity of the management arrangements in hospitals and health care.

3.3 PRIORITISATION OF HEALTH SERVICES

The Minister for Health and the government determines the Victorian policy in terms of general medical access and treatment. However, it is the Board that determines the strategic plan and organisational priorities and objectives of each health service. The Boards must each submit a strategic plan to the Minister for health. They must demonstrate that they have been regularly reviewed and must have a medium rather than long-term vision (see Section: 65ZF *Health Services (Governance) Act 2000*). Capp described the decision-making made by health service Boards as being based on 'prioritisation' and 'rationing':

> The inevitable conclusion is that with a finite amount of funds to be invested and a demand for services that is unconstrained by cost, choices have to be made about how resources are allocated. This introduces the classic economic notion of scarcity and inevitably results in a need to prioritise and ration (2001:2).

The impact of this prioritisation and rationing of health services has been felt by the community who have suffered as a result of long waiting lists for treatment and/or the cancellation of surgery due to hospital bed and staff shortages (Gough and Fitzpatrick, 2004). It appears that there may be a mismatch between the needs and expectations of the community and the ability of public health services to meet these needs and expectations. This has resulted in increased pressures and expectations on hospital governing bodies to provide essential services as efficiently as possible and to meet budgetary requirements. It is the medical staff who perform and provide medicine treatment and in some cases life saving surgery, but it is ultimately the hospital Board who must determine areas of priority. They must make the bottom line decisions regarding the allocation of resources, delivery and access to what is deemed an essential service and a fundamental right of all Australians regardless of race, creed or financial status.

3.4 AN HISTORICAL PROFILE OF GOVERNANCE IN THE VICTORIAN PUBLIC HEALTH SECTOR

As presented in Chapter 1, public sector reform is not unique to Australia and has been introduced in other OECD countries including the United Kingdom, Canada

and New Zealand over the past two decades, Palmer and Short (1999). Government initiated reform in the Australian public sector has seen dramatic structural changes in the health sector. *Victoria's Health to 2050: Developing Melbourne's Hospital Network* (Department of Health and Community Services, 1995) identified the need for a new model of health provision. The report attempted to provide the basis for a strategic framework in recognition of the accelerated pressures of new technology, an ageing population and reduced commonwealth and state funding. The implementation of a new model of health provision can be broken down into three phases.

3.4.1 Phase 1:

One of the key recommendations saw the creation of *The Metropolitan Hospital's Planning Board* in February 1995, who oversaw the implementation or creation of seven metropolitan Health Care Networks. In short, this meant a radical change from the thirty-five existing independent hospitals to seven large networks comprised of hospitals grouped and merged according to geographical proximity. This government reform and amalgamation of resources was a part of the then Liberal state government policy and was also implemented in other sectors including local government and education. The purpose of these amalgamations, 'merges' or in this instance the creation of healthcare networks, was to combine resources and centralise the governance and management of a group of hospitals into one, with the aim of reducing costs and providing a regional rather than local health service.

A similar model was also introduced after a comprehensive restructure of the New South Wales health system, with one hundred urban state Hospital Boards replaced

by twenty-three Area Health Service Boards in the late 1980s. Following further reform, this was reduced to seventeen Health Services in NSW (NSW Department of Health and the Health Services Association of NSW, 2002).

This major restructure of hospitals and access to health care also saw a dramatic change in governance structures with a move from independent Hospital Boards of Management, to seven Victorian Health Care Network Boards of Directors. Each of the network directors were now appointed by the Minister and remunerated for their time and service, the criteria for appointment being based on the professional and commercial experience and expertise they offered in relation to the skill requirements and identified needs of each Board (see Appendix 1).

The newly configured health service Boards are in contrast to their previous Committee of Management counterparts, who were selected for their prominence in the local community, and most often primarily composed of current or retired medical personnel including surgeons, specialists and local general practitioners. This was the beginning of a shift in both the composition of and expectations and duties of directors, with an emphasis on a business orientation and performance.

3.4.2 Phase 2

The seven metropolitan health networks were reaggregated into twelve Health Care Services with the introduction of the *Health Services (Governance) Act 2000* (see Appendix 7). This Act amended the *Health Services Act 1988* to allow the disaggregation of several health care networks and further reorganisation and restructure of metropolitan public health care agencies. The creation of this new

legislation followed a Ministerial Review in 1999 - The *Duckett Review*. The aim of the review was to identify savings of eighteen million dollars per annum and to establish new governance and management structures. During the period 1995 - 2000, four community hospitals were closed, signalling that performance and economic viability were essential for organisational survival.

3.4.3 Phase 3

With a change in the term 'networks' to 'health services' and further reconfigurations, the current Victorian metropolitan public hospital system consists of twelve health services. The twelve health services could be described as demographic clusters of hospitals and health centres and in some cases include up to five hospitals and health care centres serving the surrounding communities. The legislative framework for the metropolitan hospital networks is the *Health Services Act 1988.* As stated earlier, the *Health Services (Governance) Act 2000* was introduced to dissagregate some of the existing networks and the establishment of new health services. Table 3.1 lists the current Victorian Health Services and the hospital and centres that make up each service.

Table 3. 1 Victorian Metropolitan Health Services

Metropolitan Health Services	Hospitals/Health Centres
Austin Health	Austin Campus, Repatriation Campus, Royal Talbot Rehabilitation Centre
Bayside Health	Alfred Hospital, Caulfield Medical Centre Sandringham & District Memorial Hospital
Dental Health Services Victoria	
Eastern Health	Angliss Health Service, Box Hill Hospital, Maroondah Hospital, Peter James Centre, Yarra Ranges Health Service
Northern Health	Broadmeadows Health Services, Bundoora Extended Care Centre, Northern Hospital
Peninsula Health	Frankston Hospital, Mt Eliza Aged Care & Rehabilitation Service, Rosebud Hospital
Peter MacCallum Cancer Institute	
Melbourne Health	Royal Melbourne Hospital, Melbourne Extended Care & Rehabilitation Service
Royal Victoria Eye and Ear Hospital	
Southern Health	Dandenong Hospital, Hampton Rehabilitation Hospital, Kingston Centre, Monash Medical Centre-Clayton, Monash Medical Centre-Moorabbin, Cranbourne Integrated Care Centre
Western Health	Sunshine Hospital, Western Hospital, Williamstown Hospital
Women's and Children's Health	Royal Children's Hospital, Royal Women's Hospital

Source: Adapted from the *Victorian Public Hospital Governance Reform Panel Report,* August 2003, p.16.

3.5 DIFFERENCES BETWEEN PRIVATE and PUBLIC SECTOR GOVERNANCE

Central to both private and public sector organisations is corporate governance – how the business is managed both structurally and ethically in terms of accountability. While there appears to be a wealth of material on corporate governance generally, there is little on corporate governance and the public sector (Storey, 2000). The key differences distinguishing the private and public sectors are that, in the private sector, Corporations Law outlines legal compliance. Legislation or a Statutory Act

determines public sector governance. Despite different legal boundaries, the concept of corporate governance in public sector agencies can be said to be based on the same principles as its private sector counterparts, although there are a variety of differences to be considered in the 'twilight zone' between the two sectors (Horrigan, 2001). In discussing the differences between private, public (government) and non-profit Boards, Carver stated:

> They are all alike in that they all bear ultimate accountability for organisational accountability and accomplishment. They are unlike in how they are situated in the larger context of political economic life (1997:5).

There are also claims that public sector governance must:

> … satisfy a more complex range of political, economic and social objectives, and operate according to a quite different set of external constraints and influences than do private sector businesses (ANAO, 2000).

The provision and delivery of essential health services to the community is indeed complex and weighted by the demands and expectations from numerous stakeholders. It is further complicated by the fact that the Australian public health system is jointly funded by both the Commonwealth and State governments, with the major source of funding derived from federal government taxation that includes the medicare levy. The administration of public hospitals is a state responsibility. The complexity arises as, for example, aged care receives separate Commonwealth funding to general medical care. Whist the directors of each health service must

meet the bottom line, as a Board they must demonstrate accountability and organisational performance by measurement of the Key Performance Indicators (KPIs) by the Department of Human Services (DHS) and the Minister.

As presented in Chapter 2, public sector governance is more aligned with a stewardship or stakeholder model of governance, where accountability is to the organisation's many and diverse stakeholders. Private sector governance is based on an agency model, with accountability to shareholders and profit returns. However, there has been shift in the expectations of directors in the public sector, with an emphasis on organisational economic performance, sustainability and productivity. The changes to the governance and structure of the Victorian public health system have been both rapid and dramatic in this past decade with the sudden closure of hospitals not deemed as sustainable and the merging of others along with numerous restructures.

3.6 THE IMPACT OF THE NEO-LIBERAL ERA AND ECONOMIC REFORM ON PUBLIC SECTOR AGENCIES

The impact of economic reform and the resultant changes introduced to the public sector was introduced in Chapter 1. An overview of the major changes, in relation to the context of this study, the Victorian public health sector, is now presented.

Public sector organisations and particularly hospitals have undergone rapid and massive change. This change is not unique to Australia and is a result of government and business reform in all OECD countries during the past two decades (Ahn, Halligan and Wilks, 2002). Neo-liberalism has been the driving force behind this

organisational and workplace change of the past two decades in Australia (ACIRRT, 1999). Economic rationalism, bottom line, efficiency, restructure, flattened hierarchy and productivity have dominated management discourse. Economic reform in the public sector has seen:

> … a new paradigm, redistribution of power, extensive reorganisation and the systematic application of new approaches across all agencies (Halligan, 2002:41).

The new government reforms in the public sector have seen an emphasis on efficiency, accountability, consultation and a push for entrepreneurialism and sustainability (*Parliament of Victoria* 2002). The Victorian public health sector, like global, national and internal health sectors has been forced to embrace the rationalisation of already scarce resources.

As noted by the ANAO:

> In an environment which will become increasingly competitive and contestable with additional demands being placed on scarce resources, Boards will need to examine continually ways to innovate, adapt and strengthen those structures and processes within their organisations which support their leadership and decision-making and ensure sound and effective governance (2000:5).

In short, the impact of this reform on public sector organisations has seen a reduction in staff, resources and funding. In the already stretched and vulnerable market place of public health, the impact of this dramatic change is now being most felt with global shortages of medical staff, particularly nurses and general practitioners. Ward closures, bed shortages, over crowded emergency waiting rooms, a backlog of waiting lists for surgery, a shortage of vital medical equipment, and increased reports of inadequate treatment of the elderly in nursing homes are common media headlines. With government promises to the community of the delivery of a first class health system, the pressure has been placed upon the Boards of directors to strategically guide their organisations to meet both economic imperatives and social expectations.

3.7 THE CORPORATISING OF GOVERNANCE IN VICTORIAN PUBLIC HEALTH SERVICES

The roles and duties of directors appointed to the Boards of the new Health Services are significantly different from the original governors and committees of managements of the thirty-five independent hospitals, who had been selected in an honorary capacity to represent the interests of the immediate stakeholders. Today's directors are ministerially appointed and chosen on their ability to meet a range of desired criteria and skills similar to their private counterparts. With an emphasis on business strategy and entrepreneurialism, a new corporatised model of governance has been introduced. This new Victorian model aligns with the New South Wales public health model, and can be said to have followed the NHS reform in the United Kingdom.

> The reforms represent the importing of a private sector 'Boards of directors' model into the NHS… the change in language is not just cosmetic but highly significant as it indicates a desire by the centre to shift power to the top of these organisations, and to ensure that personnel with top level private sector managerial experience fit naturally into these new roles (Ferlie, Ashburner and Fitzgerald, 1995: 379).

The governance of the Victorian health services is described in the Ministerial papers as an 'amalgamated model', where one single Board is responsible for an acute health care service, which is some cases consists of up to seven hospitals and or health centres. The Victorian metropolitan public health services are established under the *Health Services Act 1988.* The functions of the Board of metropolitan health services and the duties of the directors are documented in the *Health Services (Governance) Act 2000* (see Table 3.2). Financial accountability is followed in accordance with the *Financial Management Act 1994*. Each of the seven health services is a public statutory corporation and as such accountable to the Minister for Health via legislation. It should be noted that metropolitan health services do not represent the Crown (see *Health services (Governance) Act 2000,* 65Q.) Similarly, in New South Wales, the directors of health services are appointed by the Minister for Health in accordance with the *Health Services Act, 1997*.

Duckett (2007:179) refers to the delegation of accountability via Ministerial power in the public health services as the Westminster system of governance.

Table 3.2 Section 65S Health Services (Governance) Act 2000: Functions of Boards of Directors Metropolitan Health Services

65S. Board of directors

(1) There shall be a Board of directors of each metropolitan health service.
(2) The functions of the Board of a metropolitan health service are-

(a) to monitor the performance of the metropolitan health service;
(b) to oversee the management of the metropolitan health service by the chief executive officer;
(c) to monitor the performance of the chief executive officer of the metropolitan health service;
(d) to develop strategic plans for the operation of the metropolitan health service;
(e) to develop plans, strategies and budgets to ensure accountable and efficient provision of health services by the metropolitan health service and the long term financial viability of the metropolitan health service;
(f) to establish and maintain effective systems to ensure that the health services provided meet the needs of the communities served by the metropolitan health service and that the views of users of health services are taken into account;
(g) to ensure effective and accountable systems are in place to monitor and improve the quality and effectiveness of health services provided by the metropolitan health service;
(h) to ensure that any problems identified with the quality and effectiveness of health services are addressed in a timely manner and that the metropolitan health service strives to continuously improve quality and foster innovation;
(i) to develop arrangements with other health care agencies and health service providers to enable effective and efficient service delivery and continuity of care;
(j) to establish the organisational structure, including the management structure, of the metropolitan health service;
(k) to appoint a person to fill a vacancy in the position of chief executive officer;
(l) to establish a Finance Committee, an Audit Committee and a Quality Committee and other committees to assist it in carrying out its functions;
(m) to facilitate health research and education;
(n) any other functions conferred on the Board by or under this Act.

(3) The Board of a metropolitan health service has such powers as are necessary to enable it to carry out its functions, including the power, subject to section 24, to make, amend or revoke by-laws.

Source: Adapted from the *Health Services (Governance) Act* 2000, Section 65S.

Despite the differences in the respective legislation for the governance structures for both Victoria and New South Wales, it could be said that the roles, responsibilities and accountabilities of Health Service Board members are fundamentally the same. However, it should be noted that despite the similarities of the legislation in relation to governance frameworks of governing bodies, each of the states and territories have a range of different legislation relating to areas such as employment, occupational health and safety etc.

It is the role of management of each health service to ensure that this legislation is followed throughout the organisation on a day-to-day basis, and, to immediately advise the CEO, who in turn informs the Board of any breach of compliance. Ultimate accountability rests with the Board and providing each director acts in 'good faith' personal immunity from liability is granted (see 65Y *Health Services (Governance Act)* 2000.

3.8 CLINICAL GOVERNANCE

A 'new' area of accountability has been added to health service directors - 'clinical governance'. The origins of the term 'clinical governance' can be traced to the United Kingdom's *National Health Service* (NHS) publication *A First Class Service: Quality in the New NHS* in 1988. It lists, the definition of clinical governance as:

> The framework through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence will

> flourish (refer: NSW Department of Health and the Health Services Association of NSW, 2002:37).

In order to achieve this 'environment of excellence' and implement a national and unified level of quality care, *National Service Frameworks* and *National Quality Standards* were developed in the United Kingdom, with all clinicians expected to follow these standards and together with their Boards monitor them. Clinical governance was implemented in the United Kingdom in response to a decline in standards and quality of healthcare provision and to put in place a systematic approach to ensure that patients were accessing and receiving appropriate care to avoid adverse events (see: *The Bristol Royal Infirmary Inquiry 1984-1995*, UK Department of Health, 2002). Clinical governance is now reported in all UK public health service annual reports and this trend is also evident in Victorian public health service annual reports.

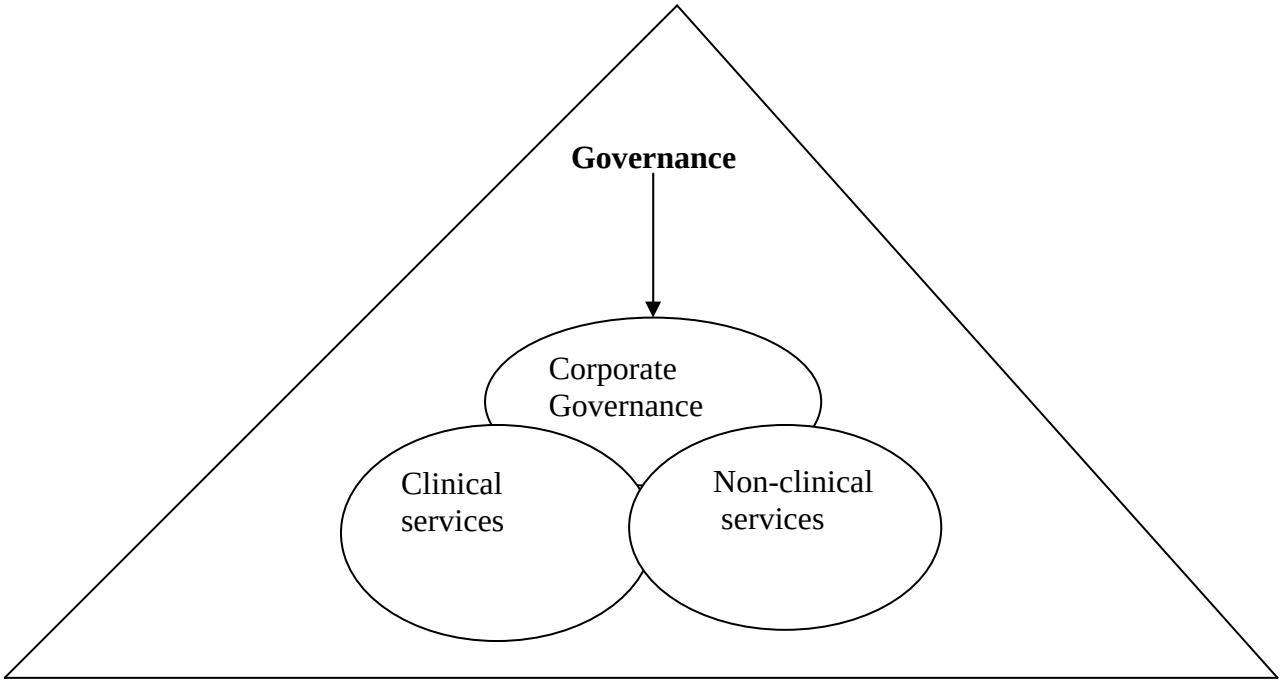
Clinical governance is now highly placed on the agendas of all health service Boards in Australia. However, it was described as a 'relatively new concept' in 2002 (refer *Royal Melbourne Hospital Inquiry Report,* p.2). The relationship between governance, accountability and in turn 'clinical governance' is best described as:

> The term 'governance' is concerned with structures and processes for decision-making, accountability, control and behaviour at the highest level of the organisation. The term 'clinical' implies both the involvement of clinicians and the notion of patient care. The combination of these terms therefore suggests that…Health Service Boards have a responsibility for the

> standards of care delivered by the service and for providing the structures and environment in which the delivery of high quality can be facilitated…implies that there is both a corporate and personal responsibility (Health Services Association of NSW, 2002:37).

As such, clinical governance can be described as the relationship between clinical and corporate responsibility. It is 'everybody's business' (McSherry and Pearce, 2002), that is, it is a mechanism for the protection of the patient to receive safe and quality healthcare by having transparent monitoring and reporting mechanisms in place, with both medical and non-medical staff. HealthCare governance is the term to show the relationship of corporate and clinical governance in the public health sector. This is shown in figure 3.1.

Figure 3.1 HealthCare governance



Source: Adapted from McSherry R., and Pearce, P 2002, p.21, *Clinical Governance: A Guide to HealthCare Professionals*, Blackwell Sciences, Oxford.

Figure 3.1 shows that corporate governance in the health sector is made up of three elements of service and unites the corporate aspects, that is, the management of healthcare, with both the clinical practice and non-clinical support. As such, despite ultimate responsibility for the strategic direction of any healthcare organisation, the successful delivery of quality healthcare becomes 'everybody's business' with clinicians and non-clinicians such as administration support workers accountable for their actions and the delivery of a quality service through the mechanism of 'clinical governance'.

The complexity of the public health sector has been argued earlier. Part of the complexity is that major life saving or threatening medical decisions must rest with clinicians. On this basis, it could be argued that they are the key decision makers in a healthcare organisation. However, with ultimate accountability resting with the Board, it is vital for a clear understanding of the areas of responsibility and effective communication between clinicians and directors. The recommended 'system' for developing effective clinical governance is presented in Table 3.3. This system described the key elements of clinical governance as the recognition and acceptance of shared responsibility and accountability of healthcare by clinicians, management and Boards and making sure that an effective system is put into place by Health Service Boards through their Chief Executive Officers.

Table 3.3 System for developing clinical governance

The term 'governance' is concerned with structures and processes for decision-making, accountability; control and behaviour at the highest level of the organisation.
The term 'clinical' implies both the involvement of clinicians and the notion of patient care. The combination of these terms suggests that:
• Health Service Boards have a responsibility for the standards of care delivered by the Service and for providing the structures and environment in which the delivery of high quality care can be facilitated
• clinicians have a responsibility for the quality and shape of not only their individual clinical performance, but more significantly, for contributing to the strategic roles of the Health Service.
Clinical governance: • is specifically aimed at the standards required and performance expected in the delivery of clinical care
• implies that there is both a corporate and personal responsibility for assessing, achieving and maintaining a high level of competence to ensure the safe and effective delivery of health care
• ensures that the quality of clinical care will be monitored and valued equally with the financial performance of the Health Service
The successful implementation of clinical governance requires:
• the development of strong and effective partnerships between clinicians and managers
• identification of clear lines of responsibility and accountability for clinical care and ensuring these are communicated throughout the organisation

Source: Adapted from *Corporate governance and accountability in health – better practice guide, 2002*, p.37.

Table 3.3 provides a logical approach to developing effective clinical and in turn corporate governance.

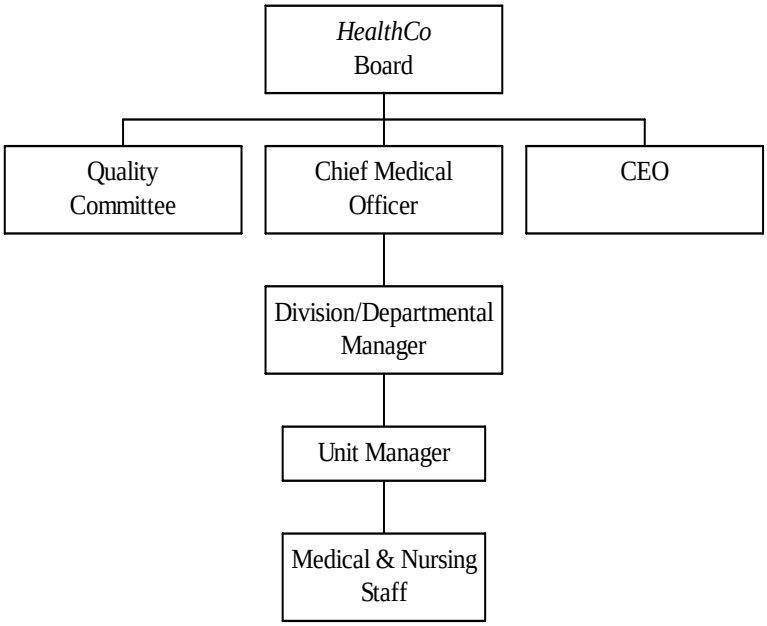
3.9 CLINICAL GOVERNANCE AT *HEALTHCO*

As part of the framework of corporate governance in Victoria, it is mandatory under legislation for all Boards to establish a Quality Committee as one of the sub committee's of the Board. Chaired by one of the directors, the Quality Committee includes clinicians, administrators and academics. It is via this committee that all Board members are kept informed of the clinical governance of their health service.

Another mandatory requirement is that each health service must produce a *Quality of Care Report* - an independent publication from the *Annual Report*. Each of the health services must report its performance in relation to specific areas, such as; waiting times for emergency treatment, complaints, adverse events and mortality rates. These are measured against the Department of Human Services (DHS) Key Performance Indicators (KPIs). The health service is also required to report on the measures used to improve in these and other areas related to the quality and delivery of patient care.

It could be said that the reaggregation of the seven Victorian health care networks into twelve health care services in 2000 was in part a response to the *Health Review Panel* who had expressed concerns that patient care and quality may have given way to commercial viability and business imperatives. The re-emphasising of care and quality is expressed in the clinical governance reporting structure at *HealthCo* as shown in Figure 3.2.

Figure 3.2 Clinical Governance Reporting at *HealthCo*



The clinical governance policy at *HealthCo* requires all medical and nursing staff to keep up-to-date and accurate records of all treatment and medications administered to patients. These records must be accessible to Unit Managers. Any adverse event must be reported internally, firstly to the Unit Head and Divisional or Departmental Managers, who in turn must inform the Chief Medical Officer. The Chief Medical Officer assesses the event and must inform the CEO and the Board immediately. All adverse events are tabled at Quality Committee Meetings. External investigation can lead to legal proceedings and if there is evidence of clinical mismanagement that has serious consequences for the welfare of a patient then liability rests with the Board if they have failed to take appropriate action.

The Chief Medical Officer was considered the most appropriate person at *HealthCo* to liaise with clinicians and managers to produce a draft model of clinical governance given his professional medical experience. This draft model was first presented to

the Board in November 2001. After subsequent planning sessions and the creation of a clinical governance committee, the model was adopted in October 2002.

As has been stated throughout, the impact of economic reform and the introduction of clinical governance have not been unique to Australia, or to the specific context of Victoria. A series of major or critical incidents related to patient care, clinical and corporate governance in recent times has resulted in major, national, local, and international inquiries and investigations. They include: *The Douglas Report – King Edward Memorial Hospital Western Australia* (2001), *The Royal Melbourne Inquiry Report* (2002) and *The Bristol Royal Infirmary Inquiry* (2002).

Each of these major government initiated inquiries and reports highlights the need for managers to have full knowledge of, and mechanisms in place to tackle any likely operational problems. The recommendations found in each stressed the need for timely and effective reporting to all members of the Board to ensure that management decisions are in the interest of patient access, safety and care. As previously stated, *The Health Services (Governance) Act* 2000, provides immunity for all of the Victorian health services directors. It reads:

> A director of a board of a metropolitan health service is not personally liable for anything done or omitted to be done in good faith (Section 65Y, p.10).

Despite this immunity, directors in the public health sector now more than ever must be vigilant in their knowledge of the clinical governance mechanisms of their health service. Carver (2002:293) warned that, 'Hospitals literally hold the power of life

and death over most of us at some point in our lives'. This statement can be claimed as a truism for most Australians, who are either born, treated or die in hospital. It may be the medical treatment that we receive from clinicians that may save or lives, but it would seem that the ultimate power could be said to be held by the directors, Boards and governing bodies.

3.10 SUMMARY

This chapter presented an overview of Australia's national health care policy *Medicare* and its origins, along with its fundamental aims to provide equitable and low to no-cost public health coverage to all Australians. It discussed the impact of economic rationalisation and reform on the pubic sector in terms of changed governance and the evolution of the current Victorian health care system and the current governance arrangements for public health services. It argued that the changes in governance are reflective of international trends for the overlay of private business values and goals on public sector entities. That is, a push for business orientation and entrepreneurialism. It introduced the concept of clinical governance, originating from the NHS in the United Kingdom and presented the clinical governance-reporting framework implemented at *HealthCo*. The chapter concluded with the argument that it is the Board of directors who are ultimately accountable for the consequences of all medical and other treatment. Their onus does not rest with their fiduciary roles, but as individuals and as a group have a corporate and personal responsibility to ‘act in good faith’.

In the Chapter 4 the methodological orientation for the study of corporate governance in the Victorian public health sector is presented.

CHAPTER 4 METHODOLOGY

4.1 INTRODUCTION

Corporate governance was introduced in Chapter 1 as a concept that has generated considerable academic discussion, media scrutiny and public concern in recent years (Clarke, 1998). ‘Corporate governance has emerged from obscurity into being a mainstream topic’ (Vinten, 2001:4). It was argued that governance in the public sector was complex, and that research in this sector on corporate governance was lacking, and, to assist in the greater understanding of both the practical issues and theoretical foundations of governance, it was necessary to investigate governance empirically.

Chapter 2 supported the call for more empirical research and argued that in order to extend the knowledge base on governance, a multi-dimensional (Bennett, 1970) and holistic approach was needed. This argument was based on the researcher's understanding that governance may be viewed through a variety of lenses and disciplines such as law, finance, economics, sociology and psychology (Turnbull, 1997), with each of these lenses or disciplines offering various perceptions and concerns regarding governance operations. Also, that in the past, the literature from these disciplines has not 'talked' to one another (Pettigrew, 1992).

This study has acknowledged the challenge to conceptualise governance from various viewpoints and theories. It concurs that there appears to be, 'no one size fits all’ model for good corporate governance (OECD 1999) and this leads to the need

for multiple perspectives to explore how governance is perceived, interpreted and structured in a public health agency.

As discussed in Chapter 2, the focus of most of the research undertaken on corporate governance is on the private sector, and on economic performance and conformance. As a consequence of this narrow focus, there is a lack of 'integrated theory' and a dominance of an 'agency theoretical perspective' in the corporate governance field (Clarke, 1998). This study addresses this gap. Rather than measuring the organisational and individual performance of directors, the purpose of this research is to provide a first-hand account of governance. The researcher uses the direct exposure to governance decision-making (the internal governance) and investigates its implications or consequences on the organisation's stakeholders (external governance). That is, the data for the study is based on fieldwork and combines naturalistic research methods and techniques over a prolonged period of time to examine the governance and management processes and practices at the pinnacle of *HealthCo*. It observes the governance processes, and examines how they are understood and acknowledged by those most affected by the decisions made by the Board, the stakeholders - more specifically, staff, patients, and the community.

4.2 RATIONALE FOR THE METHODOLOGICAL APPROACH

The researcher wanted to initiate an interpretivist study that included sustained access over an extended time period to observe Board decision-making. The pioneering work of Vernon Wilson, who observed Board meetings of regional hospitals in the United States during the 1970s (U.S. National Library of Medicine,

2001), provided an impetus for the researcher to incorporate observation of Board activities as a viable and valuable method of collecting data to build the existing knowledge base on corporate governance. She heeded the warnings of the vulnerability of the research on both a practical (Winkler, 1987) and methodological level (Brannen, 1987) and ensured that a range of strategies were in place so that the research was not compromised by any misunderstanding of the role or intentions of the researcher. A high level of trust and respect from the 'elite' participants was essential as it was they who could be described as having the power to assist in the facilitation of the research or see it come to a premature end.

The research approach and derivation of the study was determined by the 'fit' of a naturalistic paradigm (Lincoln and Guba, 1985: pp.229-232). A naturalistic inquiry using an ethnographic framework was chosen as it allowed for a holistic approach with prolonged and extensive engagement with the researcher immersed in the empirical setting over a prolonged time frame (Dey, 2002). Ethnography as a method allowed the researcher to fully explore the social complexity of corporate governance:

> Because ethnography deals with the actual practices in real world situations, it allows for relevant issues to be explored and frameworks to be developed which can be used by both practitioners and researchers…it enables a researcher to study organisations as the complex social, cultural and political systems that they are (Harvey and Myers, 1995:22).

From the initial meetings and discussions with the CEO and the Chair regarding the possibilities of conducting the study, the researcher became aware that there might be some 'complex social, cultural and political' influences impacting on the governance of the organisation. Given the topical and 'mainstream' (Vinten, 2001) interest in corporate governance, the researcher was not surprised by the eager willingness for the governance processes at *HealthC* to be explored. As discussed in Chapter 1, the impact of poor and failed governance was not restricted to the private sector and initiatives such as the *Inquiry into Corporate Governance in the Victorian Public Sector* (Public Accounts and Estimates Committee, 2002) supported organisational attempts to investigate and review governance applications in public sector entities.

The study sought to examine all of the elements of governance within *HealthCo,* including how it was understood, practiced and ultimately delivered over a two-year duration. In examining governance, the researcher sought to build on emerging issues as they occurred and applied the principles of grounded theory in the construction of questions and analysis of the data (Glasser and Strauss 1967).
It supports the call for new models and approaches to theory building in management research (Trim and Lee, 2004). In terms of this research, grounded theory is therefore defined as:

> … systematically and inductively arrived at through covariant ongoing collection and analysis of data…The grounded theory approach is a general methodology of analysis linked with data collection that uses a systematic applied set of methods to generate an inductive theory about a substantive area (Glaser, 1992:15-16).

In specific reference to the study of Boards and governance, Heracleous (1997:263) claimed that there is a multitude of research on organisational leadership and Boards of directors, but that this research has been dominated by positivist design and execution. He called for more qualitative 'observation of group dynamics' in relation to the study of Boards to enhance and provide a more in-depth view of governance. Dey's (2002) study in accounting, traditionally a field dominated by quantitative and positivist methodologies, given that its very nature and purpose is to count and measure, sheds new insights into the diverse settings in which ethnographic studies are both valuable and viable.

Dey (2002) applauded the potential of an ethnographic approach to assist in the development of new accounting systems, particularly related to social accounting. He also warned of the controversy surrounding ethnographic research in accounting and the initial difficulties in the conceptualisation and presentation of the evaluation of findings in ethnographic work. He emphasised that for ethnography to reach its potential as an active methodology, it requires 'intensive commitment by the researcher (and the researched)' (2002: 118).

Samra-Fredericks (2000) advocated the use of ethnographies on Boards and top level management. In her study of a large United Kingdom manufacturing company, she used ethnography to build theory from her observations. Her data included observations, notes, work-shadowing, interviews and audio and video recordings to 'find out what is going on' (p.323). This she claimed is a fundamental goal for corporate governance research.

4.3 MANAGEMENT AND ORGANISATIONAL RESEARCH USING GROUNDED THEORY

The application and use of grounded theory in management appears divided. Bryman (1988:85) observed that 'there are comparatively few instances of its application'. This was later supported by Partington (2000:95), who commented, 'in published management research there is little evidence of the successful application of any precisely delineated, prescribed approach'. Douglas (2003) contended that there was paucity in the diverse management field to be found in the literature. Contrary to this, Goulding (2002:155) claimed that 'grounded theory now has an established place in management research'.

A literature search, using the descriptors, 'grounded theory', and 'management' and or 'organisational' research revealed that grounded theory has been used successfully in a range of diverse management/organisational contexts. The works include: Reiple and Vyakarnam (1986), who explored management behaviour. It was also used by Wolfram-Cox (1997) in a study of organisational change and its impact on employees. Resistance to change in a small Italian manufacturing company was the focus of a grounded theory study by, Macri, Tagliaventi and Bertolotti (2002). Human resource management was explored by Konecki (1997) and accounting and management practice using grounded theory was examined by Laughlin (1995) and later by Parker and Roffey (1997). A longitudinal case study of nineteen organisations using grounded theory was conducted to examine practitioner reflexivity in the delivery of Total Quality Management by Leonard and McAdam (2001).

Whilst the methodology is still striving for recognition in the management field, it is a well-established and respected form of inquiry in the area of health, particularly in nursing (see: Chenitz and Swanson, 1986, Streubert and Carpenter 1995). This reputation generated from its founders Glaser and Strauss (1967) seminal research. They used a collaborative approach to better understand the shared experiences of the expectation of death as perceived by the patients, practitioners and relatives. It has since been used by a range of medical practitioners, especially nurses to improve the practice in a diverse range of settings and conditions. Its orientation in this sector is to improve the outcome for both practitioners and patients. Equally, it has been and continues to be used in education where it is described as 'action research' (see: McTaggart, 1988), once again, with the aim to inform and improve practice – in this case teaching. Action research as a qualitative methodology aims to provide both practical advice and advance knowledge in the area.

This synopsis of the literature is by no means a definitive account of all management related studies that have successfully used and published accounts of grounded theory. However, it clearly indicates that there appears to be a growing level of acceptance and understanding of grounded theory as a valid and valuable methodology for both data collection and analysis in the broad field of management and organisational research.

4.4 VARIATIONS IN THE APPLICATION OF GROUNDED THEORY

The original intent of grounded theory was as a methodology for sociologists (Goulding, 1998). It has since been used and adapted in a range of disciplines and

fields such as, health, education and management. It has been criticised because of its 'bewildering complexity' and not being 'universally applicable' (Partington, 2000). This criticism has a level of merit as the researcher undertaking a grounded theory approach must be prepared for a non-linear journey. That is, research questions evolve during the research process. There is not a set formula to follow, rather 'a set of fundamental processes that need to be followed' (Goulding, 1998: 53).

In undertaking a grounded theory approach, it has become necessary, and in some cases essential for researchers to decide and declare the approach taken (Skodol-Wilson and Ambler-Hutchinson, 1996). The reason for this declaration is that each version offers quite differing philosophical orientations. They are: the Glaser and Strauss (1967) original, Glaser's (1978, 1992) subsequent interpretations of grounded theory application or the contrasting Strauss and Corbin (1990) version. Rather than engage in specific details of the differences and or professed strengths and weaknesses of each version and ultimately, to 'avoid being distracted by [the] extraneous invective' between Glaser and Strauss that have ‘create[d] confusion over the assumptions, logic and research methods in grounded theory generation' (Parker and Roffey, 1997:213) a brief synopsis of the key differences is provided in a generalist overview. As stated by Goulding:

> Not only are there differences in style and terminology, but Strauss' (1987) version of the method has been reworked to incorporate a strict and complex process of systematic coding…a point of departure between Glaser, who argues that the theory should only explain the phenomenon under study, and

> Strauss, who insists on excessive use of coding matrixes to conceptualise beyond the immediate field of study (1998:52).

In simple terms, Glaser advocated that the aim of grounded theory is to generate good ideas and latent creativity on the part of the researcher (Partington, 2000). The 'drugless trip' is the term used by Glaser (1978:24) to describe the analytic process in grounded theory. Strauss and Corbin (1990) on the other hand, have set techniques and a prescriptive set of procedures that the researcher must follow (Goulding, 1998, 2000; Locke, 2001; Partington, 2000; Douglas, 2003). As with any naturalistic inquiry, theory is inductive and the design of the study emergent in response to the data that is constantly reviewed and sorted. Theory is not 'hammered' into the research; rather it emerges from the direct sources of the data. Theory is therefore generated from the ground up - from the actual data, rather than overlaying the research or inquiry with a theoretical model that must be tested.
In grounded theory:

> The researcher, rather than commencing with a theory which he or she attempts to verify, commences with an area of study and allows relevant theoretical constructs to emerge from that process of study (Parker and Roffey, 1997: 214)

The grounded theory approach used in this study is derived from the original and aligns more closely with the views of Glaser (1978, 1992) as the researcher found Strauss's (1990) coding approach 'too strict and complex'. She believed that Glaser's approach allowed for the appreciation of emergent phenomenon. The study

incorporated the principles of naturalistic inquiry (Lincoln and Guba, 1985), despite Glaser (2004:5) claiming that their fourteen characteristics of naturalistic inquiry are 'simple, redundant and trite'.

This study has adapted the original methodology and aligns it with the construction and principles of naturalistic inquiry as an ethnographic study.

4.5 THE ORIGINS OF GROUNDED THEORY

Grounded theory acknowledges the role of the researcher as part of the research but also demands 'minimal researcher intervention' (Douglas, 2003:44) in the direction of the inquiry. Grounded theory allows for a systematic yet creative approach to inquiry. It can be described as inductive research and sits within qualitative research paradigms as the data is a combination of observation and direct fieldwork. It should be noted that in its original form, the principles of grounded theory could be applied in quantitative research (Glaser and Strauss, 1967). However, it is more often used in naturalistic inquiry based on qualitative data collection. In sum, grounded theory explores the perspectives of human interactions and processes within a social context.

Glaser and Strauss developed grounded theory while conducting field-based research on the observations of how hospital staff dealt with terminal patients (see: Glaser and Strauss, 1965; 1968). The resultant publication: *The Discovery of Grounded Theory* (1967), 'was specifically aimed at developing social scientists' capacities for generating theory that would be highly relevant to their ongoing research interests'

(Parker and Roffey, 1997:214). In grounded theory the researcher starts with an interest in, and seeks to explore and find out more, about a particular social phenomenon. The researcher also brings a level of knowledge and experience to the area in question. This extant knowledge is vital, as the researcher must use her/his skills in order to analyse and generate theory rather than obvious or incidental and non-informative narrative (Glaser, 1992).

Studies using grounded theory 'require the researcher to have a creative imagination informed by significant personal and professional experience' (Parker and Roffey, 1997:225). Glaser (1978) described this as 'theoretical sensitivity'. This means that the researcher must be able to interact with the data during its collection rather than at the end of the study. She/he must also have the capacity to think about the data in terms of its theoretical meaning. Theoretical sensitivity 'can also be derived from sources outside of the researchers' disciplinary domain' (Locke, 2001:89) and can include personal experiences not restricted to the research environment and incorporate the experiences of others.

4.6 METHODS USED TO COLLECT DATA

In this inquiry, the concept and practice of corporate governance at *HealthCo* is explored holistically in an attempt to provide a greater understanding of and build upon the existing knowledge of corporate governance. The objective to 'provide a fresh slant on [the] existing knowledge [on corporate governance] (Goulding, 1998:51). A naturalistic framework was considered the most appropriate approach to collect the data that was based on fieldwork observations and human interaction in a

large public sector health organisation. Naturalistic inquiry and ethnography are complimentary approaches used to ‘build’ theory.

This is best described by Locke:

> Grounded theory shares with more ethnographic approaches a reserved and modest stance towards existing theory and a style of analysis that interweaves data collection and theory building so that, as the research progresses, the analyst successively redefines and narrows her focus of study (2001:18).

4.6.1 Naturalistic Inquiry

Naturalistic research is based on what is described as fieldwork and has a 'heavy reliance on the human as an instrument' (Lincoln and Guba 1985:250). The 'human' instrument' is the researcher who goes into the field that is the 'natural setting' for the research, to observe and ask questions specific to the inquiry. The strength of the research is reliant on the researcher's ability to capture and interpret the ideas and perceptions of those actively engaged in the research and combine these with her/his observations’ and experiences’ of the setting in a written descriptive report.

This study employed a naturalistic paradigm and used predominately qualitative methods. However, it also included several quantitative instruments, such as the questionnaires and appraisals. These quantitative instruments were used to establish general baseline data, such as, demographic profiles of age, gender, categories of employment type and profession in a large and diverse workplace. This data provided the researcher with examples of more common or general issues that could be followed up in groups or individually. They also enabled the data to be

triangulated by the incorporation of a variety of data sources, methods and techniques. Despite the inclusion of these instruments, a qualitative rather than quantitative approach was taken because:

> Where research requires accurate portrayals of stakeholder values or opinions, qualitative ethnographic data have often proven superior to survey data, particularly in cases that involve long-term field exposure and in situations where informants might feel at risk or have other reasons to provide incorrect responses, or where their "truer" responses might develop over time (Chambers 2000:859).

The collection of data over a prolonged time allowed for the researcher to engage with the stakeholders in order to capture their truer responses.

4.6.2 The Flow of Naturalistic Inquiry

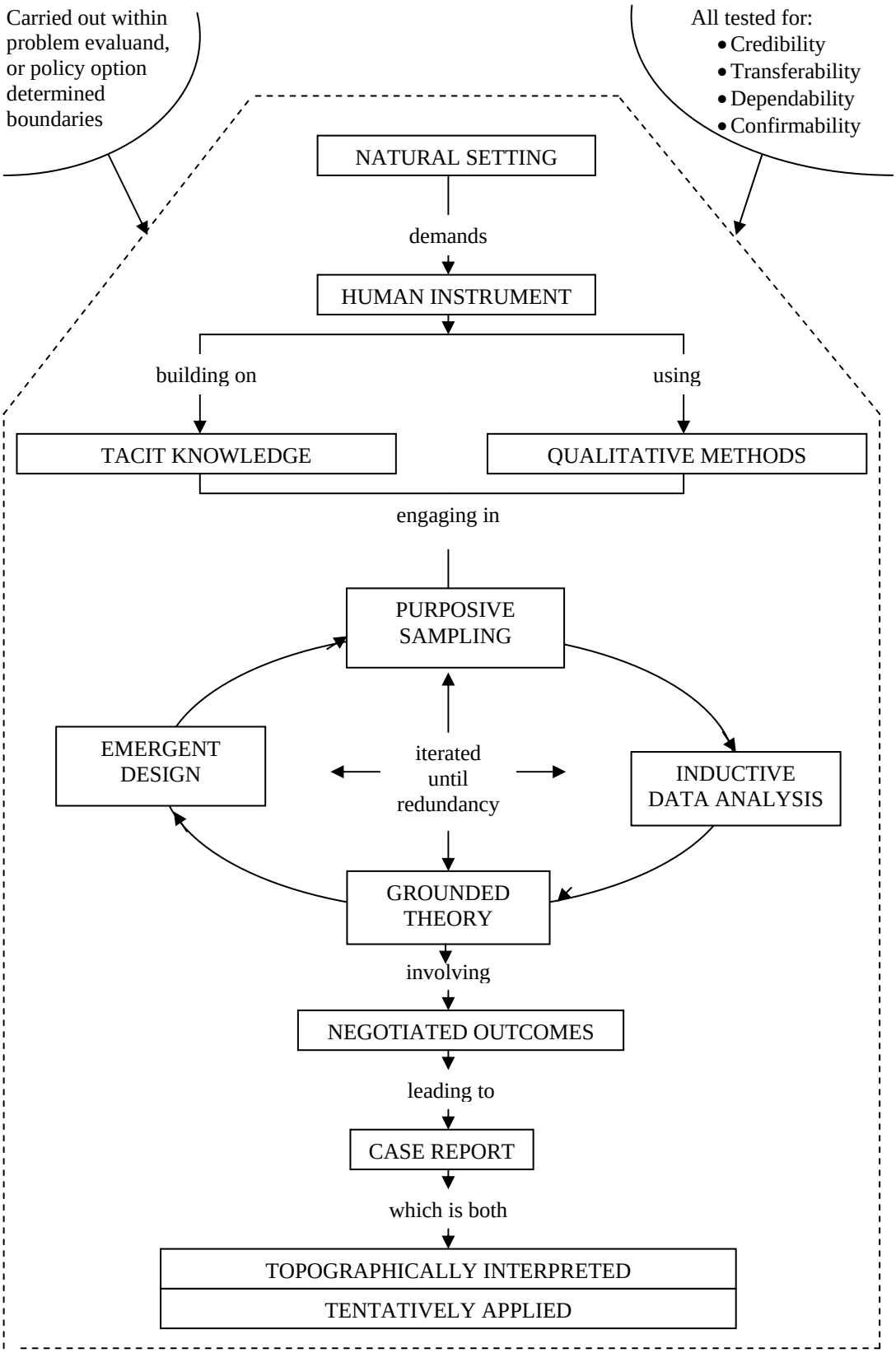
Lincoln and Guba (1985) described fourteen characteristics and the ‘flow’ of 'operational' naturalistic inquiry. These terms or elements are summarised in Table 4.1. The *Flow of Naturalistic Inquiry* is shown in Figure 4.2. This summary is the researcher’s interpretation of Lincoln and Guba's characteristics of naturalistic inquiry. The researcher used the fourteen characteristics as a checklist for establishing the credibility of the data

Table 4.1 The fourteen characteristics of naturalistic inquiry

Characteristic	Description
1. Natural Setting	The naturalist conducts the research in a natural setting. That is, the 'site'/'setting' of the research. Participant/s is/are not removed from a natural setting and placed in a laboratory.
2. Human Instrument	Humans are the 'primary data-gathering' instruments as opposed to brass instruments or 'testing' devices.
3. Utilization of tacit knowledge	The 'legitimation' of tacit knowledge - that is, what is known or felt in addition to propositional knowledge (that which is able to be expressed in language).
4. Qualitative methods	The choice for qualitative over quantitative methods (not exclusively) because they are more adaptable with dealing with multiple (and less aggregatable) realities.
5. Purposive sampling	Random or representative sampling is chosen in favour of purposive or theoretical sampling, as it increases the scope or range of data. It allows for the full array of multiple realities.
6. Inductive analysis	Preference for inductive over deductive data analysis.
7. Grounded theory	The substantive theory 'emerges' from the data. No *a priori* theory is able to encompass the multiple realities that are generated by naturalistic inquiry.
8. Emergent design	The research design allows flow. The findings 'unfold'. There can be no *a priori* as the multiple realities are unknown at the start of the research. The interaction between the inquirer and the phenomenon is unpredictable. The value systems of both the researcher and participants are unpredictable.
9. Negotiated outcomes	Meanings and interpretations are negotiated with human sources the 'respondents' or 'informants,' who are best able to understand and interpret the complexity of the mutual interactions and values.
10. Case Study reporting mode	A case study report rather than a scientific or technical report is produced as it is based on description.
11. Idiographic interpretation	The data is interpreted in terms of the particulars of the specific context or case. A total immersion in the context is required.
12. Tentative Application	The broad application of the findings is avoided, as the research is particular to one case. Empirical duplication is difficult as multiple realities exist and values may vary in different settings.
13. Focus-determined boundaries	The boundaries are set in the investigation on the basis of the emergent focus. The research is local & not abstract.
14. Special criteria for trustworthiness	*Credibility, transferability, dependability and confirmability* affirm the 'trustworthiness' of naturalistic data & research.

Source: Adapted from Lincoln, Y. and Guba, E. *Naturalistic Inquiry,* Sage, Newbury Park, pp.187-220.

Figure 4.1 The flow of naturalistic inquiry



Source: Adapted from Lincoln, Y. and Guba, E. (1985) *Naturalistic Inquiry*, Sage, Newbury Park, p. 188.

The ultimate test of naturalistic inquiry is its ability to establish 'trustworthiness'. In the words of Lincoln and Guba:

> How can an inquirer persuade his or her audiences that the findings of an inquiry are worth paying attention to, worth taking account of (1985:301)?

Trustworthiness can only be established with a range of techniques being employed. A detailed discussion of how trustworthiness was established in the research conducted at *HealthCo* is presented in Chapter 5. The techniques required for trustworthiness are highlighted in Table 5.3.

4.6.3 Ethnography

The word *Ethnos* has Greek origins and in simple terms means the similarity of certain groups - as separated by culture or race (see Smith, 1986). In this sense, *ethnography* can be described as the 'graphic' details and story of a similar people, race or culture. Vidich and Stanford describe ethnography as:

> …descriptive anthropology - in its broadest sense, the science devoted to describing ways of humankind (2000:40).

Hence, the ethnographer is one who observes, depicts and narrates the story of the specific cultural group she or he is studying. Based on anthropological traditions and the study of ancient peoples and cultures, ethnographic research has evolved from its

roots in sociology and extended as a worthy methodology to a variety of disciplines to examine a range of social phenomena. Chambers defines ethnography as being:

> …principally defined by its subject matter, which is *ethnos*, or culture, and not by its methodology, which is often but not invariably qualitative (2000: 252).

Chambers also warned that the term culture is 'ambiguous' in its meaning as it can be used in relation to describing both micro and macro groups, that is, a specific grouping of people such as students in a classroom to that of a nationality. In this study, the *ethnos* is an organisation, specifically a public sector health organisation.

Bronislaw Malinowski 's anthropological ethnographies fully embraced and included detailed descriptions of what is known as fieldwork within the contexts studied Harvey and Myers (1995). According to Erickson, Malinowski:

> …conceptualised social action as meaningful to the actor producing it, and considered the actor as taking account of the meaningful action of others... Malinowski asserted that the authority of the realist ethnographic text and other forms of interpretive, qualitative research should rest on such research describing social action from the point of view of the native (1996: 1).

It is the 'point of view of the native' or the ability to hear other voices (Hull, 1994) or the multiplicity of dialoguing voices (Tedlock, 2000), that is the essence of ethnography.

Ethnographic inquiry explores the human condition and the cultural environment and settings in which people live and work as it is not restricted to the unity and similarities of any particular group, it also explores the differences, such as: discord, power and conflict (Goulding, 2002). 'The ethnographer's method of collecting data is to live among those who are the data' (Rosen, 1991:5).

Ethnography and fieldwork challenges both the researcher and the researched:

> …in a world of infinite interconnections and overlapping contexts, the ethnographic field cannot simply exist, awaiting discovery. It has to be laboriously constructed, prised apart from all other possibilities for contextualisation to which its constituent relationships and connections could be referred (Amit, 2000:6).

Wolcott (1988:189) described the tenuous and difficult role of the researcher to manage the diverse relationships during ethnographic research as ‘walking a fine line’. Tedlock (2000) also describes the difficulty of the role:

> ... ethnographers traverse both territorial and semantic boundaries, fashioning cultures and cultural understandings through an intertwining of voices, they appear heroic to some and ludicrous to others. They are cross-dressers, outsiders wearing insiders' clothes while gradually acquiring the language and behaviours that go along with them (2000:455).

It is the balance between the two boundaries that is required and not easily achieved. During the course of this study, the 'fine line' walked by the researcher was that between Board and management, management and staff. That is, the design of the research required the researcher to be on site for two days per week. The office that she occupied was situated on the 'executive floor' and was originally occupied by the CEO. As such the researcher was quickly labelled as being on the side of management simply because of the location of the office.

These challenges were also faced by others who have adopted such a methodology. Samra-Fredericks described her interpretation as to why such challenges exist. She said:

> …human interaction in organizations does not unfold neatly. It is a layered and complex lived experience which defies simple findings and prescription (2000:323).

The complex and unpredictable nature of human existence and interaction beyond the boundaries of an organisation is further described by Schwartz and Ogilvy:

> A conscious being - say, a human being - is very complex and unpredictable…When people interact they affect each other. Because of this complexity of interaction, people don't always see the same things; they have unique perspective's. In the same way, the emergent paradigm of the actual world is complex, holographic, heterogeneous, indeterminate, mutually

> causal, morphogenetic, and perspectival…we are like the world we see (1979:15).

Despite the challenges, the use of ethnographic research to explore the organisational perspectives' of both management and workers appears to be growing. Examples can be found in different workplace contexts and areas such as manufacturing, information systems, Boards, management, unions and accounting (see: Harvey and Myers (1995), Watson, (1996), Ram (1996), Brown, (1998), Black, Greene and Ackers (1999), Samra-Friedericks, (2000), Dey (2002), and others. Ram (1996) argued the value of using ethnography as a methodological approach for building knowledge in the area of labour management. In his study of a small West Midlands clothing manufacturer, he stated:

> The ethnographic approach was crucial to the unraveling of the complexities and tensions inherent in the management process. Insights generated by the method allow prevailing views of managerial practices in such settings to be questioned; and more generally, highlight the potential of ethnography as a means of management research (1996:35).

4.7 ELEMENTS OF GROUNDED THEORY

In what follows, a synopsis of the processes used in grounded theory is presented. It is an overview of the original method created by Glaser and Strauss (1967) and incorporates further insights from Glaser (1992). It has been adapted by the researcher, who also includes the work of Lincoln and Guba (1985) to present this

naturalistic inquiry. It is therefore an interpretation of grounded theory as seen by the researcher.

The initial phase of a grounded theory study commences with the researcher having, 'an abstract wonderment of what is going on that is the issue and how it is handled. Or what is the core process that continually resolves the main concern of the subjects' (Glaser, 1992:22). Unlike a positivist study, there is not an exhaustive literature review conducted at the beginning of a grounded study. According to Glaser (1992:32) 'the literature will always be there. It does not go away!' The process is summarised by Leonard and McAdam:

> … the researcher starts with minimalist *a priori* constructs, inquires deeply into organisational behaviour and events and gradually tests and forms theoretical constructs (2001:182).

This does not mean that the literature is ignored; rather the researcher reads 'in a substantive field different from the research' (Goulding, 1998:53). Once theories emerge from the data, the literature is checked and 'is analysed in order to draw comparisons, build on, or offer an alternative perspective' (Goulding, 1998:53). This process with the literature is in contrast to positivist studies that commence with a literature review and then test and replicate related research. According to Goulding:

> Usually researchers adopt grounded theory when the topic of interest has been relatively ignored in the literature or has been given only superficial attention…most researchers will have their own disciplinary background

which will provide a perspective from which to investigate the problem (2002:55).

In this research, the researcher was aware of a gap in the literature on corporate governance and the public sector. Her own 'disciplinary background' and orientation in qualitative organisational research was the impetus to use a grounded theory approach.

4.7.1 Generating Theory

The collection of data is referred to as conducting fieldwork - 'observations, interviews, meetings and the inspection of documentation where appropriate or possible' (Douglas, 2003:46). The researcher commences analysis of the data and 'generating theory' from the initial data collection by immersing themselves in and with the data and looking for dimensions or themes (Berg, 2004). This process is described by Glaser and Strauss (1967) as 'coding' the data. The theoretical perspective that is generated from the theory is determined by the researcher's approach and the personal interests and academic background in the area.

4.7.2 Coding

The coding of the data is a continuous process over the duration of the inquiry with the researcher breaking down the data and looking for connections, similarities and differences as it emerges. The categories are not predetermined, rather discovered by being immersed in the data. In sum, coding occurs from asking questions of the data

and assigning 'provisional' answers or 'theories' until all data is collected and analysed (Douglas, 2003).

In the initial coding phase, the researcher codes or 'names' an incident, event or perception of the phenomenon that emerges from the data. The name or code provides researcher's initial interpretation of what is happening. The same incident can be renamed, or allocated a mix of names or codes at this stage. This process can be described as a 'brainstorming' activity to enable broad thinking about the incident's meaning (Goulding, 1998). The naming or coding is usually written in the margins of the field notes, transcripts etc. or prepared using index cards. These incidents can be renamed or re-coded during subsequent analysis or additional data sources. The data is then checked for similarities and differences. This comparison of the data is used to create conceptual categories and build theory. Glaser (1992) emphasised the importance of 'constant comparison' of the data, codes and categories 'to allow conceptual properties to emerge' (Douglas, 2003:48).

During the analysis and coding, the researcher looks for alternative explanations to test or confirm the emergent concepts and theories. This is done to ensure that the theory is conceptually adequate (Glaser and Strauss, 1967). The collection of data ceases upon 'saturation' - that is, when no new or relevant theories can be drawn for all existing data.

There are several layers of coding: *open coding* in which unrestricted labels are attached to the data. Reflection of existing data combined with new data is also coded 'openly' at this stage, as is a check for similarities and differences. Following

this open coding process is *axial coding* in which the researcher regroups the data and identifies the relationships between open codes. The final coding is known as *selective coding* in which the central phenomenon emerges from the axial coding. Following this, 'a theoretical framework of interrelated concepts can be developed' (Douglas, 2003:48). Throughout the coding process and the reflection on the data, the researcher writes theoretical questions and summaries of the codes. This process is described as *memoing,* in which the researcher is writing memos to her/his self. Memos become the basis of the narrative used by the researcher in the final phase, to write up or report the data.

As stated earlier, the researcher may at first be overwhelmed with the 'flood' of data and be unsure as to how much data is necessary, as there is no definitive measure to answer this. Goulding (1998:56) warned intending researchers that as a methodology, it is 'time-consuming, often frustrating [and] requires patience, an open mind and flexibility'. Partington (2000:101) supports Goulding and describes the qualities needed by qualitative researchers as, 'sensitivity, creativity, patience, perseverance, courage and luck'. The researcher must be willing to 'continuously expand and refine' their ideas and once they have done so, it is time to write up their findings as the study has 'ceased'.

4.8 ASSESSING THE QUALITY OF GROUNDED THEORY

Quantitative research is focused on measurement and testing, whereas qualitative research is interpretative. It relies on the qualification of responses from actors in a

social setting. Glaser and Strauss (1967) identified four questions to ask in order to evaluate the worthiness or quality of a grounded theory study. They are:

(1) Fit - does the theory fit the substantive area in which it will be used?

(2) Understandability - will non-professionals concerned with the substantive area understand the theory?

(3) Generalisability - does the theory apply to a wide range of situations in the substantive area?

(4) Control - does the theory allow the user some control over the "structure and process of daily situations as they change through time?"

These questions were asked by the researcher prior to and over the duration of the study and research process. They will be readdressed at the conclusion of the thesis by the researcher in order to provide a framework for assessing the suitability and contribution to knowledge of this study.

4.9 SUMMARY

In this chapter, the rationale for a naturalistic based inquiry using an ethnographic framework was presented. The processes and principles of grounded theory were outlined along with a discussion of its original inception and the subsequent development and division of the original techniques and procedures advocated by founders Glaser and Strauss (1967). The potential of grounded theory as a valuable methodology in management and organisational studies was also presented along

with examples of its application in the broader context of management studies including: human resource management, accounting and total quality management.

The chapter concluded with an endorsement for more research involving theory building in management studies so that the following statement can be withdrawn or successfully challenged:

> The approach to discovering theory from data known as *grounded theory* is much-cited but little understood (Partington, 2000:93).

In the following chapter, the methods used to collect data in a naturalistic inquiry are outlined along with a detailed description of ethnography as a research methodology. The fundamental differences between naturalistic and positivist paradigms are also presented.

CHAPTER 5 OUTLINE OF RESEARCH SETTING, INSTRUMENTS AND DATA SOURCES

5.1 INTRODUCTION

As part of ethnographic reporting, the context and setting of the research should be described along with the techniques used to achieve trustworthiness of the data such as member-checking and triangulation. This chapter contextualises the study and describes how trustworthiness was achieved. A narrative on how the research was negotiated and conducted, including the ethical requirements is also described.

5.2 CONTEXT AND RESEARCH SETTING

As presented in Chapter 1 (see 1.8), the context and 'natural' setting of this research is the main campus of a public health organisation, specifically an acute metropolitan health service. It should be pointed out that there was a range of sites in which the research was conducted. That is, *HealthCo* is a multi-campus or multi-hospital organisation and the researcher spent equal time at each of the hospitals during the course of the research. The aim of this was to observe and be familiar with the day-to-day operations of each hospital and to become familiar with the staff. In all cases the researcher was based in the executive offices.

Each of the hospitals differed in size, scope and appearance. They could be described as having a blend of architecture - with some of the older buildings remaining amongst their more contemporary counterparts. Renovations to the older buildings to accommodate contemporary technological and electronic requirements

for medical equipment and computer communication are clearly visible. Their geographical location could be described as one of the clustered demographic areas in metropolitan Victoria. The organisation has been given the pseudonym *HealthCo* to provide anonymity for all participants in the study and those employed or involved with the organisation. This was part of the ethical contract between *HealthCo* and the researcher.

The settings for the 'external interviews' varied across offices in different inner city locations. Unlike the 'thick description' of Malinowskian ethnography specific detail of the settings has been purposefully omitted, as the researcher agreed to limit any geographical and demographical description of each hospital so as to further protect the anonymity of *HealthCo* and all research participants. Malinowski's field diary of his study of the Trobriand natives in New Guinea (1922) contained rich description. This was described as 'exhaustive research' by Young (1979) because of this detail. However, in this case the researcher did not believe that additional descriptions of the context and setting would enhance the written narrative.

The evidence or the proof of the lived experience or the 'I was there' (Erickson, 1996) in this account of governance was documented in the researcher's journal and diaries over the two-year period and includes details of attendance at meetings and other organisational functions.

5.3 INITIATING THE STUDY

In the conceptualisation of this study, there appeared to be a dearth of information on what governance may actually mean in terms of application and more specifically in the changed and changing face of the public sector. This sparked the initial interest or 'abstract wonderment' (Glaser, 1992) to investigate the actualities of governance in a public sector agency. After reading media reports of the planned governance restructure in the public health system, the researcher contacted several of the metropolitan 'networks' directly about her research idea. The newly appointed Chair of *HealthCo* expressed an interest to discuss the study. This expression of interest was formalised by the Chief Executive Officer who invited the researcher to meet and present the research proposal.

A meeting was scheduled with the researcher and *HealthCo's* Chief Executive Officer to discuss the potential research. Following this meeting, an in principle agreement to conduct the research was granted by the CEO pending ultimate approval from the Board and the senior executives of the organisation. The researcher presented the proposal at the June 2001 Board meeting. A subsequent meeting and presentation to the senior executives followed several days later. Following the two presentations, it was agreed by both the Board and management that permission to conduct the research be granted.

5.4 ETHICAL REQUIREMENTS

An essential component of any naturalistic inquiry is a commitment to an ethical arrangement that guarantees strict confidentiality of what is said by the research

participants, and in turn heard and seen by the researcher. The researcher must respect her/his role as the 'privileged observer' (Wolcott, 1988). That is, they are privy to seeing, hearing and reading what may be described as confidential and private information and accordingly demonstrate respect for this privilege. The need for sound ethical principles and respect in qualitative research is emphasised by Stake:

> Qualitative researchers are guests in the private spaces of the world. Their manners should be good and their code of ethics strict…something of a contract exists between researcher and the researched…(2000:447).

As highlighted in Chapter 1, obtaining access to governance decision-making and prolonged access and engagement with an elite group of people (Moyser and Wagstaffe, 1987) is not easy. The researcher recognised the need to ensure that a 'contract' existed between both parties and this was established by a series of negotiations with the CEO, Chair, the researcher and her supervisor prior to the commencement of the study. There were three major ethical documents established to satisfy the needs of all parties. Each of the documents was externally viewed, vetted and approved by the appropriate committees. The three documents were: (1) The University Human Research Ethics Application (2) *HealthCo's* external Ethics Committee and (3) a Memorandum of Understanding signed by both the CEO and the researcher.

The major parties involved in the research were given the opportunity to contribute to each of the documents and final approval was granted from the senior executive

and the Board. Each of the participants in the study and the relevant institutional ethics committees were given or granted access to the documents. The documents were considered as the contract between all parties. They also represented the moral obligation (Schwandt, 1993) between the researcher and the researched. With both of these documents in place, the study commenced.

5.5 OUTLINE OF HOW THE STUDY WAS CONDUCTED

The researcher observed the daily activities of the largest campus site for two days a week for general observation of the organisation - an equal amount of time was spent at the other campuses over the duration of the study. This observation was concurrent with attendance to all of the monthly Board and any of the bi-monthly sub-committee meetings as an observer. The researcher was to be given a copy of the Board agenda prior to all meetings and permission to have access to all of the Board minutes was granted on the proviso that the minutes were read on site and in the presence of the corporate secretary. The researcher was invited to stay as a guest to any lunches or dinners with the CEO and members of the Board at the conclusion of the meetings and or retreats.

The researcher also established monthly meetings with the CEO and the Corporate Secretary so that she could report on the progress of the study in terms of the activities that she had planned to collect data and to provide an update on any literature or information on governance that she felt of relevance to the organisation. The meetings provided a forum for the CEO and Corporate Secretary to express their views on governance and contribute their ideas and suggestions to the study. It was

agreed that the meetings run for no less than an hour with as minimal interruption as possible. This was difficult to achieve given the demands of the CEO who often received telephone calls from a variety of sources that required his immediate response.

It was also agreed that the researcher formalise these meeting by setting and sending an agenda to the CEO and Corporate Secretary prior to each meeting. The researcher also agreed to send electronic copies of the minutes within twenty-four hours listing the recommended or agreed actions and outcomes. These meetings and the minutes became 'active memos' in that the researcher used them as a basis for further inquiry/activity. They were an invaluable arena for discussing any relevant materials and information on governance. For example, the researcher saw the *Victorian Public Accounts and Estimates Committee* (PAEC) *Inquiry into Corporate Governance in the Victorian Public Sector* call for submissions advertised in a Melbourne newspaper in March 2002. She believed that it would be of benefit to *HealthCo* to use this as a mechanism to create discussion regarding how the directors perceived governance. After presenting a copy of the submission guidelines at one of these meetings, it was agreed by the CEO that the details of the inquiry were to be included with the April 2002 Board meeting Agenda and papers by the Corporate Secretary.

The Board endorsed that a response to this submission be undertaken. However, despite an invitation to contribute, none of the directors contacted the researcher to take part. After several meetings with the CEO and Chair, a draft was compiled. The researcher also consulted with several senior executives including the Chief Finance

Officer regarding questions in relation to the *Financial Management Act*, and the Human Resource Manager regarding the organisation's development of a *Code of Conduct*. The final submission was written by the researcher and sent to the PAEC in July 2002. A copy of this PAEC *Issues Paper* and a copy of the submission can be found in the appendices. This submission did not identify the health service and the pseudonym *HealthCo* appears throughout.

The tripartite meetings between the CEO, the corporate secretary and the researcher commenced in August 2001 and finished in September 2002.

The generated theory in this study was enabled with the researcher establishing a positive identification that there were unanswered questions on the understanding, interpretation and application of corporate governance in public sector agencies. This was evidenced in the academic literature (macro level) and clearly by *HealthCo* (micro level) who had agreed to the research in the belief that it may assist the organisation; more specifically the Board and Executive adopt and deliver 'good' corporate governance.

5.6 RESEARCH INSTRUMENTS

In a naturalistic inquiry, the primary instrument to collect data is the researcher or research team, thus the research instrument is referred to as the 'human instrument' (Linclon and Guba 1985). As a human instrument, the researcher brings her/his own values to the research. She/he must acknowledge these values or biases in the reporting of the data. As the research instrument, the tasks of the researcher are to:

observe, listen, take notes, ask questions, read and at times 'work shadow' (see Wolcott, 1988). Tedlock describes what is meant by the human instrument in naturalistic inquiry:

> The human being, the object and subject of their inquiry, exists in multiple stratas of reality, which are organised in different ways. The realm of meaning is emergent from the material and organic strata rather than a product of them (2000:471).

In an ethnographic study, the researcher or ethnographer becomes immersed in the research by living with those who are the data (Rosen, 1991) - or as in this instance, working, socialising, observing and being with all of the participants in the study over a regular and prolonged period. Participant observation is the primary source of data and a range of other data collection tools, such as, interviews - both structured and non-structured and the administration of questionnaires is used to 'supplement' the participant observation (Sanday, 1979).

This research also included a range of personal interviews with different types of participants. Eight interviews with individuals who had no association with *HealthCo* were conducted over the duration of the study as part of its emergent design. Individual interviews were also conducted with a range of the key stakeholders, including: directors, the Chair, management, staff, community representatives and patients. Supporting the interviews were several questionnaires that have been described in earlier chapters.

5.7 FIELDWORK

The basis or anthropological origins of fieldwork has been adapted by social scientists in a range of disciplines to conduct a naturalistic inquiry. This methodology requires the researcher to have direct experience and exposure to what she/he is investigating. The field trip is often romanticised, or as stated by Wolcott:

> The mystique surrounding ethnography is associated with being in the field because we all harbor romantic ideas of "going off to spend a year with the natives" (1988: 191).

The researcher becomes immersed in the world of the researched and it is this immersion that is fieldwork. The data is the result of the multiple sources and encounters in the field and the setting of the research, or in this study, settings. Despite no standard approach for describing fieldwork (Wolcott, 1988), it is based upon a range of techniques including: participant observation, interviewing, questionnaires, work shadowing, note taking and document or artefact analysis. Described as the 'marginal native' Freilich, (1970) and as the 'professional stranger' Agar, (1996), the field worker, researcher or ethnographer's observations are not limited or restricted to the workplace, but often:

> …includes not only as close to full-time as possible in the work site during official hours, but socialising with organisation members outside work as well: eating, drinking, fishing, shopping, dancing, driving, partying, running, playing ball, and otherwise getting to know people's work and outside-work selves (Rosen, 1991:20).

The researcher did not 'dance, run or fish' with any of the participants of the study, but did engage in a variety of social activities whilst at *HealthCo,* for example, joining in for morning teas with staff and dining with the directors after Board meetings. It was not always easy to be accepted into the different groups and the researcher experienced the ambivalence of being perceived as either a friend or stranger by the different participants.

In Table 5.1 details of the fieldwork including the techniques used to collect data are presented. It is not a template of what must be included as fieldwork in an organisational ethnography, rather a social construction of the researcher's footprints in the inquiry of governance at *HealthCo*.

Table 5.1 Fieldwork: methods and data sources

Data Sources	Methods Used
External Interviews	Eight interviews conducted with a range of professionals holding senior positions at various organisations/agencies including: government, academia and health care (each interview conducted in the interviewees office) Content of interviews regarding key issues from literature on corporate governance. Approx 45-60 mins duration. All of the interviews were transcribed and returned to participant for confirmation of accuracy and as procedural 'member-checking'.
Observation Participation & Attendance at executive & staff meetings Attendance at formal functions social functions etc	Up to two days per week on three sites or campuses (approximately 20 weeks per campus over 18 month period) This included attending meetings, observing various work areas, site audits, interviews and checking policy documents etc Annual General Meeting, Clinical Services Planning and Reviews, Hospital Open Days. Social functions included: staff Christmas luncheon, birthdays, farewells, fundraising evening etc.
Privileged observer Board meetings and at strategic planning retreats	Attend monthly Board meetings: November 01 – December 2002 (Board meetings usually 3 hours duration held in the evening, with dinner following). The researcher was invited to and stayed for most dinners to try and get to know the Board members more informally. The researcher was also invited to two of the strategic planning day retreats. These were held 'off site'.
Observer/ participant (sub committees for Board)	The role varied pending the nature/function of the committees. In most cases as observer, but in some instances where the make-up of the committee included stakeholders from community etc, input was given regarding terms of reference etc. Most committees meet bi-monthly.

Participant/ observer	Facilitated monthly meeting with CEO and Company Secretary (and/or CEO only) regarding progress and intended activities)
Participant/ observer	Facilitated discussion of and wrote submission to the *Public Accounts and Estimates Committee Issues Paper* – this was submitted in July 2002). A series of meetings with Chair and CEO with drafts were presented. (A copy of the submission is included in the appendices).
Observer as participant	Distribution, collection and analysis of staff questionnaire on governance and satisfaction. Individual interviews with mixed stakeholders including: Board members, employees, the community, and other providers. (Semi-structured interviews approx 45-60 minutes duration, transcribed and returned to participants for authenticity and 'member-checking'.
Collaboration through research	Investigation of corporate citizenship and corporate social responsibility reporting mechanisms addressing triple bottom line. Regular meetings held with the *Chief Finance Officer* who was assigned to head an investigation into sustainability. Support via provisions of materials for on governance supplied to Board members (this included 3 appraisal documents). One of the Appraisals was posted out to the Directors. The other two were distributed at the Board 'retreats'.

5.8 KEY DATA SOURCES

As has been discussed in earlier chapters, a grounded theoretical perspective of governance was developed using a range of data sources methods and techniques. Each of the data sources was significant and contributed to the final analysis. The key data sources for this study are now detailed along with an annotation of the memo and coding process.

5.8.1 Observation

Observation was one of the key data sources. This has been described as an 'impossible method' due to the issues surrounding access and confidentiality (Clarke 1998:58). The researcher acknowledged that it was not easy to convince the Board to allow an 'outsider' to be privy to their decision-making, and, in order for the study to proceed and succeed, a range of discussions and presentations to various elite parties were required prior to and over the course of the study.

At all times, she respected the role as 'privileged observer' (Wolcott, 1988) and wanted to demonstrate her understanding and commitment to transparency and accountability by providing clear guidelines and an audit trail of all activities undertaken to gather data for all parties involved in the research. She also ensured that clear ethical guidelines were in place so that each party understood their roles and requirements in the study.

The observational data can be broken down into four different types - as an observer: at Board meetings and retreats, in typical daily organisational setting, as participant observer at specialist meetings with senior management and with the CEO, Chair and Corporate Secretary, and more informally as an observer at social functions.

5.8.2 External Interviews

Following some initial inquiry and general questions to the CEO and other senior staff at *HealthCo,* the researcher reviewed her notes and found that the first memo identified the need to examine if there was a consistent definition of corporate governance as there appeared to be various opinions as to what corporate governance

was and/or a level of uncertainty in describing individual perceptions of governance. She also 'noted' a question asked for the history of governance from a Board member needed further exploration.

In an attempt to answer these questions and build a grounded theory, the researcher selected two concurrent activities. These were to compile a list of definitions of governance that appeared in the critical literature and to ask this question to those who could be described as corporate governance professionals. That is, a cross section of people who worked in different professional spheres in governance roles or had a history as a governance professional such as serving on Boards.

The selection of their suitability was based on demonstrated experience in governance roles. The researcher also wanted a mix of ages and gender to see if these variables influenced the responses. She used her own professional and personal networks and the recommendations from colleagues to contact a mix of potential informants. She selected an equal ratio of men and women and a range of occupations related to governance. The demographic details of the eight interviewees, including, gender, age, professional background and governance related experience is presented in Table 5.2.

The interview schedule developed over the course of the research. That is, additional questions were added and asked as issues emerged throughout the research. At all times, the researcher aimed for an open approach to the questions to see if these professionals unveiled an issue that had not yet been discussed in the literature evident in the other data. The questions were designed to be broader or more general at the beginning and to become more specific in the middle section of the

interview. The final questions then became more general and open. A total of eight interviews were conducted between June 2001 and May 2003.

All interviews were recorded and transcribed and each of the participants received a copy of the transcripts with a request to return them to the researcher with any changes they believed necessary, along with a signed declaration that they attested that the transcripts were an accurate reflection of what they had said. Generally, each interview was returned to the researcher in its verbatim form. However, one of the interviewees required three drafts. This process of returning transcripts and certification is a technique known as 'member checking' and used to demonstrate the 'credibility' of the data.

Table 5.2 Demographic Profiles of 'External' Interviewees

Gender	Age (approx)	Professional Background	Experience as a Board member
Male	60-70	Law, Government Policy, and Academic	Numerous positions in private, public and not-for-profit sectors Held position of Chair for various appointments
Female	50-55	State Politics, Law & Education	As above
Male	50-55	Corporate Lawyer, Director, Manager and Academic Researcher in Governance	As above
Female	40-45	Nursing. Current member of a Health Service Board and a specific women's health Board	All experience is with the public and *Not-for-Profit* sectors. Has experience as Chair
Female	50-55	Academic who has taught and researched areas in the areas of corporate governance, business ethics and corporate social responsibility (CSR) both in Australia and internationally	Predominantly in the Not-for-Profit and voluntary or community sectors
Male	45-50	Accountant and academic. In managerial role and has been a local government councillor	Public, local government and statutory authorities
Male	40-45	Former accountant. Has been a company secretary. Current manager	Experience on private and public sector Boards
Female	40-45	Ministerial position specifically addressing corporate governance issues Non Departmental Public Entities (NDPs)	Has served on public and not for profit Boards

5.8.3 Board Appraisals

After attending and observing several Board meetings, the researcher had written a memo to include the perceptions of the understanding of roles and responsibilities of each director on the Board at *HealthCo.* In the initial presentation of the research to the Board, the researcher outlined the additional information that she sought from the directors apart from attendance and observations of meetings. Most of the directors indicated that it was difficult to provide time for individual interviews, but they were happy to respond to anonymous questionnaires. The researcher discovered a suitable instrument to use as a questionnaire – a five page *Board Self-Appraisal* published in the New South Wales *Corporate Governance in Health Better Practice Guide*. After being granted permission from the authors, she modified some of the questions. A copy of the *Self-Appraisal* appears as Appendix 8.

The 'appraisals' were included with the minutes and agenda for the July 2001 Board meeting and posted to the directors by the Corporate Secretary. The appraisals consisted of forty-three questions using a five point Likert scale. Rather than being used as an appraisal it was a data source that could be analysed to reveal an overall perception of the understanding of the corporate governance expectations at *HealthCo*. It also allowed the researcher to check for consistency and inconsistency with responses that could be coded and categorised with other data sources to help build a theoretical understanding of the nature of governance at *HealthCo.*

At the time of distribution of the self-appraisals, there were a total of seven Board members (this included the Chair). Accompanying the appraisals was a letter of consent to participate in the research. Two of the new Ministerial appointments to the

Board had not been announced at this stage and it was not until the September 2001 Board meeting that these were given to the new directors. A further appointment to the Board to replace one of the Board members whose term had expired was made in March 2002. An appraisal was completed by the new director in April 2002.

As such, the data was collected over an extended time frame with the researcher needing to send reminders by email to several Board members. Over the course of the collection of this data, the researcher was able to reflect and check for other data sources to build upon. A formal presentation of the findings of the appraisals was conducted at the November 2001 Board meeting. The researcher also provided answers to some of the questions she had received from Board members concerning the definition and application of governance within a public sector health context, along with a general progress report on the research activities to date. The findings of the Board Appraisal are presented in the following chapter along with a full demographic profile of the *HealthCo* Board.

5.8.4 Board self evaluations and rating of Board performance

Following the Board appraisal, the researcher wanted to find out the strategies employed at *HealthCo* to measure Board performance both individually and collectively. In her reading of the literature on how to achieve better governance or ensure good governance, recommendations for an annual review of each director and the Board as a whole were suggested. After the first twelve months as an observer at *HealthCo*, no reviews had been conducted. In discussion at the meetings with the CEO and Corporate Secretary, it was suggested that the researcher design an instrument for this purpose.

In the publication *Building a Better Hospital Board*, the author John Witt recommended that both a self-evaluation of each individual Board member and then a self-evaluation of their perceptions of the Board's performance be undertaken concurrently. Witt (1987) designed two instruments for this purpose and the researcher wanted to adapt these for the directors at *HealthCo.* She conducted an internet search in order to contact the now retired United States author for permission to use his materials. This was granted. The individual self-rating document consisted of fifteen questions predominantly asking for a rating from 1-10 in regard to some more general to more complex governance issues. Examples of the questions included:

- *Rate your attendance at Board and committee meetings*
- *Rate your involvement in the process of overseeing management recommendations for corporate goals and objectives*

The individual self-rating performance questionnaires also asked each director to mark on the list their strongest areas of knowledge, experience and expertise, and if they believed that there were any areas that may be considered as a conflict of interest in serving on the Board.

The second part of the self-evaluation contained forty-one questions concerning the individual perceptions of each Board member in relation to Board performance. The questions were a mix of simple 'yes' and 'no' responses, and ten point Likert Scales. Both questionnaires were administered to all Board members present at a *Clinical Governance* Board Retreat, held in October 2002.

5.8.5 Staff Satisfaction and governance

The corporate governance literature supports the need to investigate the understanding of stakeholder perceptions of governance, especially key stakeholders such as staff. Kendall & Kendall stated that 'good' corporate governance includes:

> *…considering and caring for the interests of employees, past, present and future, which we take to comprise the whole life-cycle including planning future needs, recruitment, training, working environment, severance and retirement procedures, through to looking after pensioners* (1998:30).

Effective (good) governance, staff satisfaction and productivity have been linked (Francis 2000). However, there appears to be no empirical research investigating job satisfaction and employee understanding of organisational governance to support this link.

The rationale for using a satisfaction survey as a vehicle was based on the overall strategic plan to make a genuine commitment to consult with staff (the researcher found this as one of the Strategic Goals documented in what can be described as organisational artefact materials). One of the core organisational goals was to be regarded as an *employer of choice*. The Board and management at *HealthCo* believed that this could be achieved through the creation of a safe and progressive working environment that in turn would act as a positive influence on the professional development of staff and their well being. *HealthCo* wanted to be recognised as an employer that genuinely respected and valued its staff through its recruitment and employment practices.

Given the global, national and local shortages in medical, allied health and nursing staff (Gough and Fitzpatrick, 2004) and thus a competitive employment market between the other public health providers, *HealthCo* declared its intentions to be an employer who prioritised and rewarded staff for their commitment and performance. They believed that this would create both a healthy workplace with staff better able to assist the organisation in reaching the *KPIs* set by the *DHS*, and in turn a better health service for its clients – patients and potential patients.

The initial interest in exploring staff satisfaction by the managers at *HealthCo* originated at one of the early executive meetings that the researcher attended (late 2001). After lengthy discussions, six drafts and another ethics application, the *Staff Satisfaction Survey* was finally approved in July 2002. The researcher had decided that the most efficient and cost effective way of distribution was to attach a questionnaire to each staff member's payslip. Staff were asked to return the completed questionnaires to *Human Resources* using the internal mail system. All of the returned surveys were placed in the box for the researcher to collect. The questionnaire was promoted via articles published in the staff newsletters and this was reinforced by the weekly news email from the CEO, who encouraged staff to take part.

Rather than replicate an existing staff satisfaction survey, the researcher chose to select and if possible incorporate related research in the field of health. This included the pioneering work of Herzberg et al (1959) on the dimensions of job satisfaction within the medical profession and Desphande (1996) and Joseph and Deshpande (1997), on middle managers and nurses in non-profit organisations. As

previously mentioned, the researcher also included questions that she considered relevant for her own investigation into stakeholder perceptions of governance. A discussion on the findings from the *HealthCo* staff satisfaction, particularly in relation to the questions on governance will be presented in Chapter 8.

The questions for the *HealthCo* questionnaire were based on a range of empirical studies on staff satisfaction and incorporate specific questions designed by the researcher in relation to corporate governance, of which little has been done. She used numerous artefacts such as materials from Annual reports, company policies, memorandums and the published 'Mission' and 'Values' statements (Examples of these are not documented for confidentiality). This was the first major survey of staff perceptions to be undertaken by *HealthCo* since its organisational restructure that combined three hospitals and two health providers to become one.

The final questionnaire was produced from a series of five drafts in consultation with the CEO and corporate secretary. The questionnaire was then piloted with fifteen health care workers (non-*HealthCo* employees). A final draft was presented to the Board on April 4, 2002 and the Executive Management Team on April 22 2002. Discussion, comments and suggestions were sought from all of the above parties. No major concerns were voiced with only one request for more detailed occupation categories to be included. These categories were expanded from those listed as reportable Human Resource categories. The CEO requested that no invitation or space for participants to record comments be included on the questionnaire. Following the Executive Management Team meeting on 22 April, it was decided that it was necessary to have ethics approval from the central Victorian medical ethics

body, despite the questionnaire having ethics approval from the *Victoria University Human Research Ethics Committee* and sanction from the Board. The new ethics application required in a 20-page document detailing the administration and analysis of the questionnaire. Sponsorship from one of *HealthCo's* departments and a fee for several hundred dollars was also required. The Human Resource Manager agreed to act as sponsor/co-researcher as she believed that the research was both necessary and an invaluable opportunity to find out employee perceptions'. The submission was lodged on July 3 (for the July 17 meeting). Approval to distribute and conduct the survey was granted by the central body on July 20. No changes were requested. A final copy of the questionnaire was presented together with a copy of the ethics approval to the CEO for final approval.

The questionnaire was then printed in a format so that every response could be optically scanned into a database. Any written responses were recorded by the researcher. The questionnaires were distributed to the employees of the five sites, with different coloured paper used to identify each site. The researcher, with assistance from several volunteers stapled a copy of the questionnaire to all of the employees pay slips over a two week period for the two pay runs: 6th and 13th August 2002.

Each employee received a:

- letter of invitation to participate. This letter included contact details of the researcher and the ethical agreement for anonymity and confidentiality.
- Copy of the questionnaire (see Staff Satisfaction Survey).

There were two components of the questionnaire:

- Page one requested basic demographic information including: occupation, age, gender, mode of employment, length of service, etc.
- A total of 31 questions were asked using a 5 point Likert Scale (strongly agree to strongly disagree)

Participants were initially given until September 30 to complete and return their questionnaires. Rather than a 'follow-up' the time frame was extended until mid December.

The researcher used this opportunity to capture staff opinions on their perceptions and understanding of governance. She included a range of questions in relation to the organisational Mission and Values statements (these had been set by senior management and the Board) and more specifically governance. The questions were:

- *The practices and decisions made by the Board and management match the mission and values statements.*
- *I believe that management and the Board consider staff to be key stakeholders of HealthCo.*
- *I believe my opinions would have little impact on Board decisions.*

The inclusion of these questions was derived from both the researcher's curiosity to see if staff, as key stakeholders believed that they were part of the governance processes, and the academic literature's support for further investigation of stakeholder perceptions of governance (Kendall and Kendall, 1998).

Of the 3762 surveys distributed, a total of 839 completed surveys were returned. This represents a 22% response rate. A full report of the findings regarding staff satisfaction was produced by the researcher and presented to the CEO, who then proposed that it be tabled for discussion at the next meeting of campus heads and divisional managers in January 2003. The researcher did not receive any questions or feedback from management about the report.

5.8.6 Overview of other data sources

There were a series of other data sources that the researcher used to help shape and frame further questions that in turn assisted in the construction of a grounded theoretical perspective on corporate governance. Each of these data sources made a significant contribution to the research. They included: individual stakeholder interviews, notes from meetings as an observer at committee meetings, Board retreats and management planning days and social interactions, the collaborative submission to the *Public Estimates and Accounts Committee*, the *HealthCo* annual reports and the collection of the reflective notes written by the researcher over the eighteen-month period.

5.9 ESTABLISHING TRUSTWORTHINESS IN ANATURALISTIC INQUIRY

The terms 'reliability' and 'validity' are essential components of conventional scientific research. In addition, the study must be capable of being replicated. Lincoln and Guba (1985) argued that these terms are inappropriate for naturalistic

inquiry and that the 'test' of good naturalistic inquiry is in its 'assurance of trustworthiness'. They also claimed that trustworthiness could only be established if the research is able to demonstrate all of the 'techniques' listed in Table 5.4. It is only after the research can demonstrate the use of all of these techniques that it is deemed 'credible', 'transferable', 'dependable' and 'confirmable'.

These terms reflect the different discourse used between quantitative or positivist research to qualitative or naturalistic inquiry. That is, the term validity - both external and internal can be replaced by trustworthiness. Reliability is used in positivist research whereas it is the 'credibility' of naturalistic data. The differences in the meanings of these terms are presented in Table 5.3.

Table 5.3 Comparison of qualitative and quantitative research terms

QUALITATIVE CRITERIA	INTERPRETATION	QUANTITATIVE EQIVALENT	INTERPRETATION
Credibility	Research is able to demonstrate: • Prolonged engagement • Persistent observation • Triangulation (use of different data sources). • External check on inquiry & data eg probing • Member checks Eg returning transcriptions to participants to verify accuracy.	Internal Validity	Internal validity can be defined as how the research can be proven to be a true and accurate description of the particular reality examined. For example, the accuracy of the instruments used in testing etc can jeopardise the internal validity.
Transferability	The ability of the data or research to be used in another context/study.	External Validity	The accuracy for the descriptions of the data to be applied to like groups or samples. The generalisability of the findings in terms of broader application
Dependability	The process and actual collection of data can be audited.	Reliability	The stability and consistency of the measurement. It is the criteria to check if the study can be reproduced using the same procedures.
Confirmability	As above, the research narrative or written report can demonstrate that the researcher was there and the data are real.	Objectivity	The results of the experiment are based on fact.

Source: Adapted from Lincoln Y.S. and Guba, E.G. (1985) *Naturalistic Inquiry*, Sage Publications, Newbury Park, California.

With a heavy reliance on the human instrument (Lincoln and Guba 1985), naturalistic studies reflect the unpredictability of human nature and are based on a cyclic process (Wadsworth, 1997) rather than the more linear and formulaic approach of positivist research. A summary of the essential elements for establishing 'trustworthiness' is presented in Table 5.4.

Table 5.4 Summary of techniques for establishing trustworthiness

Criterion Area		*Technique*
Credibility	(1)	activities in the field that increase the probability Of high credibility
		(a) prolonged engagement
		(b) persistent observation
		(c) triangulation (sources, methods and investigators)
	(2)	peer debriefing
	(3)	negative case analysis
	(4)	referential adequacy
	(5)	member checks (in process and terminal)
Transferability	(6)	thick description
Dependability	(7a)	the dependability audit, including the audit trail
Confirmability	(7b)	the confirmability audit, including the audit trail
All of the above	(8)	the reflexive journal

Adapted from: Lincoln, Y. and Guba, E. 1985, 'Summary of Techniques for Establishing Trustworthiness', *Naturalistic Inquiry*, Sage Publications, Newbury Park, California.

Trustworthiness is said to have been achieved if the four criteria, *credibility, transferability, dependability* and *confirmability* listed above can be demonstrated. Lincoln and Guba (1985) advised that the criteria are not prescriptive of how an inquiry should be constructed. They are to be used to guide and assist the researcher in building the written report.

Trustworthiness of the data and 'high credibility ' can be demonstrated in the study at *HealthCo*. It was a study reliant on 'prolonged and persistent engagement and

observation over a period of time and incorporated various data sources and methods'. The researcher was the only investigator and she kept a 'reflexive journal' over the duration of the research. The 'audit trails' are evident in the passage of the research from its inception to its end. Member checking is the means of confirming the accuracy of interviews. Each of the interviewees in this research received original transcripts and was asked to sign a declaration of their accuracy and authenticity.

The researcher believed that there were clear examples of the level of trust shown to her. They included; sharing an office with the CEO and being granted access to read filed copies of the minutes of all Board meetings. She was also invited to be part of a team with the staff for a fundraising evening.

5.10 TRIANGULATION OF THE DATA

The concept of triangulation in qualitative research can be compared to marine navigation. Triangulation in the marine context is a navigational term used to describe a vessel's position or intended position at sea. It is done by the navigator using at least two, but preferably three reference points or fixes to determine position. In simple terms, a triangle should be able to be drawn in the area so that the navigator can accurately account for and measure the vessel's passage.

Triangulation is also used in other navigational or positioning practices. For example, in military and marine operations to locate an object's exact position by using three reference points. In a naturalistic inquiry the researcher uses

triangulation to show the navigation of the data sources to a central point. The ‘lived experience’ of the researcher is cross referenced using other data sources such as interviews and or other participants to examine a central theme or issue.
Denzin (1989:291) defined triangulation in qualitative research as 'the combination of methodologies in the study of the same phenomenon'. For example, the participant observation and interviews may be supplemented with a survey. Triangulation can also be achieved by using different or 'multiple' data sources and or methods to investigate the research questions or by including different types of data - for example, interviews with different stakeholders or 'actors' in the organisation. Stake provided the following definition:

> Triangulation has been generally considered a process of using multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretation (2000:443).

The importance of multiple sources to confirm data is to develop converging lines (Yin, 1994). The converging lines come together to triangulate the data in the same manner as those from three plotted fixes on a navigational chart.

A variety of techniques and methods were employed to triangulate the data in the research on governance at *HealthCo.* A visual outline of the 'multiple' data sources is shown in Figure 5.1. It also shows the emergent design of the study as each of the sources fed into each other and were cross checked throughout the duration of the study. For example, issues related to governance that emerged in the external interviews became the basis of the questions asked to other identified stakeholders.

If questions and or issues were replicated, the researcher would check any relevant literature. During the study the issue of Board composition emerged through external and other interviews. The researcher 'triangulated' the data with a collection of data sources on Board composition and the broader academic literature to substantiate the issue of Board composition and gender (see Chapter 8).

Figure 5.1: Data sources and methods of triangulation

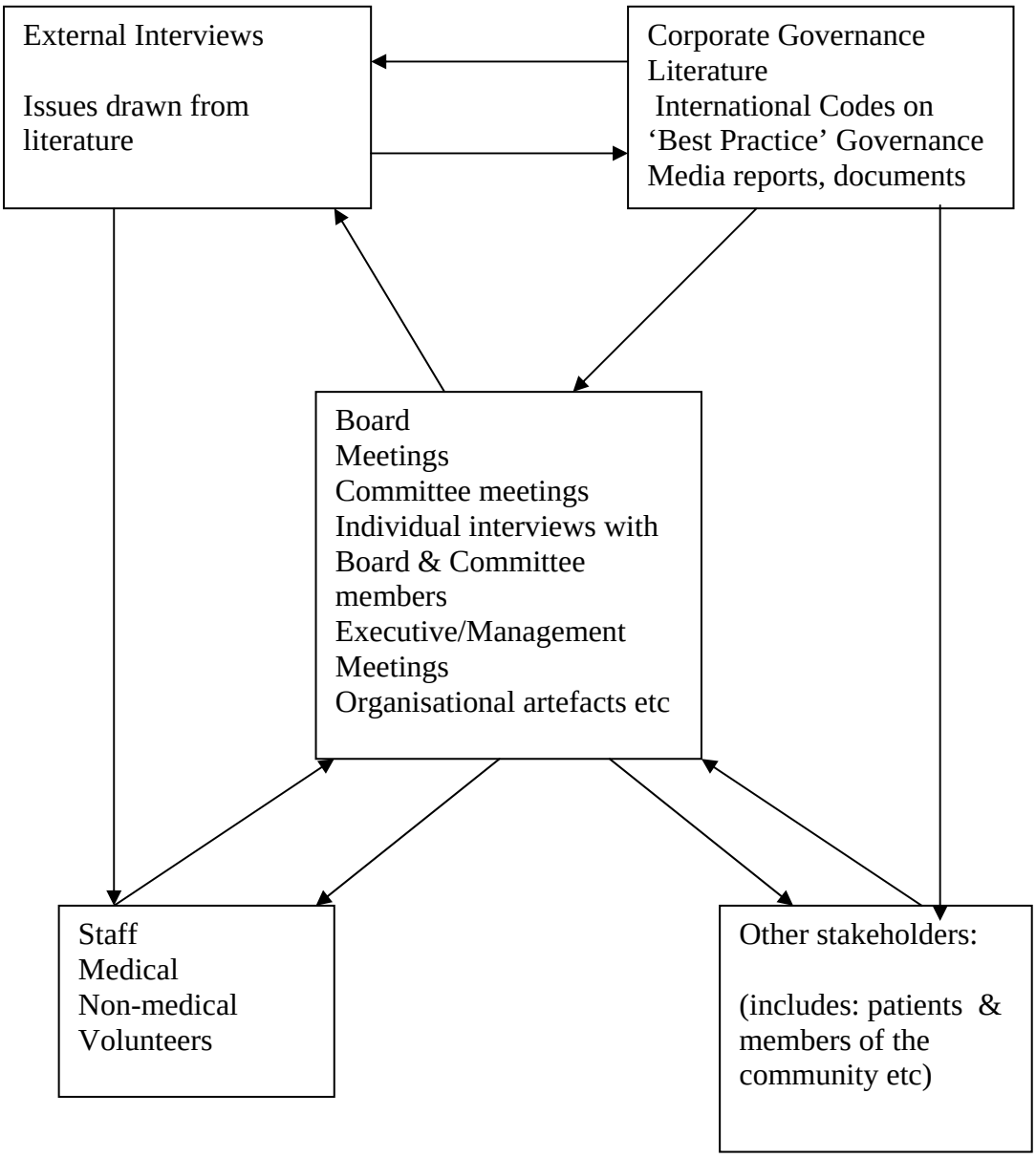


Figure 5.1. This shows the variety of perspectives, questions and issues on governance used to examine and test governance processes. Each box represents a different data source.

5.11 SUMMARY

This chapter outlined the context and setting of the study, the fieldwork including details of the data sources and the research instruments. It also outlined how the study was conducted and described the ethical mechanisms put in place to ensure confidentiality. The chapter details the differences in terms and approaches between positivist and naturalistic research. It concludes with the need to establish trustworthiness in naturalistic inquiry and how this was achieved in this study by using a variety of techniques including member checking and triangulation

In Chapter 6, the key elements used to construct a grounded theoretical model of corporate governance in the Victorian public health sector is outlined.

CHAPTER 6 PRESENTING AND INTERPRETING THE DATA

6.1 INTRODUCTION

Chapter 5 presented the details of the context and setting, data sources, research instruments and methods of establishing trustworthiness. It also outlined how the study was conducted. This chapter begins with a synopsis of the observational data collected. This is presented as *testimonio*, the reflective narration from the notes recorded in the researcher's journal and diaries. The approaches taken to sort and present data from the other major data sources are also outlined (see Table 6.1).

Given the sheer volume of the data collected during the entire study, it is not viable to present a detailed account of the analysis of every data source. Also, some of the data sources revealed little or no new outcomes to add to the inquiry or 'saturation' had been reached (Dick, 2002). This was more specific to the observational data gathered from the various social occasions, with the primary objective of attending these occasions to build a rapport and establish trust with as many people involved with *HealthCo* as possible. Rapport and trust is essential for further questioning and interviewing (Fontana and Frey, 2000).

As previously stated throughout the thesis, the emergent design of the study enabled the researcher to do a broad exploration of the concept of governance. This included over one hundred hours of both formal and informal interviews with those participants who can be described as relevant or significant contributors to the investigation of governance and not only limited to those with direct involvement at *HealthCo*, for example the 'external' governance professionals, who were

interviewed in their own settings. It also included the fieldwork notes recorded in the researcher's journal and diaries of the estimated 500 hours spent as an observer in the various settings that included; Board, committee and senior management meetings, retreats and planning days, on site and the various formal and informal social occasions.

An example of a 'formal' social occasion was when the researcher had prior notice of the event such as a guest at a Board dinner or attendance at the *Annual General Meeting* (AGM) or a fund-raising evening. Examples of informal occasions included the more spontaneous 'corridor conversations', morning teas and lunches. As it was inappropriate for the researcher to record notes during such occasions, she would either write a brief summary of the event in her diary or type notes up after the event. The content of these notes included the type of occasion, date, venue, who was in attendance and reactions to the researcher and any relevant information or questions that arose. This may have included questions about the research and or general discussions on governance between various individuals and the researcher. These notes generated the initial memos that were used to assist in setting an analytic course for the study (Charmaz, 2000).

Table 6.1 Outline of data sources

OBSERVATION	BOARD QUESTIONNAIRES	INTERVIEWS	STAFF QUESTIONNAIRE	SUBMISSION to the PUBLIC ACCOUNTS & ESTIMATES COMMITTEE	ARTEFACTS
• Board meetings • sub-committee meetings • retreats • executive meetings • planning sessions • on-site presence • social occasions	• Board appraisal (1) • Board appraisal (2) • Board appraisal (3)	• 'external' interviews • CEO • Chair • Senior managers • Staff • Community/patients • discussions • emails	• responses to questions • qualitative* comments * despite no room for qualitative comments being allocated at the CEO's request, many of the responses had comments written in the margins next to specific questions. These comments were included as a data source by the researcher.	• notes taken during the preparation of the submissions with the CEO, Chair and other relevant senior executives at *HealthCo*	• annual reports • internal documents (memos, minutes from meetings) • internal communication (newsletters and CEO weekly email message. • External documents – For example *Department of Human Services* memos and newsletters.

6.2 AN ETHNOGRAPHIC ACCOUNT OF THE BOARD AT *HEALTHCO*

Observation of a range of settings, times, places and of different individuals and groups was a significant element of the research. The researcher recognised that one of the major challenges she faced was which data to select from the numerous pages of notes she had written over the duration of the research. Hours of direct observation of what can be deemed as 'formal Board' activity generated pages of notes and memos in this research, likewise, the time spent as a participant/observer on the three main campuses or sites yielded a journal full of entries with descriptions of people, places and events. The researcher in this instance had to critically select what data was the most valuable to report in terms of its relevance to the investigation and its contribution to the study.

Figure 6.1 Collecting the data

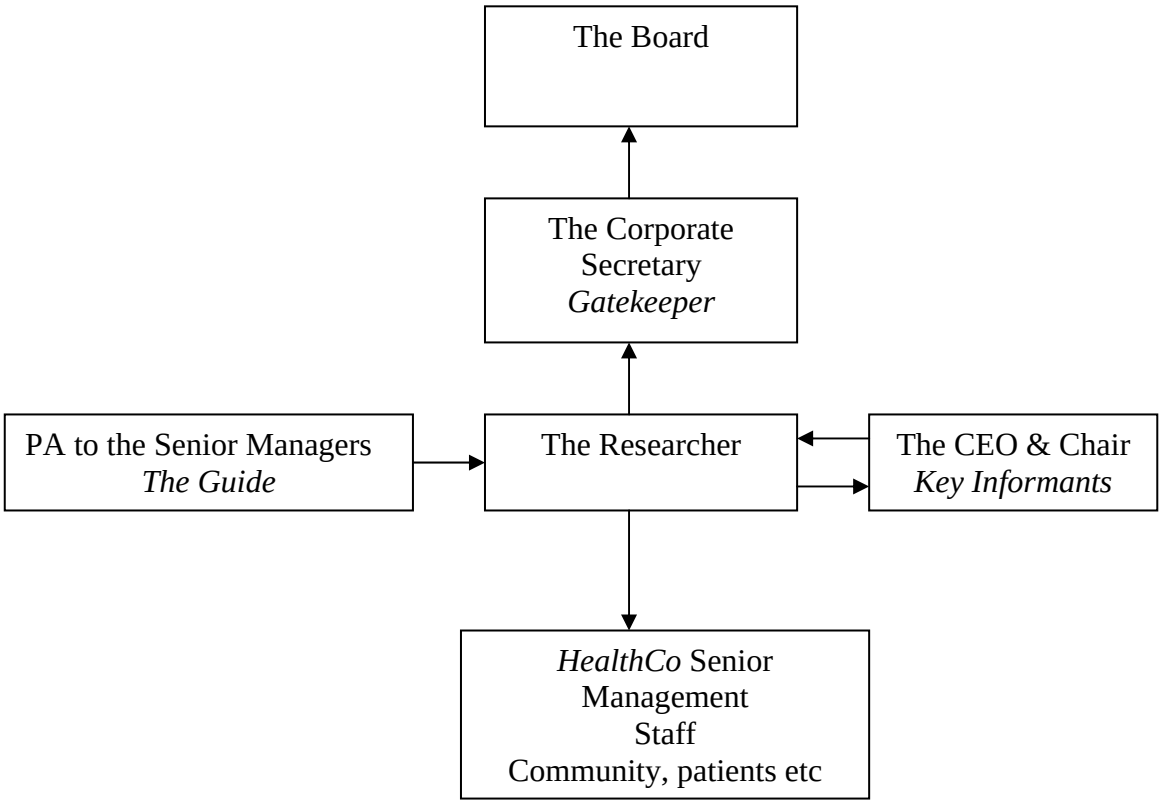


Figure 6.1 shows the line of communication diagrammatically. It also uses the labels of *key informant*, *gatekeeper* and *guide*. The term *key informant* is a common ethnographic label given by a researcher to describe the main person that she/he communicates and collects data from. The term *gatekeeper* is the person who must be approached in order to make contact and collect data from significant persons or groups in the research. The *gatekeeper* in this research was the Corporate Secretary, whose primary role was to ensure that the communication flow to the Board be directed through her. The *guide* was the senior executive administration officer who assisted in guiding the researcher to the areas and people she needed during the research (See Berg 2004:160).

In the initial conceptualisation of this study, the researcher stated that she wanted to 'provide a first-hand account of realities of governance as it happens [via] the direct exposure to governance decision-making'. In following the traditions of anthropological diaries, the researcher's combined personal reflections and notes about the observational data was the narrative or *testimonio*. Beverley described *testimonio* as:

> The presence of the voice, which the reader is meant to experience as the voice of a *real* rather than fictional person, is the mark of a desire not to be silenced or defeated, to impose oneself on an institution of power and privilege from the position of the excluded, the marginal, the subaltern (2000:556).

The researcher was both optimistic and wary as she embarked on her lengthy and unknown journey observing and gathering information from what could be conceived as 'the institution of power and privilege' - the private and confidential area known as corporate governance. In what follows, the researcher's 'trail of discovery' (Descombe, 2003) is narrated through the empirical journey of the perceptions and application of governance in a Victorian public sector health organisation.

6.2.1 Board meetings

Thirteen of the standard monthly Board meetings in the period from November 2001 until December 2002 were observed. Each meeting ran for approximately three hours. Several Board strategic planning days/retreats were also attended and this represented a further total of two days over the duration of the study (14 hours). In addition to these meetings, the researcher also observed three of the mandatory statutory sub-committees of the Board (see Health Services Act 1958 65ZA). They were the: *Community Advisory Committee* (CAC), *Primary Care and Population Health Advisory Committee* (PCPHAC) and the *Quality Committee.* Each of these committees met bi-monthly.

The researcher attended a total of six *CAC* meetings, with the duration of each meeting scheduled for 1.5 hours. She attended one *Quality* meeting (2 hours) and two *PCPHAC* meetings. In addition to the statutory advisory committees, the researcher also attended one of the non-statutory advisory committee meetings on two occasions. *HealthCo's* internal non-mandatory committees were held quarterly. One of the new non-statutory committees failed to meet over the duration of the research.

As advisory committees they were established by the Board prior to the commencement of this study. The names of these committees are not stated for confidentiality purposes given that each metropolitan health service is able to nominate, name and establish any other non-mandatory committees they regard as relevant. After reading the various Health Services annual reports, it was clear that the name of the committee was unique and could identify *HealthCo*.

Over eighty hours were dedicated to specific direct observation of the full Board or individual Board members in their capacity as Chairs or members of sub-committee meetings.

Approximately twenty hours of informal observation and discussion occurred in the researcher's capacity as a guest at Board dinners and lunches. The objective of this social interaction was to develop a relationship based on an interest in the research and trust in the researcher, who was always conscious that studies based on or incorporating observation are heavily reliant on trust (Winkler, 1987).

6.2.2 Observing the Board

In Chapter 3, the background to the creation and establishment of the 'new' Victorian Health services was discussed. *HealthCo* can be described as one of the then twelve (now thirteen) metropolitan Health services, with the formal Board appointments commencing on July 2, 2000. As documented by the Department of Human Services:

> *The Health services are governed by a Board of directors comprising between six and nine members. The Governor in Council appoints Board directors on the recommendation of the Minister. The Governor in Council also appoints the chair of the Board on the recommendation of the Minister…Under the Act each Board must include at "least one person who is able to reflect the perspectives of users of health services". In addition, women and men must be adequately represented…The Act provides for Board directors to hold office for not more than three years from the date of appointment. Directors are eligible for re-appointment for subsequent terms of office* (2002:21).

At the first meeting with the Board as an observer (excluding the initial presentation of the research to the Board several months earlier), there were a total of eight 'non-executive' directors. This included the Chair who was formally appointed by the Minister in accordance with the *Health Services Act*. A ninth director was to commence early in the new year and it was anticipated that this director would attend the first meeting in February as no Board meetings were scheduled in January.

Both the CEO and Corporate Secretary were present as executive officers at each meeting. The role of the CEO was to report to the Board directly and to answer any questions that they may have and to outline proposals for their consideration or approval. The corporate secretary had an administrative role. She was responsible for the distribution of all documents including the agenda and any other materials that may not have been posted to the Board in advance of the meeting. She also recorded the minutes of the meeting.

The researcher asked the CEO how the appointment as Corporate Secretary was made and was told that in this case it was an internal appointment, as *HealthCo* did not have funding for an external appointment with the desired legal background. As the corporate secretary did not hold any legal qualifications, she was sponsored by *HealthCo* to complete the *Australian Institute of Company Directors* course in corporate governance to assist her in this role.

6.2.3 From the outside – a narrative account

These were the notes recorded in the researcher's diary after attending the first Board meeting as an observer. (The notes are written in the present tense, as they are the actual thoughts of the researcher at the time).

Not being familiar with this campus, I am a little unsure of where the entrance to the car park is. It is peak hour and on a main road, there's lots of traffic. I arrive early, but don't want to appear over eager. I wanted to make sure that I would fit in, so I wore what could be described as smart business attire.

Fifteen minutes before the meeting, I decide to make my way to the Boardroom. I notice that the entrance to the main building is bright and what could be described as a contemporary design. I follow the signs to the Executive Offices.

Several of the directors arrive, they greet one another. The door opens and the CEO welcomes me in. The room is much larger than the other Boardroom, but has the same style of high back black leather chairs. The large table is oval in shape. It is

contemporary in style. I am not sure where to sit. I decide on the far end of the table. I say hello to the Chair and the Corporate Secretary who are already in the room. After several minutes, all but two of the directors arrive.

The meeting opens and I am formally introduced by the CEO. I have a pen and my diary. I wait to receive the Agenda from the Corporate Secretary. The first half of the meeting is devoted to the CEO and other management reports, with the report from the Chief Finance Officer taking up the most time. His presentation includes a range of overheads and slides and discussion of where HealthCo is placed against the other health services. It is at this point that I recognise that there is reference to 'our competitors' and make a note of this.

One of the directors arrives thirty minutes after the meeting has started. Another of the female directors arrives half way through the meeting. She sits down and starts reading through the large bundle of documents. I notice that the Chief Finance Officer and one of the Campus Heads stays until the second half of the meeting which is dedicated to the sub-committee reports that are rushed to allow time for the guest presentations. Tonight, the Public Relation's Manager presents a proposal for a new fund raising initiative. I am presenting my research to give the directors an opportunity to ask questions and if any, concerns about the research. This is the last item on the agenda. I am also invited to stay and join the Board for dinner at the conclusion of the meeting.

Summary of the researcher's notes from general observations:

- The meeting could be described as being formal in style and content. That is, the agenda items were followed and questions from individual directors to any of the executive were directed via the Chair.
- Doesn't appear to be much discussion or debate from Board members, almost a basic acceptance of all reports
- One of the Board members makes no eye contact with me and doesn't show much interest in my presentation, choosing to read his papers instead. He doesn't stay for dinner.
- The main speaker throughout the meeting (apart from presenters) is the Chair
- No time limit on any item on the agenda. The finance report runs for over forty-five minutes. As a result, the sub-committee reports have to be rushed through with no discussion.
- I am asked for a comprehensive historical account of corporate governance by one of the directors.

[Memo: Is this a typical meeting? Several directors do not question anything during the meeting. One director appears a little uneasy about my presence. I am surprised by the rich cakes and biscuits served during the meeting considering dinner is to follow and with the discussion about the proposed healthy food and exercise awareness campaign for the community. I make a note to consult the literature to prepare a summary on the history of corporate governance in response to a request by one of the directors.]

6.2.4 Introducing *HealthCo's* directors

In November 2001 there were eight directors. Early in the following year, there were a total of nine directors. Over the duration of the research, various three-year

appointments expired. One of the original directors was not reinstated at the expiration of her term and was replaced by a new director – a male. To protect the anonymity of the directors a general rather than specific description follows. This is based on observation and individual conversations with the directors.

There are an equal number of men and women on the Board. The Chair is a woman in her early 50s with a strong background in public heath. Two of the male directors would be in their mid 50s, one from a medical background, the other a legal professional. Two of the women are senior academics, both in their mid 50s and with research interests and experience that includes public and community health. Three of the other directors are more junior in age. One of them is a female finance professional in her early 30s. One, a male is also in his early 30s and heads several prominent community organisations. The other two directors are male, one in his early 40s, and the other in his early 50s. Both have strong private sector business experience (one of the original Board members, a female in her early 40s with a nursing management background was replaced by the male in his 50s with a private sector business background).

> *[Memo: Did the composition of the Board reflect the guidelines of the Act? Is it important to have a gender and or age balance? Are there any differences between the thinking and actions of male/female or younger/older Board members? What is the relationship between the CEO and Chair like? What is the relationship between the directors and the chair? Is the Board harmonious? How were complex decisions reached?]*

This memo led to a range of codes for some of the existing data – namely questions asked to the external participants concerning Board make-up and balance. The researcher then asked these questions to the Chair and CEO. The researcher wanted to reflect on these questions over the total observation period of the Board, this included observations made during social interactions.

6.2.5 Organisational observation

An estimated total of four hundred and fifty hours was spent as a participant/observer at *HealthCo.* This comprised of two days per week for ten weeks at each of the three main hospital campuses. The researcher incorporated this as part of the study to enable active interaction and engagement with one of the main stakeholders, the staff. She also wanted to experience a 'typical day' that, according to a report to the community in 2001 stated that *HealthCo*:

- treated several hundred people in the Emergency Departments,
- delivered babies,
- served several thousand meals,
- performed between 50 and 80 operations,
- cared for more than 500 patients in hospital beds,
- treated over several hundred outpatients in specialist clinics,

(Note: actual numbers not given for the purposes of confidentiality).

The intent of the researcher in this instance was not to verify the accuracy of these statistics, rather to observe and have an understanding of the daily activities and

engage with the diverse range of staff. The notes written by the researcher describing her first day at *HealthCo* follow.

6.2.6 First impressions – *HealthCo* August 8, 2001

I use the main entrance and pass the cafeteria and the information desk. People are walking on both sides of the corridor. Some are obviously staff as they have identification tags around their necks; some are doctors and or theatre staff who are wearing the disposable protective operating theatre clothing including the 'shower' style caps on their heads.

As I make my way to the lift well, I see the signs to a range of wards including the X-ray and Emergency departments. I travel in the lift that is big enough to take a patient on a trolley as well as about six people.

I arrive at the floor where the Executive Offices are situated. They occupy one half of the floor the other is a general ward. On each side of the main corridor of the executive floor are offices. The first office on the left has 'Chief Executive Officer' on the door – this is the office that I will use as the CEO has recently moved to one of the other campuses. The door is open, but I must meet the Corporate Secretary (CS) (who is also a senior manager) to collect my key. Her office is about twenty metres down on the same side. Her door is open, she is on the phone, and so I sit and wait on a chair outside.

After fifteen minutes has passed, I knock on her door. CS gestures to wait. I introduce myself as she opens her drawer and removes a yellow envelope with my

name on it. She appears rushed and tells me that this is a very important key and to be extremely careful with it. She takes me to the office and swiftly removes some envelopes and emphasises how I must not look at any material with the CEO's name on it. She also locks the filing cabinet and takes the key as I explain that I am to use the top two drawers of the filing cabinet. CS seems very uncomfortable about my presence so I try to make light conversation and ask if there is a staff area to make tea and coffee. She tells me that there is a cafeteria or that I should bring my own cup and tea and coffee and indicates that there is a kitchen that is used to service the patients just near the lift to get boiling water.

After putting some of my things in the office, I head up to Human Resources to collect my identification tag that must be worn by all staff at all times while being on the premises.

(Notes: The title *gatekeeper* allocated to the Corporate Secretary).

6.2.7 Several weeks later

I am only now starting to feel a little more comfortable about being here. CS is still rather cool toward me but I have got to know several staff working on the floor, especially one of the executive assistants who have taken me under her wing and helps me with any of my queries. All of my typed documents go to a shared printer behind her desk, so I see her a lot. While waiting for my document to print, we talk about our mutual weekend activities. During the conversation she politely asks why I bring my own supply of tea bags, I tell her that this is what I have been told to do. She laughs and then shows me two small kitchen/areas on the floor that are available to all staff. Tea, coffee and milk are all supplied.

Memo: this is a busy area as the Boardroom and staffroom are used for meetings. There are lots of people who pass the office often looking back to see who is in the CEO's office. Some people seem quite surprised to see me in the seat and come back for a second look. The offices are well equipped and furnished, but they could not be described as plush or elaborate. The Boardroom has a long classic mahogany polished table and all of the chairs are made of black leather with high backs. Photographs of past and the present Chairpersons are hung on the walls.

6.2.8 Time with the CEO, Chair and other senior managers

As well as observing the Board and Committee meetings, the researcher also attended eight Executive or senior managers meetings. She held ten project meetings with the CEO and Corporate Secretary. This accounted for approximately a further twelve hours of observation by the researcher. The main purpose of the meetings with the CEO and Corporate Secretary was to keep them up to date with the progress of the research. It also allowed for involvement and feedback with the research instruments such as the Board Appraisals.

The CEO could be described as one of the key informants in this study (the other being the Chair), as he was the person with whom the researcher spent the most time overall. It was the Chair's access and knowledge of both *HealthCo* and public health that made her a key informant. Regular and even daily communication with the CEO was common, especially via email that the researcher used to ask questions or to provide details of things that she needed, for example, where to find certain policies and procedures or the contact details of various project staff. This form of communication contributed to the researcher's observations and could be described

as ‘electronic ethnography’ (Pink, 2000:109). The CEO made an effort to reply or answer any questions as soon as he could, with the researcher understanding that this could not always be instant given his commitments. There were several delays in communication that influenced the progress of the study.

The researcher also met with the Chair regularly with the primary purposes of keeping the Chair informed and to gauge the Board’s interest in the study via any feedback to the Chair. For example, the researcher met with the Chair outside of working hours and asked her to trial the *Board Appraisal* that she planned to distribute to the directors. During these meetings, the researcher conducted informal interviews and asked questions regarding both the current and past governance structures and practices, as the Chair had been a former director of the organisation prior to its major restructure and as such, had an extensive knowledge of the public health sector and likewise the community that *HealthCo* serviced.

6.2.9 An overview of the meetings with the Executive, the CEO, Chair and Corporate Secretary

The *HealthCo* Executive met weekly. The location of the meetings rotated between each campus. The researcher attended eight meetings over the course of the study; however, she was not present for the duration of the entire meetings, rather only invited to be present according to her place on the agenda. Her role in this instance was more as a participant/observer than purely observer as senior management were interested in using the researcher’s skills and expertise to design and implement a

staff survey to find out about their perceptions of job satisfaction and how they rated *HealthCo* as an employer.

The researcher was asked by the senior managers to present a proposal on the feasibility of such a survey to the group. This proposal with, if possible, a draft of the survey including a sample of the questions that would be asked was to be presented in one month's time.

As part of her fieldwork, the researcher recorded notes in her diary of her observation. On more than one occasion, she had observed that there was often a level of tension at these meetings. The tension did not appear to be caused by the study as the managers seemed genuinely interested and receptive to the survey and several made positive suggestions regarding its design and distribution. Over the course of the research, the cause of the tension emerged; the impact of several restructures saw a downsizing and some sideways moves with the management team.

6.2.10 The construction and implementation of the – *Staff Satisfaction Survey*

The researcher placed the staff questionnaire as a key agenda item for discussion with the CEO and the Corporate Secretary. Given the size and diversity of the workforce, the researcher needed to workshop ideas regarding the most effective and efficient way to administer the questionnaire. This and other logistical issues were discussed and it was at this meeting, the researcher agreed to design the survey so that it could be electronically scanned for processing and analysis.

Questions specific to governance were allowed to be included as this was the primary focus of the larger research. She was informed by the CEO at this meeting that just prior to the organizational restructure of the health 'network' to the now health service *HealthCo*, a staff survey had been administered and was negatively received by the staff. She was reminded of the need for strict confidentiality and advised that no additional room for comments be included. It was also at this stage that the researcher asked if any additional ethics approval was necessary. The CEO considered that both the University ethics approval and the *Memorandum of Understanding* between the researcher and *HealthCo* were adequate. The findings of this study are presented in Chapter 8.

6.2.11 Social interactions

A range of social occasions such as joining the Board and or the senior managers for lunch and or dinner were listed as social interactions in the researcher's journal. The conversation on these occasions usually concerned more general topics such as current affairs. It was an opportunity for the researcher and the directors to build a personal rapport and understanding. The researcher noted that one of the male directors never stayed for dinner nor engaged in conversation with the researcher. It was the same director who seemed uneasy with the researcher's presence at meetings. The researcher also observed that the CEO appeared to be relaxed and seemed to have a good relationship with all of the directors.

On the days that the researcher was at *HealthCo*, she made an effort to move around to get to know the various departments. She often had lunch in the cafeteria with others on the floor (there was a partitioned area for staff to sit) and or went to some

morning or afternoon teas to celebrate various staff birthdays etc. She attended any general staff information forums or presentations from doctors or nurses on areas of research. She used this as an avenue to get to know some of the staff and this made it easier to ask them questions related to her own work. She was invited to join a table at one of the fund raising evenings and saw this as a positive sign of trust. It also gave her an opportunity to see people in a more relaxed or casual environment, especially the senior managers. Her observations were that in general, there was a good camaraderie between the majority of the staff and a lack of hierarchy, with senior managers, doctors etc mixed amongst general staff.

6.2.11 Summary of observational data

In each of the settings described, the researcher recorded notes of her direct experiences and observations of her inquiry into governance at *HealthCo*. The actual processes and observations are integrated to become the 'thick description', which is a key component of naturalistic inquiry. Examples of the memos are also presented. In the following section, the researcher illustrates the initial coding and categorisation of three questionnaires given to the Board. The analysis of this data, including how it links to the other data sources is presented in Chapter 9.

6.3 THE BOARD'S PERCEPTION OF GOVERNANCE

As previously discussed, three Board appraisals were given to each Board member. The first was posted with materials for the next Board meeting. The other two were given directly to those directors remaining in attendance at a half-day planning

workshop that had been dedicated to a presentation on the clinical governance framework at *HealthCo* and a more general discussion on governance (see Table 6.1). Each of the appraisals contained a range of questions specific to governance. One of the appraisals differed in that it asked the directors to respond to questions on their opinions of their own performance as a health service director. The questions asked, along with the responses given and the researcher's interpretations are presented in Tables 6.2, 6.3 and 6.4.

Table 6. 2 Board self-appraisal (1) (*administered July 2, 2001 – April, 2002)*

Question Area	Responses	Interpretation of responses	Researcher's response based on observations
Corporate Governance			
1. The role, responsibilities and objectives of the Board are clearly stated and well understood by Board members.	1 x strongly agree 6 x agree 1 x undecided	The role, responsibilities and objectives of the Board are both clearly stated and understood.	The directors appear to be confident in their capacity as Board members.
2. The corporate plan of the organisation is regularly reviewed to ensure it remains consistent with the direction the Board wishes to take.	2 x strongly agree. 4 x agree 2 x undecided	The corporate plan is regularly reviewed for consistency of direction the Board wishes to take.	A lot of meeting time dedicated to this – discussion and presentations.
3. The Board and management are successfully communicating the organisation's corporate strategies at all levels within the organisation.	2 x strongly agree 1 x agree 5 x undecided	The Board are not convinced that the Board and management are communicating *HealthCo's* corporate strategies at all levels.	Little evidence to demonstrate successful communication at all levels.
4. The Board ensures that the corporate strategies of the organisation are regularly monitored and reviewed.	2 x strongly agree 3 x agree 2 x undecided	Corporate strategies are regularly monitored and reviewed.	Considerable discussion about corporate strategies.
5. The vision and strategies for the organisation guide the Board's decision making.	2 x strongly agree 6 x agree	Decision-making at Board level is guided by vision and strategies.	Decisions not always determined by 'vision' but rather constrained by budget/government.
6. The Board regularly reviews the performance of management.	4 x agree 3 x undecided 1 x disagree	Not clear agreement on this.	Little discussion of this at meetings.
7. Finances and other resources of the Organisation are well controlled through the finance and audit committees of the Board.	4 x strongly agree 3 x agree	Clear agreement that *HealthCo's* finances are well controlled through the finance and audit committees.	Appears to be. Finance & audit committee always listed as 1st on the agenda and tends to receive most time/discussion.

8. The Board ensures that there is an effective & efficient management and control system in place to see that its plans and decisions are implemented.	2 x strongly agree 4 x agree 2 x undecided	General consensus that effective & efficient management and control systems are in place at *HealthCo* for plans and decisions to be implemented.	Appears to be, although difficulty at times in finding policies related to codes etc.
9. The Board and management maintain effective communication with the Minister on important issues.	3 x strongly agree 4 x agree 1 x undecided	Consensus that effective communication between Board, management & the Minister occurs on important issues.	Communication with Minister is only via CEO (unless a policy Memo or public announcement).
10. The Board and management maintain effective communication with the Director-General on important issues	2 x agree 5 x undecided 1 x no response	Board appears unsure about communication with Director-General.	Not aware of need for communication.
11. A strong sense of coordination and teamwork underpins Boardroom behaviour and decision-making.	3 x strongly agree 4 x agree 1 x no response	Consensus that the *HealthCo* Board is coordinated and makes decisions as a team.	Undecided if Board are a co-ordinated and effective team. (refer observation diarised notes)
12. Board members comply with legal & other statutory requirements imposed upon them.	1 x strongly agree 7 x agree	Full agreement that compliance with legal and statutory requirements met.	No evidence to suggest that they don't.
13. Board members understand the prescribed functions of the Health Service Boards as detailed in the *Health Services Act* 1988.	2 x strongly agree 6 x agree	All agree that they understand their functions as per legislation.	There has been no discussion on this during observed meetings.
14. Board room conflict of interest are effectively avoided.	4 x strongly agree 4 x agree	Consensus that Boardroom conflicts are effectively avoided.	No evidence of conflict witnessed.
15. Board members stay abreast of issues and trends which could affect the strategic or business plan of the organisation.	1 x strongly agree 6 x agree 1 x undecided	*HealthCo* Board members abreast of issues and trends, which may affect the strategic or business plan of the organisation.	Once again, observations suggest that they do.
16. Board members understand the necessity for maintaining confidentiality in the conduct of Board business.	3 x strongly agree 4 x agree 1 x disagree	Majority agree and understand the necessity for confidentiality in relation to Board business, however, one response is 'disagree'.	There have been no recorded breaches of confidentiality during the research period.

17. Board members understand that self-interest comes second to the interests of their organisation	3 x strongly agree 5 x agree	Strong agreement that the interests of *HealthCo* are priority rather than self-interest.	Appears sound. Desire to build partnerships with local organisations rather than 'self'.
18. Board members understand that the role of the Board as a whole is one of governing rather than managing the organisation.	1 x strongly agree 5 x agree 1 x undecided	*HealthCo* Board in agreement that their role is to govern, not to manage.	Appears Board govern and management manage, but committees management 'heavy'.
19. Board members understand the difference between the Board's policy-making role and the role of management to manage.	1 x strongly agree 5 x agree 1 x undecided	*HealthCo* Board members understand the differences between policy making and management.	Board members appear to understand this (see comment above vis committees).
20. The Board is able to clearly communicate its concerns, expectations and ideas to the CEO.	2 x strongly agree 4 x agree 1 x undecided	*HealthCo* Board can communicate with CEO effectively.	Communication appears via Chair (who often speaks as 'we').
21. Board members understand the essential characteristics of governance	1 x strongly agree 5 x agree 1 x undecided	The essential characteristics of governance are understood by the *HealthCo* Board	Appear to but no discussion about the elements of governance *researcher to present to Board.
22. The Board has endorsed a formal fraud control strategy for the organisation	1 x agree 5 x undecided 1 x disagree	*HealthCo* Board unsure if a formal fraud control strategy is in place.	A discussion about this but not finalised over the duration of the research
23. The Board details its corporate governance practices in annual report as an effective way of providing operational transparency for the organisation.	2 x strongly agree 4 x agree 2 x undecided	Majority of Board agree that the governance practices at *HealthCo* are provided in the Annual Report demonstrating operational transparency.	Appears to be evolving in terms of input. A minimal standard listing of activities listed in the Annual Report
24. The Board has been successful in establishing, through management, effective and regular liaison with: • the community • staff	 1 x strongly agree 4 x agree 3 x undecided 1 x strongly agree 6 x agree 1 x undecided	 Majority of Board agree that they have Succeeded, through management with effective and regular liaison with the community. Clear agreement that the Board through management have succeeded with	 Some Board members appear more active than others e.g. attendance at community events. Liaison with staff seems to be management driven.

• employee associations	1 x strongly agree 1 x agree 4 x undecided 2 x no response	effective and regular liaison with staff. Majority are undecided that successful, effective & regular liaison with employee associations occurs.	Little evidence or discussion to support that regular liaison with employee association occurs.
25. The Board and management have been successful in establishing regular liaison with the local community.	1 x strongly agree 6 x agree 1 x undecided	Consensus that Board and management have been successful in establishing regular liaison with the local community.	Appears to be fairly proactive in this area.
26. The Board has put systems in place to assign accountabilities of Board members, committees and auditors for monitoring management.	4 x strongly agree 3 x agree 1 x undecided	Strong agreement that the Board has systems in place to assign accountabilities of Board members, committees and auditors for monitoring management.	Appears to have in place.
27. Board members have a clear understanding of the core business of the organisation and key measures of performance.	2 x strongly agree 6 x agree	Consensus that Board members have a clear understanding of the core business of the organisation and the key members of performance.	The focus of the discussions clearly indicates that this is the case.
28. Board members have a clear understanding of the by-laws of the Health Service.	1 x agree 7 x undecided	Majority of Board members are undecided as to whether they have a clear understanding of the by-laws of the Health Service.	Not discussed at meetings.
29. The Board has access to sources of expert advice.	3 x strongly agree 4 x agree 1 x undecided	Majority of Board members agree that they have access to sources of expert advice.	'Experts' often make presentations as special 'guests' at conclusion of Board meetings.
Health Service Delivery and Policy			
30.The Board ensures, through management, that the quality of service delivery is continually monitored and improvements made where necessary.	4 x strongly agree 4 x agree	Consensus that the Board ensures, through management that the quality of service delivery is continually monitored and improvements made where necessary.	Appears to – predominantly via *Quality Committee*.
31. The Board ensures that it is	2 x strongly agree	Despite a majority, there is a level of	Some discussion on this at

continually kept aware of the health status of its community and changes in demography.	3 x agree 2 x undecided 1 x disagree	uncertainty as to whether the Board is kept aware of the health status of its community and changes in demography.	meetings – usually receives information via the relevant sub-committees.
32. The Board ensures that there is an appropriate balance between prevention, early intervention, curative, rehabilitative/palliative care	1 x strongly agree 3 x agree 2 x undecided 1 x disagree 1 x no answer	Level of indecision as to whether Board ensures that there is an appropriate balance between prevention, early intervention, curative, rehabilitative/palliative care.	Not generally discussed at Board meetings, rather, discussion occurs in *Quality* and the *Population Committees* – also as part of clinical governance. Should this be role of a Board?
33. The Board ensures it is kept abreast of any changes in major health policies	2 x strongly agree 3 x agree 2 x undecided 1 x disagree	Majority of Board agree that it is kept abreast of any changes in major health policies. One member disagrees.	No discussion of changes in Health policies at meetings. Rather, funding and change of government.
34. The Board monitors the impact which these changes may have on an organisation.	1 x strongly agree 4 x agree 2 x undecided 1 x no answer	Majority of Board members in agreement that it monitors the impact which these changes (major health policies) have on their organisation.	No evidence of monitoring changes. Tends to happen at Executive level.
The Board's committee structure			
35. The Board receives sufficient, appropriate and timely information from the following committees, or their equivalents: • finance & audit committee • quality committee • community committee	5 x strongly agree 3 x agree 4 x strongly agree 4 x agree 3 x strongly agree 1 x agree 1 x undecided 3 x disagree	Consensus of agreement on receipt of appropriate and timely information for finance & audit committee. Consensus for quality committee. Split decision whether the Board receives sufficient, appropriate & timely information from the community committee	The finance and audit committee are considered to be exemplary in terms of efficiency and detailed reporting by all of the directors. Finance always dominates discussions at meetings Appears to. Little evidence of this.

• population committee	1 x strongly agree 1 x agree 2 x undecided 3 x disagree 1 x no answer	Majority of Board members indicate that they do not receive sufficient, appropriate & timely information from the population committee.	Limited discussion * general observations of other non-statutory meetings, tend to be less 'formal' in format with more questioning and discussion.
Board Composition			
36. The range of qualifications and experience that individual Board members bring to the Board enhances its ability to govern.	4 x strongly agree 4 x agree	Consensus that the range of skills and qualifications of Board members enhances *HealthCo's* ability to govern.	Appears to be working successfully.
Board meetings			
37. The Board ensures it has been provided with meeting agendas, accompanied with the necessary information far enough in advance of the scheduled meetings to: • be adequately prepared.	3 x strongly agree 3 x agree 2 x disagree	Not all Board members agree that they receive agendas and necessary information to be adequately prepared.	Evidence that there is delay at times.
• make sure the agenda enables Board business to be dealt with efficiently.	3 x strongly agree 5 x agree	Consensus that information is received in advance to ensure the agenda allows Board business to be dealt with efficiently. Despite majority agreeing that there is sufficient time for discussion of issues requiring major decisions, 1 Board member disagrees that materials are received in advance.	Appears to be working. The agenda is followed, but there are no time restraints on items. Finance report always takes up the most time with little time for discussion on issues raised in sub-committee reports. * appears to be an assumption that the reports are read.
• make sure there is sufficient time for discussion of issues requiring major decisions.	3 x strongly agree 4 x agree 1 x disagree		
38. Board meetings are conducted in a way	4 x strongly agree	Consensus that Board meetings are	Finance tends to dominate

that encourages contributions from all Board members, constructive participation and timely decision-making.	4 x agree	conducted to encourage equitable contribution and constructive. participation from all Board members.	discussions. Formal in format, little interaction between directors.
39. The frequency of scheduled Board meetings is appropriate in order to address the business of the organisation effectively.	4 x strongly agree 4 x agree	Consensus that the frequency of the Board meetings is appropriate to address the business of the organisation effectively.	Frequency of meetings seems appropriate, but agenda is always dominated by finance.
40. The most effective way of finalising decisions of the Board is by consensus rather than formal vote.	3 x strongly agree 5 x agree	Unanimous opinion is the most effective way of finalising *HealthCo* Board decisions rather than formal vote.	'formal voting' not evidenced at meetings.
Board CEO relationships			
41. The Board's communication with management through the CEO is open, honest and based on mutual respect.	4 x strongly agree 4 x agree	Consensus that the Board's communication with management, through the CEO, is open, honest and based on mutual respect.	Undecided – some managers definitely 'not' communicating in this manner. Constant restructure and level of uncertainty.
42. The Board has ensured that the CEO has sufficient delegated authority to manage the Organisation.	4 x strongly agree 4 x agree	Consensus that the Board has ensured that the CEO has sufficient delegated authority to manage the Organisation.	Appears to have appropriate level of delegated authority.
43. The Board is satisfied that steps have been taken to develop members skills and update their knowledge by:			
• the provision of a comprehensive and informative orientation program for new Board members.	1 x strongly agree 3 x agree 3 x undecided 1 x disagree	Not clear agreement that there is a comprehensive & informative orientation program for new Board members.	Not aware of one.
• access to continuing education and training programs.	1 x agree 4 x undecided 3 x disagree	Undecided/disagree that there is access to continuing education and training programs.	No education/training provided during study apart from presentations on study etc.
• suggestions for improving the Board's	3 x agree	Indecision/disagreement that suggestions	

performance.	2 x undecided 3 x disagree	for improving the Board's performance are made.	Not really offered. Little incentive/interest in 'appraisal' documents.

A full annotation of Table 6.1 follows after Figure 6.2 below. This figure was created from the shaded areas in this table. The shading highlights areas where the researcher noticed either differences in the perceptions of the director's or clear disagreement regarding various questions. The text is also coloured in blue in Column 3 'Interpretation of responses' to represent uncertainty/indecision or disagreement to statements. The researcher's responses based on observation are in pale blue indication that there she had observed these indecisions/disagreements. The text is in plum when clear consensus reached and the researcher's observations supported the agreement. These became the basis of Figure 6.2. It is an example of the method used by the researcher to establish initial categorisation, coding and theoretical note making from the data. This was done for each data source and emerging patterns and themes were compared from each data source. Key similarities and differences led to theory construction. Tables 6.2 – 6.4 are also shaded in the same manner.

Figure 6.2 Examples of early coding and development of theoretical notes from Board self-appraisal 1

Category	Code	Researcher's observations	Theoretical notes
Corporate Governance	Organisational Vision	*Decisions not always determined by*	Decision making may be
	(Board's decision making processes)	*Vision but maybe constrained.…..*	overshadowed by economics
	Review of Management Performance	*Little discussion of this at meetings*	Is this one of Board's roles?
	Communication/Teamwork	*Difficult to see evidence of this*	Governance requires teamwork?
	Essential characteristics of governance	*Not evidenced at meetings*	Essential elements of governance?
	Bi-Laws of the Health Service	*No discussion at meetings*	Knowledge of all legal areas
Health Service Delivery & Policy	Health care prevention through to Palliative care	*Indecision*	Role of Board?
Committee Structure Finance & Audit	Timing of information to Board	*Agreement & Satisfaction*	Finance & Audit priority
Community Committee	"	*Difficult to ascertain*	Communication/links with stakeholders
Board Composition	Skills/qualifications	*Happy with skills & qualifications*	Skills in governance
Board Meetings	Information for meetings	*Indication that could be better*	Flow of Information/timing
Agenda items	Time spent on items	*Assumption that all read materials*	Construction of an agenda
		Dominance of finance	Discussion
Board/CEO Relationships	Communication managers/CEO	*Not apparent, level of uncertainty*	Transparency of relationships
Education & Training	Skills/ Knowledge of role	*No formal training/education*	Significance of training vis roles
Performance of Board	Measurement of Outcomes	*Little evidence of discussion*	Performance in governance

Table 6.2 consists of four columns. The first column is a copy of the 43 questions contained in the appraisal. The questions are grouped into the categories of governance as outlined in the original appraisal. The six categories are: *corporate governance, health service delivery and policy, the Board's committee structure, Board composition, Board meetings*, and *Board CEO relationships.* The total of the individual responses are shown in the second column. The third column is an interpretation of the collective responses in terms of agreement/disagreement or indecision to each question. In the final column, the researcher's comments/memos based on this information combined with her own observations' of Board and committee meetings and discussions with the Chair and CEO are presented. Eight sections within the table are shaded to indicate initial coding of the data. The shading indicates possible differences between the Board's perceptions and answers to questions and the observations made by the researcher. These formed the basis of further inquiry. The researcher's overall interpretation of the data in relation to each of the six categories follows below.

6.3.1 Corporate Governance

The majority of the directors say that they have a good understanding of their roles and responsibilities and from observations this appears to be the case. This includes the distinction between their roles as directors versus that of management. That is, the directors agree that it is their role to strategically direct *HealthCo* and allow the executives to manage the organisation's operational functions. However, the responses given by the directors were split and the researcher found little evidence in relation to Question 6: *The Board regularly reviews the performance of management*.

The researcher observed that several senior managers were always present for the first half of Board meetings. They included the Chief Finance and Medical Officers, the Public Relations Manager and the various heads of campuses. Most of the sub-committees comprised of two or more managers. Whilst this does not reveal any interference with each role, it indicates that *HealthCo's* governance structure included a strong representation and management input from the sub-committees of the Board.

The directors perceived that they operated as a team, the researcher however, noticed the dominance of some Board members and little verbal contribution from others. In a summary of the notes written by the researcher based on her observations she had written: *Doesn't appear to be much discussion or debate from Board members, almost a basic acceptance of all reports*. The researcher used the code 'Communication' from this and again investigated if this emerged in other data sources.

The researcher agreed that the Board and management had not fully communicated *HealthCo's* corporate strategies at all levels of the organisation and this was evidenced in the *Staff Satisfaction Survey* responses to an awareness of the organisational Mission and Values (see Chapter 9). There appeared a general level of uncertainty by some of the senior managers and this could have been influenced by a series of changes and restructures that were occurring during the study (*HealthCo's* organisational structure was changed three times over this period). The changes were not simply new managers, but actual shifts in the level of key positions. The

researcher referred to the Annual Report to confirm this. The researcher also noted that the decisions made at times appeared to be constrained by budget and funding. Neither the Board nor the researcher knew whether the performance of management was regularly reviewed and what the process for performance actually was. After the distribution of the self-appraisal, the researcher agreed to do a presentation on governance after several requests from directors. In this presentation, the researcher discussed the 'essential characteristics' (see question 21) of governance along with a discussion of the results of the appraisal. One of the outcomes of this presentation was a discussion on the content of *HealthCo's* by-laws (see question 28).

6.3.2 Health service delivery and policy

The quality of service delivery was considered extremely important by the Board. They were unclear as to whether they were kept abreast of any changes in major health policies and/or monitored the impact of these changes. The researcher did not witness any major discussion on health policies at Board or organisational level. There was a level of indecision as to whether the Board ensured that an appropriate balance between prevention of disease and illness and rehabilitative/palliative care occurred (see question 32). The researcher consulted with the CEO and Chair regarding this level of indecision and it was their opinion that this was more of a practitioner rather than Board responsibility. Overall, the researcher believed that the quality of the health service and delivery was monitored effectively through the *Quality* and the *Primary Care and Population* committees. This perception was based on her observations of the discussion and procedures whilst in attendance at the two committee meetings. Both of these sub-committees were mandatory as part

of the governance structure for Health Services according to the *Health Services Act 1988*.

6.3.3 The Board's committee structure

The general consensus of the directors was that the delivery of information from the various committees was appropriate and timely. There was full agreement that both the *Finance and Audit* and the *Quality* committees provided appropriate and timely information. There was a level of indecision that the *Community Advisory Committee* provided adequate and timely information. The majority of Board members felt that that they had not received sufficient, appropriate and timely information from the population committee. The researcher believed that in terms of reporting, the order of the agenda may influence this as the *Audit and Finance* and the *Quality Committees* were always listed as the two first reports and often Board meetings ran over time with 'expert' speakers waiting to present and as such, other tabled committee reports were not discussed. She also observed that there was a contrast in the level of formality between the full Board and sub-committee meetings. That is, in general, the Board meetings observed formal meeting protocols. Several of the sub committees, in particular the non-statutory committees, adopted a more casual approach. However, this may have been the result of the type of meeting – for example; the Chair of the advisory committee had a very personable approach. There appeared genuine open discussion and involvement at these meetings. The *Quality* Committee meetings followed the Board meeting format and the researcher observed that they had large numbers in attendance.

6.3.4 Board composition

There was a full consensus that the range of skills and qualifications of each of the directors enhanced *HealthCo's* ability to govern. The researcher considered that there was a good mix and balance of professional skills offered by each director to assist in the effective governance of *HealthCo.* She believed that the Board mirrored the desired composition as outlined in the *Health Services Act* (Further discussion of Board composition is presented in Chapter 9).

6.3.5 Board meetings

Overall, the Board considered that meetings were conducted effectively and efficiently. However, some Board members indicated that they did not always receive their agendas and papers far enough in advance to be as prepared as they could for meetings. Despite requesting an agenda in advance, the researcher more often received a copy of the agenda on the night of the meeting. The researcher observed that several directors did not appear to have pre-read their Board materials that were posted out several weeks in advance of the meetings. This observation was made as she watched several directors open the package for what appeared to be the first time. She also noted that some of the other directors had highlighted markings on their notes and referred to specific items from the materials. She concluded that the directors who had such notes tended to be more vocal and make more contribution to the discussions than those who may have been reading their materials for the first time.

6.3.6 Board/CEO relationships

The majority of directors, including the Chair, indicated that they had good communication with the CEO and that they ensured that he had sufficient delegated authority to manage *HealthCo*. The researcher observed good communication with each of the director's and the CEO. She noted that the relationship between the CEO and Chair seemed to be based on mutual respect. This category also had questions related to the Board's orientation, education and training programs. There was no agreement about a comprehensive and informative orientation program for new Board members, and indecision and disagreement about access to continuing education and training programs. Indecision was the overall comment for the final question on suggestions for the Board's performance.

The researcher agreed with the overall Board opinion and was not aware of any orientation, training or on-going education on governance for the directors. She was told by the Chair, that the *Department of Human Services* conducted an orientation workshop for the members of the newly formed *HealthCo* Board in July 2000. At this time, two of the directors had not yet been officially appointed and so this could account for two of the indecision/disagreement responses. This led the researcher to ask each director if they had knowledge of attending an orientation or training/education session since joining the Board. Most indicated that this was not offered and that they would welcome an opportunity to have access to training and or education in specific areas, this included performance measurement and clinical governance. There was no formal evaluation of the Board or individual director's performance over the duration of the study.

6.3.7 Memos and emerging themes from the Board appraisal (1)

The researcher recorded a number of memos after reading the self-appraisal. These formed the basis of further inquiry, predominantly individual questions to the CEO, Chair and the directors. The memos recorded by the researcher were:

> *[What evidence is there of successful communication by both the Board and management of HealthCo's corporate strategies at all levels of the organisation? (Q3). Is such communication an important element of governance?]*
>
> *[Is HealthCo's 'vision' discussed at meetings or incorporated as part of the decision making process (Q.5)]*
>
> *[Is the performance of management actively reviewed by the Board (Q.6)? That is, is management performance itemised as an agenda item at meetings or is it seen as confidential?]*
>
> *[Do the Board and management need to communicate directly with the Director-General (Q.10)? Under what circumstances? Is this mentioned in the Act?]*
>
> *[Does the Board operate as a team (Q.11)? Does 'good teamwork' make/ enhance governance? How can individual directors become better team players?]*
>
> *[Is the Health Services Act 1988 ever discussed in terms of directors' roles and responsibilities (Q.12)?]*
>
> *[Is there evidence of conflicts of interest (Q.13)?]*
>
> *[Does the Board govern or are they involved with management of the organisation (Q.18]*

[What are the essential characteristics of governance (Q.21)? How are they interpreted or demonstrated?]

[Are and should the Board be actively involved in the Annual Report (Q.23)? What is their level of involvement? How does this influence effective governance?]

[How does the Board liaise with the 'community', 'staff' 'employee associations'(Q.24). Is this important?]

[Are the by-laws of HealthCo ever discussed/reviewed (Q.28)?]

[How does the Board stay aware of the health status of the community and changes in demography (Q.31)?]

[Should the Board have a role in the balance between prevention, rehabilitative and palliative care (Q 32.)? How? Why?]

[How are the changes in health policy conveyed to the Board (Q.33)?]

[How is the information from the three committees distributed (Q.35) Who is responsible for distribution?]

[Are the skills, qualifications and experience of each individual director known to the Board (Q.36)? Are these skills fully utilised?]

[Are there established timelines for receiving the agenda and relevant materials for meetings? (Q.37)]

[Are decision-making processes at HealthCo based on consensus or formal vote (Q.40)]?

[What is the communication between the CEO and managers and the CEO and the Board (Q.41)? Are there for example noticeable tensions? Is there evidence of mutual respect, trust etc?]

[Is or was there an orientation for new directors (Q.43)? When does/did it occur and what is covered in the orientation? Do directors have access to training and education? Is it necessary to conduct education/training sessions? Why? Why not?

Are their suggestions for improving the Board's performance and how are they received?]

These questions formed the basis of inquiry and analysis of the subsequent appraisals that were administered to those Board members in attendance at the half-day workshop on governance and clinical governance. The appraisals were given to the Board prior to the end of the workshop and unfortunately only four of the nine Board members remained for the second part of the workshop. The questions, responses and comments of these further appraisals are presented in Tables 6.4 and 6.5. The comments included notes from the on-going observation of the Board since the first appraisal was administered.

Table 6.3 Board self-appraisal (2) *(Administered October 14, 2002)*

Question	Response (1-10)	Comments	Researcher's interpretation
1. Rate your knowledge of and familiarity with the organisation on whose Board you serve, regarding services, key personnel, corporate mission, goals and objectives.	6, 7, 8, 10	Sound - High knowledge & familiarity of the organization its mission and objectives.	Appears sound.
2. How well do you understand your own responsibilities as a Board member?	7, 8 x 2, 10	Sound – high understanding of own responsibilities as Board member.	Appears sound.
3. Rate your relationship with other directors.	6, 8 x 2, 10	Sound/good relationship with Others.	Level of camaraderie observed.
4. Rate your knowledge of the health care industry compared to other hospital Board members nationwide.	5, 7, 8 x2	Moderate knowledge of healthcare industry nationwide.	Not tested.
5. Rate your understanding of the Health Service competitors in the marketplace.	N/a, 4, 5, 8	Poor- average understanding of health service competitors.	Directors don't regard other health services as 'competitors'.
6. Rate your involvement in the process of overseeing management recommendations for corporate goals and objectives.	4, 5, 6, 10	Moderate involvement in overseeing Management vis recommendations and corporate goals.	Agree.
7. Rate your knowledge of the hospitals' physical facilities, for maintenance or replacement.	4 x 3, 10	Poor knowledge of hospital facilities for maintenance etc.	Despite rotational campus meetings knowledge of each hospital/campus appears somewhat limited.
8. Rate your attendance at Board and committee meetings.	9, 10 x 3	100% attendance at Board/ committee meetings.	Individual attendance rates high, however, concern over some directors constantly late or leave prior to end of meeting and or non-attendance at planning/ retreat days.
9. Rate your participation in Board meetings.	7, 8,	Strong participation in Board	Some more involved and 'vocal'

	9, 10	meetings	than others
10. Rate your reading of minutes and other information prior to Board and committee meetings.	9 x 2, 10 x 2	Strong/high reading of minutes prior to meetings.	Some members have highlights on minutes/materials. Several directors appear to arrive with their materials freshly opened.
11. Rate your willingness to keep Board and committee discussions out of non-policy management operating issues.	7 x 2, 10 x2	Moderate/ high willingness to keep committee discussions out of non-policy areas.	Appears sound.
12. Are there any real or potential conflicts of interest in your services as a member or officer of the Board?	NO (4)	NO	None witnessed.
13. What do you feel are your strongest areas of knowledge, experience, and competence? (Mark all that apply) Advertising and promotion Consumer wants and habits (3) Employee relations (2) Energy Engineering Environmental issues (2) Financial management (3) Governmental affairs (local) (1) Governmental affairs (state and national) (3) Investments (1) Legal Management information systems (1) Materials management Medicine (1) Marketing (1) New product or service introduction Planning (3) Real Estate		3 x consumer wants & habits 2 x employee relations 2 x environmental issues 3 x financial issues 1 x local governmental affairs 3 x state and national gov't affairs 1 x investments 1 x management info systems 1 x medicine 1 x marketing 3 x planning	*Strongest:* • consumer wants and habits • Gov't affairs, state/national • planning *Medium:* • employee relations, • environmental issues *Others indicated*: • medicine, • marketing • Investments, • local gov't affairs, • management info systems *Possible gaps appear to be*: • advertising & promotion • energy • engineering • legal

Technology Memo[are all areas required? E.g. energy, engineering?]			• materials management • new product or service intro • real estate • technology.
14. Are there any areas of expertise that the Board or CEO are not using to get the greatest benefit from directors on the health service?	YES YES NO x 2	Planning – at earlier stage employee relations. fundraising and investment strategies.	This information needs to be fed back to the CEO.
15. Rate your overall performance as a member of this Board.	7, 8 x 2, 10	Moderate - high performance.	Difficult to fully assess as no defined performance indicators.

Table 6.4 Board appraisal 3 ***(Administered October 14, 2002)***

Question	**Response** (1-10) or Yes/No	**Comments**	**Researcher's interpretation**
1. The Board periodically reviews the mission statement and corporate objectives to determine both current and future direction of the institution.	8 x 2 9 x 1 10 x 1	Regular review.	Mission statement is reinforced at meetings.
2. The Board understands and accepts its responsibility for reviewing the appropriateness of long-range planning and corporate strategy.	8 x 2, 9 x 1 10 x 1	High understanding and acceptance of reviewing corporate strategy.	Appears to understand this.
3. The Board assists management to review its short and long range planning assumptions as they relate to economic, political and market projections.	3 x 1 6 x1 9 x 2	Moderate assistance with management.	Appears to come from management then to Board.
4. The Board periodically studies the institution's competitive position in its market by assisting management to review comparative trends and data concerning similar organisations.	3 x 1 4 x 1 6 x 1 n/a x 1	Poor/low study of competitive position.	The CEO is active in this. The Boar don't seem to be concerned about 'competitors'.

5. Does the management information system for the organisation allow for sophisticated planning techniques?	YES x 2 NO x 1 Don't Know	Mixed if whether this allows for sophisticated planning.	Not discussed.
6. Does the Board regularly refer to approved goals, objectives, and plans to guide its decision making process?	YES x 4	YES regularly refers to approved goals/objectives.	Often discussed – particularly in terms of meeting government set *Performance Indicators*.
7. Is there an understanding and acceptance that the organisation is managed and led by the CEO, who serves at the pleasure of the Board?	YES x 4	YES – acceptance of how CEO leads Board.	Appears to have good support, especially from Chair.
8. Does the Board understand its need for a succession plan for the position of CEO that includes how people will be identified, reviewed, and selected – whether internally or externally?	YES x3 NO x 1	Appears that understanding of its need for a succession plan for CEO.	This issue was raised at several meetings.
9. Does the Board have a succession plan for itself, in terms of how Board members are identified, reviewed and selected?	NO x 2 YES 1 x n/a	Undecided regarding succession plan for itself. Memo [Is this not Ministerial duty?]	Board members are selected by the Minister. Chair & CEO can make recommendations only.
10. Does the Board have a written conflict of interest policy that reviews annually and Board member's business that does business with the health service?	NO x2 YES x 2	Equal split concerning conflict of interest policy.	Not really on the agenda.
11. Other than their Board service, are there any services that are sold to the institution by members of the Board?	1 x none 1 x3	None.	Appears that there aren't any.
12. Has the Board's structure been designed to help the institution achieve its purposes and goals?	YES x 4	Board's structure designed to help the institution achieve its purposes and goals.	Yes.
13. Does the Board have an adequate range of expertise and Board experience to make it effective?	YES x 4	YES – unanimous that Board has adequate range of expertise and Board experience.	Board members appear happy with the expertise offered by others.
14. Are the majority of directors devoting adequate time to their Board responsibilities?	YES x 4	Unanimous – majority of Board members devoting adequate time for Board duties.	Most appear to some Board members continually late. One does not stay for meals).

15. Should the Board consider changes in its by-laws concerning any of the following: Board size? Age Composition? Sex composition? Geographical composition? Tenure in office? Compensation? Membership on Boards or partnerships or competing organisations?	NO x3 NO x3 NO x3 NO x3 NO x3 NO x 3, YES NO x 3 (*all above determined by gov't*).	Agreement with: Board size, age gender, geographical, tenure. compensation = 1 yes One of the Board members commented that these elements are pre-determined by the government.	Current arrangements appear to be working. This is not listed in the by-laws. Memo [this may ensure equitable selection – rather than 'old boy network'?] Memo[This is listed in the *Health Services Act 1988*. Should not be part of bylaws?
16. Should the committee system be reviewed and revised?	NO x2, NO (*just Completed*) 1 x n/a	No need to review & revise committee system.	The committee system appears to be working. Two of the committe less active.
17. Do all committees have written statements of purpose?	YES x 4 (*align objectives to organisation*)	Unanimous all committees have written statements of purpose.	One of the committees took over 12 months to complete this.
18. Do all Board members serve on at least one committee?	YES x 4	Unanimous – all Board members serve on at least one committee.	YES.
19. How would you rate the chairperson's ability to run effective meetings?	8, 9, 10 1 x n/a	Meetings are effectively run by the Chair.	Need to allocate time – sub-com minutes always rushed.
20. Does the chairperson of the Board have a written position description and personal specifications?	NO x 3, *(not aware of)* 1 x n/a	Appears no written position description and personal specifications.	Have not seen evidence of.
21. How would you rate the Board's ability to focus on substantial policy matters as opposed to minutiae and administrative details?	6, 7, 10 x 2	Moderate/high ability of Board to focus on substantial policy matters rather than minutiae.	Focus of discussions as per agenda/business issues–details/ 'minutiae' left for management to discuss.
22. Does a specific committee (i.e. executive compensation, audit, or personnel) have a responsibility for evaluation of the CEO's performance and compensation?	YES x 3 NO x 1 ? x 1	Appears there is a specific committee for executive and CEO performance and compensation.	Part of finance & audit portfolio.

23. Does the Board have a list of specifications for Board membership?	NO x 2, YES No answer	Appears not clear if a list of specification for Board membership exists.	Have not seen one
24. Does the Board do a strengths and weaknesses audit to pinpoint areas of expertise that it lacks?	NO x 2, YES No answer	Undecided if strengths/ weakness audit happens	Never discussed at meetings.
25. Does the Board have a disciplinary policy for Board members?	NO x 3 No answer	No disciplinary policy for Board members	Never discussed at meetings.
26. Does it have a plan to get rid of non-contributing Board members?	NO x 3 No answer	No plan to get rid of non-contributing Board members	Never discussed Memo [Is this role of Board or in legislation?]
27. Does the Board understand and accept its fiduciary accountability in areas of financial performance?	YES x 4	Full agreement that fiduciary accountability vis financial performance understood and accepted.	Full agreement. However, often concerns raised that difficult to meet budgets.
28. Does the Board regularly get financial information and data that are understandable, timely and useful?	YES x 4	Full agreement that financial information data can be understood, is timely and useful.	No evidence of problems. *Memo* [Do no questions mean that it is understood?]
29. Does the Board feel there is adequate opportunity to discuss trends in the organisation's financial performance?	YES x 4	Full agreement that there is adequate opportunity to discuss trends in the organisation's financial performance.	Considerable meeting time given to this.
30. Does the Board have an approved audit policy, and does it review the implementation of auditor's recommendations?	YES x 4	Full agreement that there is an approved audit policy and review of auditor recommendations	Appears sound. Reported in annual report as part of demonstration of accountability.
31. Does the Board annually approve and select outside auditors?	NO (*gov't Does*) YES x2 No answer	Undecided. 1 member acknowledges auditors appointed by government.	This is 'external'. Part of legislation Not role of Board.
32. Does the Board have a written policy and procedure for CEO evaluation and compensation?	YES x 3 1 x NO	Appears that there is a written policy for CEO evaluation and performance	Have not been privy to this.

33. Does the Board have an established set of performance standards of criteria that allow for periodic evaluation of a director's performance?	NO x 3 YES	Appears no established set of performance standards or criteria for periodic evaluation of a director's performance.	None witnessed. Appraisals to assist in this?
34. Does the Board understand the art of asking penetrating pertinent questions?	YES x 3 NO	Appears agreement that Board skilled in asking penetrating and pertinent questions.	Most directors. Several directors rarely ask questions or make comment.
35. Does the Board have an educational development policy with annual time requirements for all directors?	NO x 3 YES	Appears no policy on educational development for all Board members.	None seen.
36. Does the CEO have the necessary authority to manage the organisation?	YES x 4	Full agreement that CEO has necessary authority to manage the organization.	Appears to have necessary authority.
37. Does the Board understand the need to ensure that the institution is understood and appreciated by its publics?	YES x 4	Full agreement that the Board needs to ensure that the institution is understood and appreciated by its publics.	This appears to be very important and often raised by the Chair.
38. Do Board members share market information or perspectives from their outside worlds with the organisation's CEO?	YES x 3 (*could be more*) no answer	Appears Board members share outside market information.	Have not witnessed.
39. Do Board members occasionally request additional financial information for their own edification or clarification?	YES x 4	Appears all Board members occasionally request additional financial information.	Agree.
39. How would you rate the credibility and trust between the Board and the CEO?	8, 9, 10, (*high*)	High level of credibility and trust between the Board & CEO.	Appears a genuine respect & trust for CEO.
41. How would you rate the advance information materials you receive for Board meetings?	5 x 2, 10,	Mixed response re: advance information materials	Have had to wait for the agenda on several occasions.

Tables 6.3 and 6.4 are presented in the same format as Table 6.2 and show the questions asked, the actual individual responses and a summation of the researcher's comments based on the data and observation. The same shading and text colouring used in Table 6.1 was used in Table 6.2. Appraisals two and three differ in that the second appraisal asks the director's to respond about how they perceive themselves and their performance as individual directors. The third asks the director's to appraise the Board as a group. The three appraisals enabled the researcher to code and categorise the data thematically.

Table 6.5 shows the breakdown of the six categories as outlined in the original appraisal/questionnaire given to the Board. This is followed with the responses from Appraisals 2 and 3 grouped into the six categories with the researcher's interpretation of the responses in Table 6.6. A total of the collective perceptions of the Board in relation to the six categories from all of the appraisals are presented in Table 6.7.

Table 6.5 List of areas included in each of the six categories of governance

Category	Areas in relation to questions from appraisals
Corporate Governance	• roles and responsibilities of directors, • planning, • goals, objectives, 'vision' • fiduciary duties and accountability • statutory and legal compliance • understanding of need for confidentiality • transparency – e.g. reporting in *Annual Report* • overseeing/supporting management decisions, • evaluation of management performance • review of Board performance
Health Service Delivery and Policy	knowledge of: • broader healthcare industry, • 'competitors' – includes other healthcare services both public and private • policy and how any changes may affect *HealthCo*, • the service's facilities and maintenance needs • the demographic and health profile of the community/population it services.

Board's Committee Structure	• Is the structure appropriate or is there a need to change? • Is there a statement of purpose for each committee? • Do directors serve on at least one committee, • Are minutes of committee meetings provided sufficiently and adequately for full Board meetings? • Is there effective liaison with key stakeholders (staff, community, contractors, employer associations etc)?
Board Composition	Balance of: • skills and expertise, • ages and gender • strengths and weaknesses list • disciplinary policy
Board meetings	• Adequacy of timing for supply of agenda and other reading materials for meetings, • participation in meetings, • teamwork, • ability to ask questions, • Chair's ability to run effective meetings.
Board CEO Relationships	• relationship between directors and CEO (trust) • relationship with Chair • delegation of authority to CEO • evaluation of CEO's performance and remuneration Is there a list of criteria for measuring performance? • access to on-going education and training for directors.

Table 6.6 Combined responses and interpretation of data from appraisals 2 and 3

Category	Appraisal 2	Appraisal 3	Comments (areas of weakness/uncertainty).
Corporate Governance	1, 2, 3, 6, (11), 12, 15	1, 2, 3, 6, 8, 9, 10, 11, 12, 14, 15, 20, 21, 22, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 36, 37, 38, 39	No written position description for Chair No disciplinary policy for directors No established set of criteria for evaluation of director's performance
Health Service Delivery & Policy	4, 5, 7	4, 5	Poor knowledge of 'competitors' Poor knowledge of hospital facilities/maintenance
Board's Committee Structure	11	16, 17, 18	No problems identified

Board Composition	13, 14,	13, (15), 23,	No problems identified * some directors identified skills that are not utilised by CEO.
Board meetings	8, 9, 10, 11	19, 41	No problems identified
Board CEO Relationships		7, 35, 40,	No problems identified

Note: Numbers refer to positive responses 'yes' the actual question numbers of the appraisals. .Parenthesis denote where there have been multiple responses to this.

Table 6.7 Summary of the collective responses from the three Board appraisals.

Category	Interpretation of responses
Corporate Governance	• High understanding of roles & responsibilities. • High understanding of corporate strategy, planning, vision. • Board works as a team. • Appropriate structure to achieve *HealthCo's* purpose and goals. • Self-Rating of performance = high.
Health Service Delivery and Policy	• Have identified that not a great deal of knowledge in this area especially in terms *HealthCo's* current physical facilities and problems such as maintenance. Board do not discuss the idea of other healthcare services as competitors.
Board's Committee Structure	• Good committee structure and all directors serving on at least one or more committees.
Board Composition	• Adequate range of expertise and experience
Board meetings	• High attendance rate and participation in meetings and reading of all materials supplied for meetings.
Board CEO Relationships	• High respect, credibility and level of trust in CEO. • CEO has necessary delegated authority to manage *HealthCo.* • Little knowledge of any education or training programs for directors.

The comparison of the responses related to the six initial categories used in the first appraisal provided a means of triangulation of the data. That is, the appraisals differed in content and one was specific to individual perceptions. Also, the

appraisals were administered at different times and in different contexts. Despite the differences in the appraisals, there was a level of consistency with the questions asked. Equally, the responses did not appear to change significantly over time. The final analysis combining the appraisals, observations and other data sources will be presented in the concluding chapter.

6.4 SUMMARY

In this chapter the researcher presented several of the major data sources used to construct a grounded theory on corporate governance. The researcher gave specific examples of how the theory was constructed or built from each data source using notes and memos to code, categorise and finally analyse what they revealed. In the next chapter, other key data sources are interpreted using the same processes and then compared and triangulated with other data. A discussion of the researcher's interpretation of the data is then presented.

CHAPTER 7 AN ANALYSIS OF EMERGENT THEORY OF CORPORATE GOVERNANGE PRACTICE AT *HEALTHCO*

7.1 INTRODUCTION

The key data sources used in this study were presented in Chapter 6. In this chapter, the 'deliberate interweaving' and ultimate 'fusion' (Chamberlain. 1995) of the other key data sources is presented. A discussion of the dominant themes, issues and concepts emerging from the study on corporate governance at *HealthCo* is then compared to the key issues identified in the academic literature. The 'fit' of the study is then examined according to traditional methods of testing the 'trustworthiness' of the data; these include triangulation, member checking and reliability.

Finally, a grounded theoretical orientation toward increasing what is known about corporate governance is argued. In the writing of the theory the researcher used the necessary degree of what Glaser called creativity:

> One must write as no one else has ever on the subject. Then explore the literature to see what new property of an idea he has offered, or how it is embedded with others (1978: 22).

As has been stated earlier in the thesis, grounded theory does not have a standard prescriptive formula and the researcher must determine the best approach to present the extensive data. Figure 7.1 provides a diagram of how the researcher built the theory from the analysis of the data.

Figure 7.1 Building grounded theory: governance at *HealthCo*

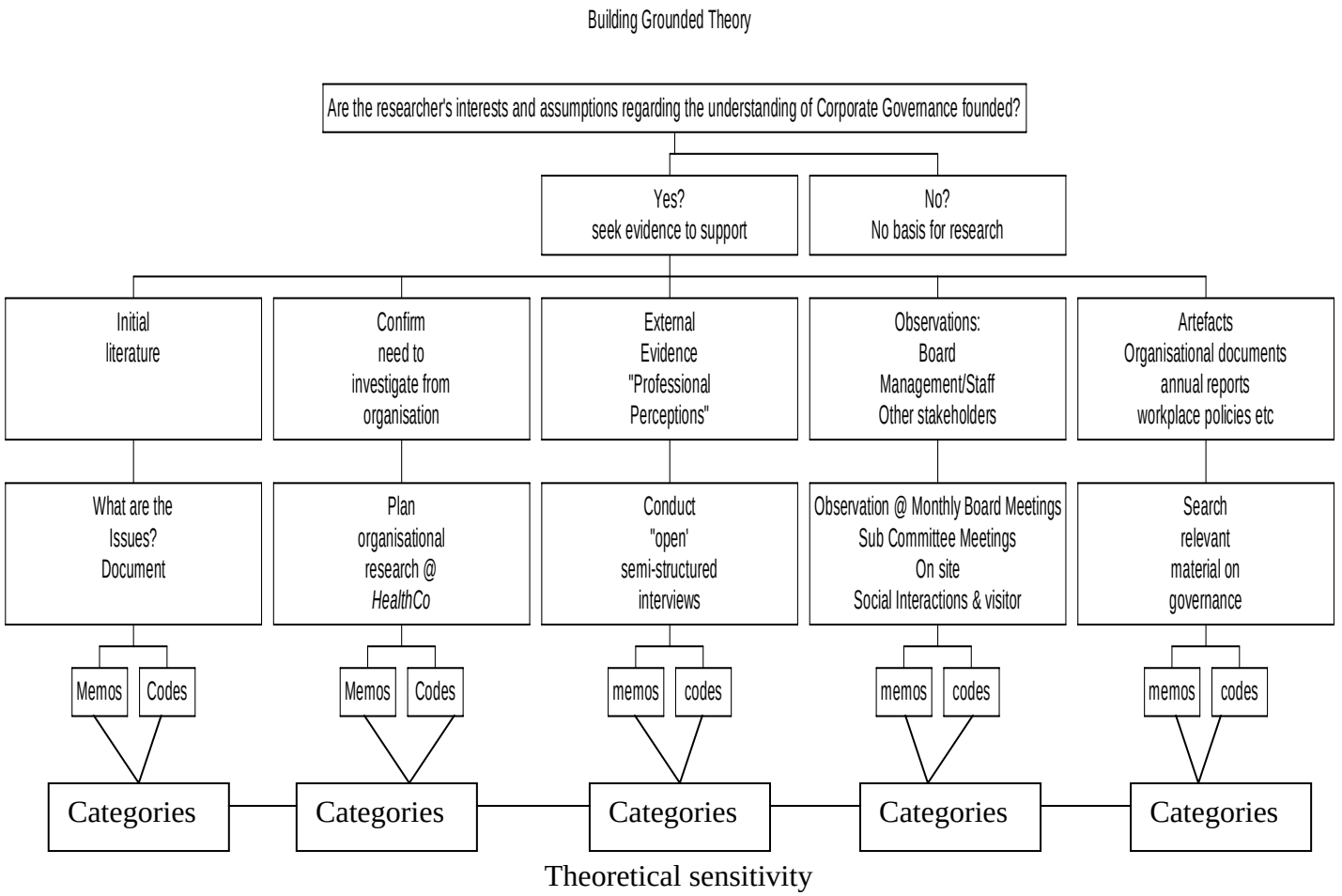


Figure 7.1 presents a visual mapping of the processes used by the researcher to examine and build theory on governance in this study.

In shaping this study, the researcher consulted the literature for what she considered relevant studies that may guide her. In the various studies, she observed that there is a slight variation in the terminology, namely the use of the terms phases and stages of grounded theory. Locke (2001) referred to four *stages* and Leonard and McAdam (2001) outlined three *phases*. The researcher considered that in essence, the terms phases and stages could be interchanged and that despite one referring to four *stages* and others three *phases*, each followed the intentions of the originators and are useful in assisting any researcher in better understanding the dimensions and application of grounded theory.

7.2 BUILDING THEORY

Parker and Roffey (1997) described three main categories of data in grounded theory research as being data that is:

- *Collected* – includes organisational records etc
- *Generated* – includes interviews, questionnaires and observation, and
- *Experimental* – the researcher's personal, professional and academic background to code, categorise and develop the emerging theory.

They also stated that the examination of both 'technical' and 'non-technical' literature is often used as a data source in grounded theory. In this research, the

broader literature includes both academic and more general literature such as media articles.

In their research on Total Quality Management (TQM) Leonard and McAdam (2001:186) used a 'modified' grounded theory approach. They described this as the 'three phase approach'. The three phases:

- *Phase 1* – the macro study (The broader view or 'big picture' involving more than one case or organisation)
- *Phase 2* – the micro study (Interviews from those who are most relevant/immediate to the research)
- *Phase 3* - the case study (Actual over time/longitudinal research at the specific organisation).

The challenge in the construction of grounded theory is that there is no definitive prescriptive formula or model to use as the research is unique to a particular context or setting. Theory is developed and built over prolonged time within this context. However, as with any study, the researcher must declare the types of data and intended approaches prior to the actual investigation in the research proposal so that all parties have a clear understanding of what is required from, in this case, *HealthCo* and the various participants taking part.

Locke (2001) has summarised what she describes as the four stages of grounded theory:

- Stage 1: comparing incidents applicable to each category
- Stage 2: integrating categories and their properties

- Stage 3: delimiting the theory
- Stage 4: writing the theory

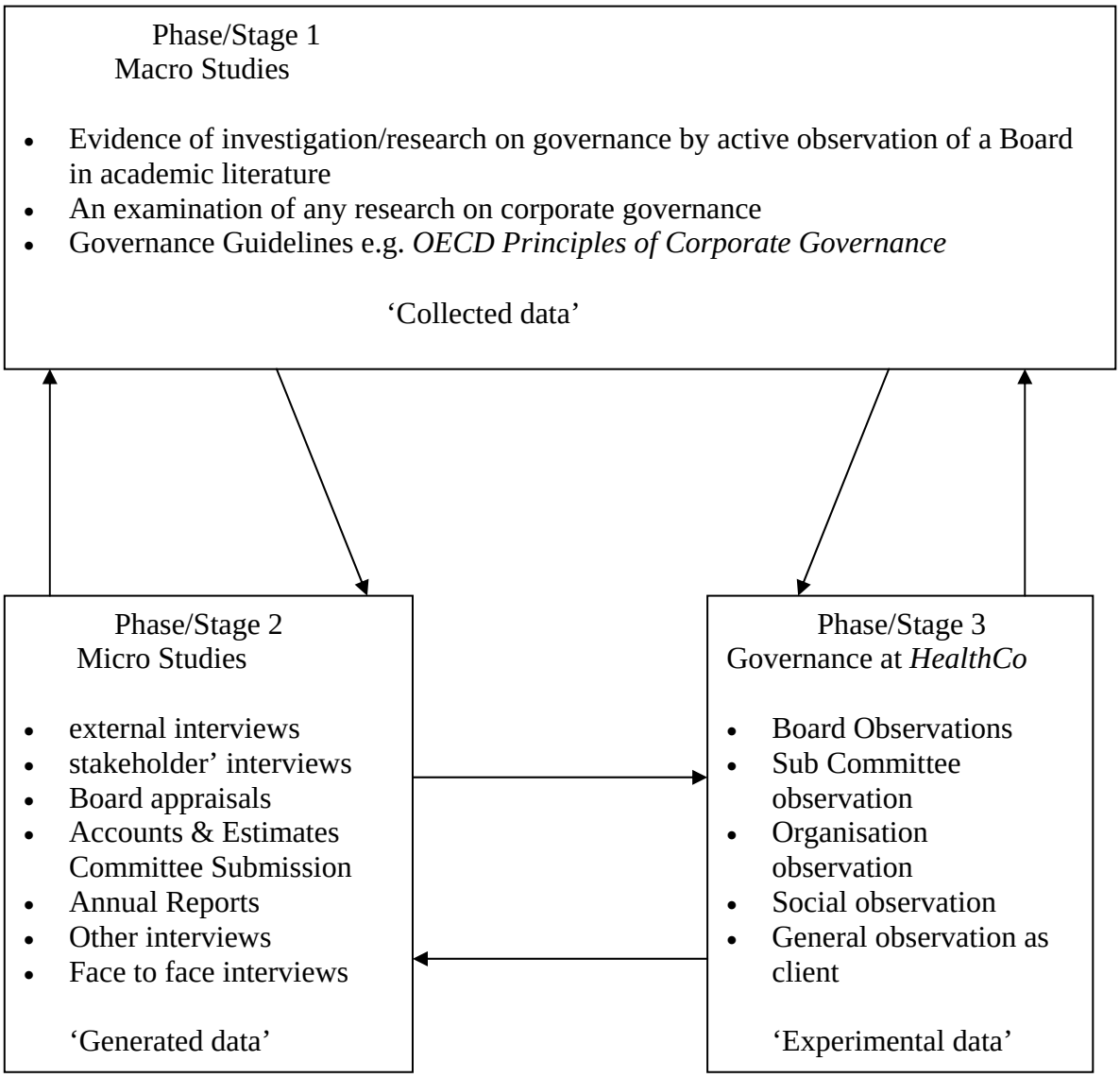
Locke's four stages are derived from the original Glaser and Strauss (1967) grounded theory. The four stages provide a simple overview for understanding the processes used in grounded theory and assist in removing the 'complexity' and 'confusion' in its application (Parker and Roffey, 1997).

For this investigation, the researcher used an adaptation of both the Parker and Roffey (1997) categorisation of the data and the three phases presented by Leonard and McAdam (2001). As can be evidenced, the two approaches cited differ, but not necessarily conflict, one emphasising the three stages of the research, the other, the three categories to describe the data. A combined approach was used in this study. That is within each of the three phases or stages of the research, the *generated, collected* and *experimental* data were analysed and sorted into codes and categories to produce a theoretical interpretation of governance at *HealthCo.*

Figure 7.2 depicts how the researcher described each phase of the study. In this research the *Macro Studies* are the broader literature on corporate governance, with an emphasis on the public sector and where possible public health. It represents the collected data. The *Micro Studies* include all of the interviews, questionnaires, documents such as annual reports etc. These represent the generated data. The *Case Study* is the narrative of the sustained observation and interactions over the eighteen-month period at *HealthCo.* It can be described as the experimental data as the researcher recorded in notes her impressions and interpretations of events. It was an

individual or subjective interpretation that generated the codes and categories to build emergent theory on corporate governance in a public health sector agency. For example, at the first meeting with the Board, the researcher observed that the composition appeared to be balanced in terms of gender, ages and professional backgrounds. A memo to further observe composition on the Board was noted by the researcher, and after conducting several of the External Interviews (refer 7.5.1) Board composition was coded.

Figure 7.2 Three phases/stages of grounded theory



The three phases/stages of data were concurrent and as themes emerged from one data source they were incorporated with other data. That is, the researcher's notes and memos contained questions that were asked through another piece of data. The analytic process for this research can be described as 'cyclic' as in action research (Wadswoth, 1997).

The researcher also recognized that it was necessary for a period of reflection prior to and during each of these activities so that she could look for patterns and themes that help shape the emerging theory. Easterby-Smith, Thorpe and Lowe (1991) describe seven stages of processing qualitative 'case' data. They are: *familiarisation, reflection, conceptualisation, cataloguing, recoding, linking* and *re-evaluation*.

The researcher recognised that 'a period of reflection, or constant reflection, can result in further opportunities/subjects to be researched' (Trim and Lee, 2004:473). In this study, the researcher would take time to reflect on and question the observations and information as it occurred. These reflections were recorded as 'memos'. An example of how the reflection enabled further opportunity was with the administration of the *Staff Questionnaire*. In the initial discussions with the CEO and Chair, they wanted to see if the research could be used to assist in finding out the satisfaction of staff at *HealthCo.*

7.3 EXPLORING A CONTEMPORARY MEANING OF GOVERNANCE

The possibility that there may be a mismatch between the interpretation and understanding of governance was introduced in Chapter 1. This initial idea, and interest to further explore both governance as a theoretical concept and a practical application, became the basis of the researcher's inquiry. That is to observe and analyse how a Board perceived governance as a theoretical concept and a practical application.

The convention of grounded theory is that the researcher commences with an interest rather than knowledge based on a full examination of the literature on the topic in question. Prior to the commencement of this study, the researcher had both an interest and awareness that corporate governance was a topical subject in the media and had created strong academic debate. She was also aware that there were a range of governance 'principles' and 'codes' and was curious to see if these codes and principles had an impact on both the understanding and practice of governance. After reading the preamble of the *OECD Principles of Corporate Governance* (1999) the researcher considered that the forty-five page document failed to clearly define governance. The 'Principles' stated that:

> One key element in improving economic efficiency is corporate governance, which involves a set of relationships between a company's management, its Board, its shareholders and other stakeholders. Corporate governance also provides the structure through which the objectives of the company are set, and the means of attaining those objectives and monitoring performance are determined (1999:11).

The memo written by the researcher in regard to this is as follows:

The focus of this description of governance appears to be on economic efficiency. Is this the first priority of governance? How are company 'objectives' set and where are they visible? How can governance monitor performance and whose performance is monitored? That is, is it organisational performance or that of the CEO or both? What are the procedures required to monitor performance? Is it necessary to define governance in order to understand it? These issues need to be explored.

The researcher wanted to explore what elements of governance were regarded as significant and if there was consensus or differences in these elements. It was a constant question throughout the research and all of the participants in the study were asked for their definition or interpretation of governance.

7.3.1 The Chief Executive Officer's concept of governance

In the general discussions with the CEO and Chair at *HealthCo*, the researcher had noted in a memo that:

Despite a constant reference for the organisation to deliver good governance and the desire to be recognised as achieving 'Best Practice' governance, the term governance seemed to be all embracing and perhaps includes management decision-making? Need to observe the decision-making process at both Board and management level to ascertain. Further enquiry needed.

The researcher asked the CEO for his interpretation of governance or what he thought it meant.

This was his response:

> *Governance is what I do all and everyday here. It's not just my relationship with the Board, but the executives and the Minister and the Department of Health Services (DHS). I have to be responsive and be prepared to make quick decisions. Some times I am able to contact if not all Board members, then at least some. I always consult with the Chair before I make a major decision. Some times things come out of left field, and I must decide on something immediately.*
>
> *It is also about the trust I put in my managers and how they in turn delegate tasks to the staff. At the end of the day, governance is about taking care of everyone here from the top executives to the cleaners. Our business is health and that's what we are here to do, take care of people's health and to do that there are many other people we must take care of our staff, doctors, nurses just to name a few. We also need to respect the communities around us, they are our neighbours and we need to be good neighbours – there's lots of issues in that respect, noise, parking to name but a few. That's one of the reasons why we have a committee (CACS) with community representatives on it. They let us know about these things. So, yes, governance is about being responsible and accountable to a big group of stakeholders.*

The CEO obviously considered the term governance to be all embracing. This is supported by his statement: *'…what I do all and everyday here'*. The researcher wanted to see if this was a shared or general perception of governance and if there

were common elements of governance emerging in the data. To test this she asked each of the 'governance professionals' to define governance. She used some slight variations to the question, such as:

"How would you define corporate governance?"

"What does corporate governance mean to you?"

"What do you understand corporate governance to mean?"

"What does the term corporate governance mean to you?"

"What is your definition of governance?"

Despite this variation, the intent of the question was for the interviewee to provide their individual definition of governance.

The eight responses are presented in the order in which they were asked, that is from the first interview conducted on 25 July 2001, to the last 23 May 2003. In order to ensure confidentiality and anonymity, alphabetic letters have been used rather than the initials of each participant. Also, any references to professional positions that may identify the participant have been removed.

7.3.2 External Practitioners define governance

A: *For me I think it signifies the set of principles by which a corporate body is governed. That is, corporate bodies have a governing body which is a Board of directors or trustees or some other name, but whatever it is, they are the people responsible for the, I don't want to use the word governance, but responsible for making sure the body is properly run in accordance with the instrument that sets it*

up, whether its an act of parliament or a private body articles of corporation or whatever. Corporate governance talks about how that governing body ought to operate.

B: *I have to say I hadn't really turned my mind to a definition of corporate governance until you asked me about this. I suppose I've always been interested, particularly since my appointment at. I've been very interested in good management in the public sector, which I suppose is part of corporate governance. I've been through various upheavals in the public sector, for instance including the introduction of performance indicators, the senior executive service the breaking-up and subsequent amalgamation of various government departments, so I'm interested in the area, but corporate governance as a description came in, in the early to mid 90s (as far as I'm aware) at a time when I was a …… with a number of quite different concerns, one of which was the management of the Department …… through the secretary of the department, but there were other aspects that were also fairly compelling at the time. I probably even now don't think in terms of the words 'corporate governance'. I'm not exactly sure, or it seems to me that there are various ways of defining it. I would still probably break the things up that I'm interested in; good management, ethical considerations, risk management, customer service, all of which I think are in various definitions of corporate governance, but I, until now rarely use the term myself.*

C: *Corporate Governance is a short hand expression for a very broad range of practices relating to the management, planning, administration and ultimately the exercise of leadership within a public, private or hybrid type organisation.*

D: *It's the Vision of any corporation to having some very clear directives for that organisation and having delegated policies some policies and procedures or guidelines with relevant monitoring systems that back it up, ensuring compliance. All importantly is good communication flow within the Board and then from that corporate level down to the CEO is how I see corporate governance and I suppose it is those key elements that I consider to be good corporate governance.*

E: *I see it as the senior end the Board of directors working with senior management who help the company to think strategically not just about current realities and not just about legal compliance, but to actually think about why that organisation exists and how to be true to the spirit of its reasons for existence and that's looking at both risks and opportunities beyond legal requirements. So obviously there is a strong fiduciary financial responsibility but corporate governance should also be looking at issues of things like occupational health and safety, EEO the factors of employing people and issues beyond the organisation such as social issues. My understanding of governance is that it is more at the policy and philosophical and broad strategic level, but obviously if there are conflicts between what is stated to be the case and the practice then those need to be taken up. I think that a Board of directors that are tempted to manage in a hands on way would be way outside its brief and that would be destructive and damaging for the organisation. That it might be where they have a part in their meeting where there are reports of where is the system failing and you have a case study approach for that sort of reporting so that that incident is presented as a practical demonstration of whether the organisation is functioning well or badly or what the major constraints are, being financial and so on.*

F: *That is an incredible question. I reckon my best response is, "I don't know!" My reason for this response is that the notion has become increasingly broad and is used to capture all sorts of issues, so that I'm not sure that I have a concise definition but I would distinguish governance from management so that governance is some notion that sits above the management concept and processes of the organisation so that its about providing broader direction for the organisation, and ensuring that broadly the appropriate processes and structures are in place within in an organisation. In some way this notion of governance has to be distinguished from management.*

G: *I try not to define it tightly. I define it as the process by which a corporation is directed, controlled and made accountable.*

H: *Well obviously governance has been a lot in the limelight in the last five years, its actually become quite a trendy thing and a lot of that has focused around issues of, particularly lately executive remuneration, composition of governance s and less it seems to me about what it is that corporate governance is actually on about, which is the, I guess, the stewardship of the organisation. That the Board or the team that oversees the organisation is there to see that the organisation fulfils its objectives, that it performs and that it continues as a robust organisation or a robust Board into the future, assuming that in fact its an organisation where you wanted to have an ongoing future, so the elements of corporate governance are not just about making sure that Boards are compliant or that organisations of Boards oversight are compliant, but it should be very much focused on the performance of the organisation against the objectives of the organisation. Because, you don't establish organisations just because you think it's a good idea. You establish them to do*

something. So the role of corporate governance is to oversight the achievement of that and the way in which it is it is achieved so that it has both the strategic setting role i.e., we are here to do 'x' we are going to perform this way, we are going to improve our performance this way, we are going to make these choices about the way we will perform, so that is the strategy side and we are going to do it in these ways and so we are going to have these forms of and this is more the compliance and we'll behave in ways the management's money is responsible and accountable. We'll be looking for best value in the management of the organisation we'll be making sure that we operate within the laws of the land, which will range from employment law to accounting and audit laws, to general financial management to OHS. To all those sorts of things that impact on the organisation, so its responsibility both as a provider of services, an employer of people and as part of the general institutional framework within which its set up so both a strategy and compliance side.

These accounts were summarised using the methodological process of coding and categorising as described in Chapter 6. A summary of the categorisation of the data used by the researcher based on the actual responses given by the external professionals is shown as Table 7.1.

Figure 7.3 Constructing a grounded theoretical approach to interptreting the perceived meaning of governance

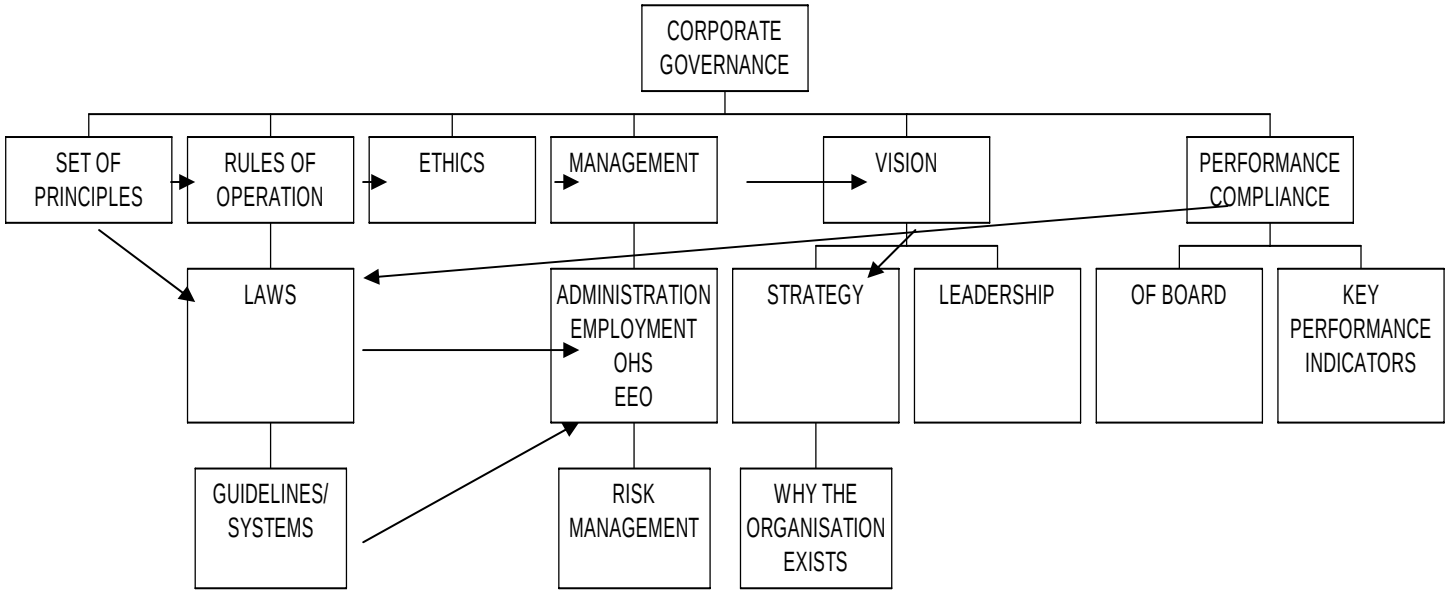


Figure 7.3 shows the coding and categorisation used by the researcher in relation to the actual meaning or understanding of what governance is and what may be considered key elements. The arrows show possible relationships between each of the categories.

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Table 7.1 Summary of the external practitioner's definitions of governance and the researcher's coding and notes

Term	Definition	Code/Category	Notes
Corporate Governance	**A =** A set of principles by which a corporate body (the people responsible for making sure that the body is properly run in accordance with the instrument (an act of parliament or articles of corporation) that sets them up) is governed.	Set of principles Rules of operation	Notion that there is set of 'Principles' 'Legal'or parliamentary instrument Difference private/public
	How the governing body ought to operate.	Ethics	Ought = ethical compliance
	B = Good management in the public sector is a part of it.	Management	Place of management?
	Various ways of defining it (break things up). It includes: • good management • ethical consideration • risk management • customer service	 ethics risk management customer service	Break up or component = Ethics Risk management Customer service
	C = A short hand expression for broad range of policies relating to the: • management • planning • administration • exercise of leadership (within a public, private or 'hybrid' type of organisation)	Management Planning Administration Exercise of leadership	How management operates in relation to: Planning Administration Leadership (Do/should management plan?)
	D = Key elements are via: The 'Vision' of any corporation: • clear directives • delegated policies, guidelines and relevant monitoring systems to ensure compliance. • Good communication flow within – down to CEO	Vision of organisation through: directives, Policies, guidelines and systems	How is the Vision of *HealthCo* revealed? Is it visible via policies, guidelines & systems?

	E = Board work with senior management to help company to think strategically (not restricted to compliance – rather 'why' the organisation exists and how to be true to the spirit of its reasons for its existence). • Risk and opportunities beyond legal requirements. • Strong fiduciary/financial responsibility. • Occupational Health & Safety (OHS) • Equal Employment Opportunities (EEO) • Employment of people taking into consideration social issues More at the policy and philosophical broad strategic level Board should address any conflicts between what is stated & practice but not manage in a hands-on way as this would be outside its brief and this would be destructive and damaging for the organisation. Reports at where the system is failing part of Board's meeting agenda	True to the 'spirit' of the organisation risk management fiduciary/financial responsibility OHS EEO Employment and social responsibility role is strategic Risk management systems	How is spirit evident – is it the Vision? Are the policies at *HealthCo* consistent and align with Vision? How involved is the Board with company policies and more directly employment practices etc? Strategy versus management/conflict Is there knowledge of failing systems?
	F =Unsure of how to define as governance as a 'notion' has become increasingly broad and used to capture all sorts of issues Must distinguish from management concept and processes: • Governance 'sits above' (about providing broader direction and ensuring the appropriate processes and structures are in place within an organisation).	Governance as broad concept Governance role is 'above' management	Most discussions claim this to be true Governance and management separated
	G = The process by which a corporation is directed, controlled and made accountable	'Cadbury' definition of governance	How is this evidenced at *HealthCo?*
	H =Has been in the limelight in past 5 years 'trendy' and focused around issues: • Executive remuneration, • composition of governance Boards It is the 'stewardship' of the organisation the Board or the team that oversees the organisation is there to:	Governance as a 'trendy' issue Exec remuneration Board composition Governance as	Agreement – media etc Private sector issue *Listed in Health Services Act 1988.*

	• see that the organisation fulfils its objectives, • that it performs • and that it continues as a robust organisation or a robust into the future The elements of corporate governance are not just about compliance, rather focussed on the performance of the organisation in relation to why the organisation exists and what its objectives are. The Board : • looks for best value in the management of the organisation • operate within laws of the land (ranging from employment law to accounting/auditing laws/general financial management, OHS. (all 'impact on an organisation), so that its responsibility as a provider of services, an employer of people and as part of the general institutional framework within which its set up so both a strategy and compliance side.	'stewardship' Future of the organisation Performance and compliance Why the organisation exists Best value management Laws/compliance in multiple areas from financial accountability to employment.	Does *HealthCo* Board really address future beyond that of immediate? How is robustness tested? Performance of organisation via KPIs – how is Board performance measured? How does *HealthCo* measure how it performs as a 'provider of services'?

The identification of key terms is highlighted in Column 1. These were then coded and categorised as shown in column two. The researcher's notes were used as guidelines with other data sources and questions. Figure 7.3 shows the coding and categorisation used by the researcher in relation to the actual meaning or understanding of what governance is and could include.

The researcher's notes reveal that governance was generally perceived as a broad concept and diverse in its meaning. There seemed to be a consensus that the notion of governance was based on a set of 'Principles' or guidelines for the organisation. There appeared somewhat of a blurring between the roles of governance and management at times, that is, reference to what may be deemed management issues such as occupational health and safety (OHS) were considered part of governance. This was not consistent with the researcher's observations of both Board and executive meetings, with OHS discussions and decisions made only at executive level.

Within these interpretations of governance, Board composition and organisational vision emerged as themes. This led the researcher to further explore the issue of Board composition through the questions asked to the external governance professionals and other participants such as the Chair. Profiles of Boards in the Victorian public health sector and the gender make-up of selected public service entities are presented. The literature is then consulted regarding Board composition and gender.

The understanding of governance, with particular reference to the organisational vision from the perspective of employees is explored in the findings from the *Staff Satisfaction Survey*.

7.4 COMPOSITION

Board composition was considered to be an important element of governance by all of the respondents. Specific to this was a notion that a Board should have a good mix of skills and experience. The issue of gender and female representation was also seen as being important. The researcher's exploration of the issue of gender balance on Boards emerged after early discussion with the Chair. The researcher asked if she believed that the composition should be balanced in terms of female representation. The Chair responded:

> *Definitely yes. It's essential. Particularly in this sector. Statistically speaking, women could be considered the biggest users of a health service. Apart from presenting for treatment for their own needs, they give birth in hospitals, bring their children for treatment and more often they are the primary carers for elderly relatives. Women know their needs. Hence, women on Boards s often have more direct experience. The health sector, like education tends to have a larger percentage of women working in a range of occupations, that is, not just nurses. I believe that no matter what the sector or industry, equal representation of male and female directors should be a given. Things have got a little better, but we still have a long way to go. I have to say, it's really hard, despite government policy to aim for equal representation, to find women who are actually available. Often the women we most want are over subscribed, they are already serving on a number of Boards and despite being interested, just physically don't have the time. I also think that women need more confidence, often they think that they don't*

have enough expertise, say like budgeting, yet often they do all the finance and budgeting of their own situation with the family.

When asked about ultimate recommendations to the Minister about perspective directors, she stated that:

Of course we want the best people. We want directors that have the skills and experience we need. Right now, we think we need some expertise in marketing and promotion. It's a competitive market out there and to be the best we need the best! Skills and experience is really important and to get the right mix is not always easy. I think it is important to attract people who have compassion for and a passion about our community. Ideally, I think every director should live in the region. They need to feel connected with the people and have a real understanding of their needs and lifestyles.

During the course of the study, the researcher observed several changes of directors. She noted that some 'expired term' directors were reappointed and several not and that one of the female appointments was replaced with a male and that this changed the equal representation status of the Board with five males and four female directors. This led the researcher to ask how appointments were made. The Chair explained that prior to any appointments, she would meet with the CEO and they would discuss what skills they thought would make the Board more effective. They would make recommendations to the Minister for the skill set and experience they sought. The Minister made the ultimate decisions regarding appointments, and at times, these were different to the recommendations given by the CEO and the Chair.

The researcher asked why a female director had been replaced by a male and was told that there were no suitably qualified and available female candidates.

In order to confirm if this was the case and to ask about the appointment processes for the public health services, the researcher contacted the administration officer in charge of Board appointments for the *Department of Human Services* (DHS). She confirmed the process outlined by the Chair and also stated that it was government policy that the *Victorian Women's Register* (The register lists women who are suitably qualified and or experienced to serve as directors on both public and private sector Boards). The Register is used as part of a broad government strategy to increase the representation of women in governance roles on Boards and committees and must be checked before any new appointments to any of the Boards are made. She informed the researcher that despite government initiatives such as this, it was a challenge to find woman who were both capable and available, with many of the most suited women already occupying directorships on other Boards. Her own words were that it was:

> *like trying to find a needle in a haystack.*

The researcher asked the external governance professionals if they thought that it was important to have gender balance on Boards. Their responses were:

A: *I think there has been an attempt to balance Board composition. I wouldn't say that it is entirely successful. It still happens that people get appointed for reasons that are extraneous to what is best for the organisation.*

B: *Yes it is important and I'm surprised how many Boards don't see it to be important to have women, this concerns me more than age…I find it extraordinary that there are so few women on Boards, particularly here in Australia…with government departments and authorities, more than half the people they are dealing with are women. Even with the best will in the world men just do not see things from a woman's point of view or understand the lifestyle of a great majority of women so that is quite important.*

C: *I think it's important to have a diverse range of values and experiences and energies brought to bear on a Board . That can happen in many different ways. Gender and age are just some of those. There is also experience and education and a degree of involvement or shareholder responsibility…Just as bodies politic need to represent the broad range of stakeholders, so should companies… it should never be forgotten that public and private companies are commercial energies driven by commercial considerations and shareholder interests and so broader constitutional notions drawn from the body politic must inevitably be subsumed within the much narrower economic considerations that come out of ownership, whether it be by government or by shareholders or the like.*

D: *I don't believe in distinguishing between ages and genders on the composition of Boards. I think its to do with if you have got women with the right experience, knowledge and skills required for that Board then that's great.* (Goes on to talk about appropriateness – having a good representation of the users of a particular service the Board heads. Gives an example of a current Board she is on saying that it has good

representation of its users, also says later that she thinks that this particular Board is too big says its 'like a party' and difficult to manage).

E: *I think that gender and age is an important consideration. What balance means in this context I don't know. I think you need a blend of experiences*… (Gives an example that community representatives can be dominated by poor language and literacy skills. She claimed that; "Professionals can stick together and drown out such voices".

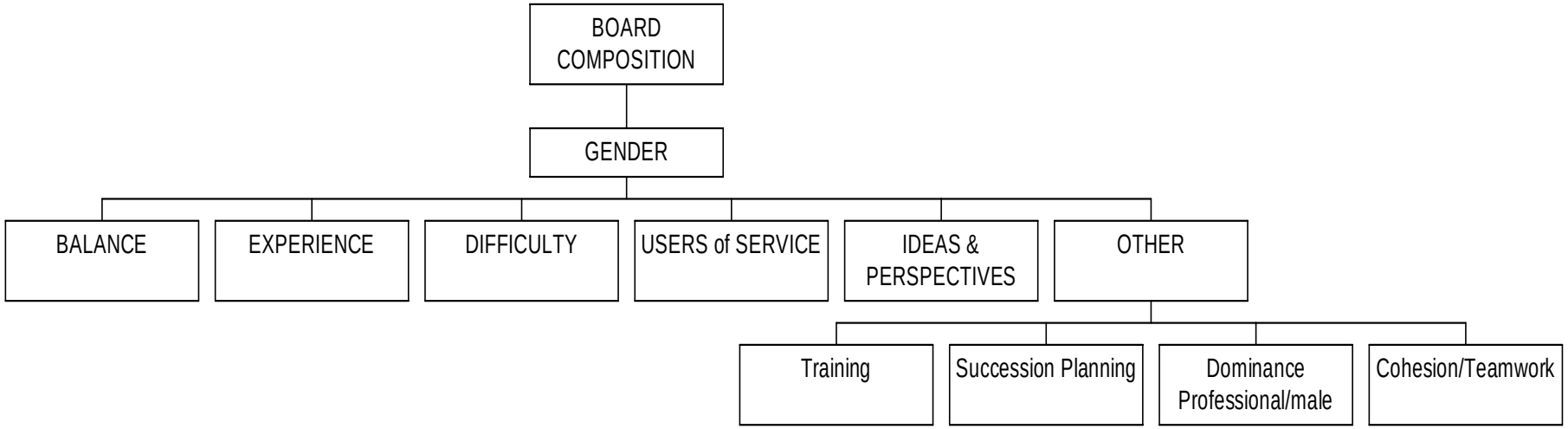
F: *I do think that there is a need for a careful consideration to be given to the composition of Boards, not only in terms of gender and age, but also in terms of discipline based backgrounds and also the range of experiences that people have had…There's a need to get the right sort of spread of the backgrounds of those people from the industries they've worked in. If you have the right people in place you hope that everything else will follow from that… I think that its important in terms of providing representation and ensuring that the various stakeholder groups are represented. Other demographic characteristics need to be reflected. I am conscious out of my own research that men and women process information differently and I've been fascinated by the research about the way men and women differently process accounting information. It found that women take a much wider range of considerations into account than men do. Males tend to focus on a much narrower range of factors. The literature is saying that women will make better decisions as bankers and auditors and so on as a consequence of human information processing differences.*

G: *Absolutely. A Board should reflect the community from which it operates* (gives an example of a public sector Board with an equal representation)…*Gender imbalance to me is different to male dominance. Gender imbalance has to be corrected…It's a fairly conscious policy of ours to get the right blend.* (G talks about specialist/professionals depending on what particular /industry. For example, chemicals may require someone with an industrial chemistry background.

H: *I think its important to have a balance of viewpoints on the Board and I actually think age makes a difference in viewpoint and that gender makes a difference and other things also make a difference and that Boards ought to seriously, they need to both search for cohesion or people who are able to work well together, but working well together doesn't mean that everyone agrees all of the time. So a different world view is incredibly important for Boards because essentially s exist to ensure that something happens, and that something happens not to them, but to a set of clients somewhere else and those clients change, they don't all age at the same rate as the Board does or rather they don't have the same life experiences, so I think it is very important… If you have the right people in place you hope that everything else will follow from that.*

The researcher explored the broader notion of Board composition to address the area of gender by breaking down the interview data (including that of the Chair and the representative from the Department of Human Services*), the outline regarding Board composition in the* Health Services Act 1988*, and finally, consulted the literature on Board composition and gender. Figure 7.3 is an outline of how the researcher coded and categorised this data.*

Figure 7.4 Constructing a grounded theoretical approach to interpreting Board composition specific to gender balance



The breakdown of the responses by category given by each of the external interviewees is presented in Table 7.2

Table 7.2 Breakdown of responses in allocated categories

BALANCE	EXPERIENCE/ SKILLS	USERS OF SERVICE	IDEAS/ PERSPECTIVES	DIFFICULTY	OTHER: Training/Succession/ Cohesion/Dominance
A: has been an attempt. Not entirely successful. People get appointed which are really 'extraneous' to what is best for the organisation.	I think increasingly people responsible for appointing members to Boards of public sector bodies are looking to see what is the skill mix that is required and seeking people with appropriate skills. I think that is the way it ought to be done				
B: Yes. Surprised that many Boards don't consider important to have women on Boards. Finds it extraordinary so few women on Boards in Australia.		75% of users are women	Even with the best will in the world, men don't see from a woman's point or understand women's lifestyle	mentions that Victorian Government's *Register* must be searched to see if someone is relevant It is difficult to get women, mostly people who nominate are men	

C: Gender is only one consideration. Balance of diverse range of values, experiences and energies on the Board	getting the right mix and balance of skills on any an important challenge. Not always people appointed for skill/mix. may be political or friends. Experience, education and a degree of involvement or shareholder responsibility				
D: Doesn't believe in gender distinction on Boards. Not relevant	Great if have women with right experience, knowledge and skills. Need full range of people. Not all from business sector	Government push for representation of the users of service on one of the Boards she is on. It is appropriate in this case, but not all Boards			
E: Gender an important consideration. Not sure what 'balance' means in this context.	Need a 'blend' of experiences				Training- especially for those who are Non-English speaking or older less educated as professionals can dominate them.

F: Need for careful consideration not just gender but 'discipline' based backgrounds	Range of experience – right 'spread of professional backgrounds. Representation of various stakeholder groups		Men and women 'process' information differently. Women consider wider range of options than men. Claims the literature says that women make better decisions in finance roles as a consequence of information processing differences.		Succession plan for replacement of directors
G: Absolutely. Gender imbalance has to be corrected. Gender 'imbalance' is different to male 'dominance'	Right experience 'skill set'	Should reflect the community from which it operates			
H: Important to have a balance of viewpoints					Emphasis on search for cohesive set of people.

Once again, each of the responses was broken down into identified categories. The researcher now presents an interpretation of the responses according to categories.

7.4.1 Balance

In this study, whilst gender balance was recognised as important by the majority of those interviewed, it was considered as only one consideration in the appointment of directors. Professional experience and skill mix were nominated as the key issues rather than gender and age. One of the responses mentioned the importance of having a balance of male and female viewpoints and also the viewpoints of various stakeholders. Gender distinction on Boards was not considered to be *relevant* by one of the interviewees and one responded that they were not sure what *balance* meant in the context of Board appointments. One of the interviewees stated that he considered it vital to correct gender imbalance, it was important to distinguish between imbalance and what he described as male dominance.

The requirement for public sector agencies to consult the *Victorian's Women's Register* prior to making any appointments supports that gender balance is considered as an important element of governance. The *Accounts and Estimates Committee Report on Corporate Governance in the Public Sector* (PAEC), (2005) also highlighted the need to address gender balance as a means of 'improving' corporate governance as a result from the submissions received from their 2002 inquiry into corporate governance. In response to the question on the criteria for the appointment of directors, *HealthCo* included gender as one of the key criteria:

A mix of skills and experience, gender, residency and background are used as key criteria. An understanding of the diverse cultures that the agency serves is also sought.

7.4.2 Experience

Experience was deemed to be the most important consideration in Board composition. The process of Board appointments in the public sector was asked and the researcher looked for the link between this question and references to gender and or experience. One of the participants mentioned the requirement for public sector agencies to consult the *Victorian Women's Register* for finding suitably experienced and qualified women. One of the interviewees discussed the need for a *range* of experiences. The terms *blend* and *spread* were also used by others indicating that whilst experience was important it was equally important to have a range of experience on Boards.

7.4.3 Users of service

Recognition that women represent a high percentage of users of public health services emerged and one participant quoted that seventy-five percent of health services users are women. The Chair also agreed that women were higher users of health services and attributed this to the biological factors of women having children and therefore needing a range of additional health services. She also believed that the Board should reflect its community. Whilst not directly related to this category, one of the participants commented that she estimated that *more than half of the people in government departments and authorities are women.*

7.4.4 Ideas and perceptions

In relation to this question, it emerged that two of the participants thought that women brought a different perspective and that the needs and lifestyle of women may be foreign to men. It was also the view that if women were in fact the dominant users of public health services, then they should be considered important at Board level in regard to understanding the needs of the majority of users. One of the participants went on further to say that research indicated that women perceived things differently and brought more of a human understanding to the Board table. One made the comment, *Even with the best will in the world men just do not see things from a woman's point of view or understand the lifestyle of a great majority of women so that is quite important.*

It could be said that this comment aligns with users of service. That is, women having a better understanding of particular health care needs being somewhat foreign to men.

7.4.5 Difficulty

Difficulty in finding women directors was not highlighted by any of the external experts. Rather, the need for *careful consideration* in finding the right people. Difficulty in finding suitable women as candidates to serve on Boards was highlighted by both the Chair and the *Department of Human Services* officer.

7.4.6 Other

The researcher allocated the category *other* for the responses that did not align with the other five categories. The four issues to emerge were in relation to training,

especially those who may be disadvantaged such as older, less educated or those from community background with poor language and literacy skills. She claimed that, *Professionals can stick together and drown out such voices.*

This also could be placed in the category 'dominance' of one group over another. One respondent also used the term male dominance. Succession plans for replacing directors was also stated to be an important consideration for Board composition and from the researcher's observations this did not appear to be in place with directors being appointed pending availability, and as stated by one of the interviewees, *It still happens that people get appointed for reasons which are extraneous to what is best for the organisation.* One also mentioned the need for an emphasis on finding *a cohesive set of people* and one of the others believed that ...*if you have the right people in place you hope that everything will follow from that.* The notion of teamwork was discussed in Chapter 6 in the Board appraisals.

7.5 GENDER COMPOSITION: VICTORIAN METROPOLITAN HEALTH SERVICE BOARDS

The findings from all of the combined sources on Board composition indicated that gender balance was considered an important element of governance. In her investigation of the issue of gender balance, the researcher was alerted to the Victorian government initiatives and pledges to achieve a stronger and equal representation of women on public sector Boards. She consulted the *Department of Human Services* website and publications to collate the representation of women on metropolitan health service Boards over a four year span 2002 – 2005. To

triangulate the data, she also checked each metropolitan health services website and their Annual Reports.

It should be acknowledged that there might be slight variations during each of the years presented as in some cases; new appointments and reappointments do not coincide. A total number of nine directors per health service are recommended and the data from the tables shows that the majority of health services had nine directors. The percentages of male, female and total directors are presented as Figure 7.5 and 7.6

Figure 7.5 Gender profiles of directors on metropolitan health service boards

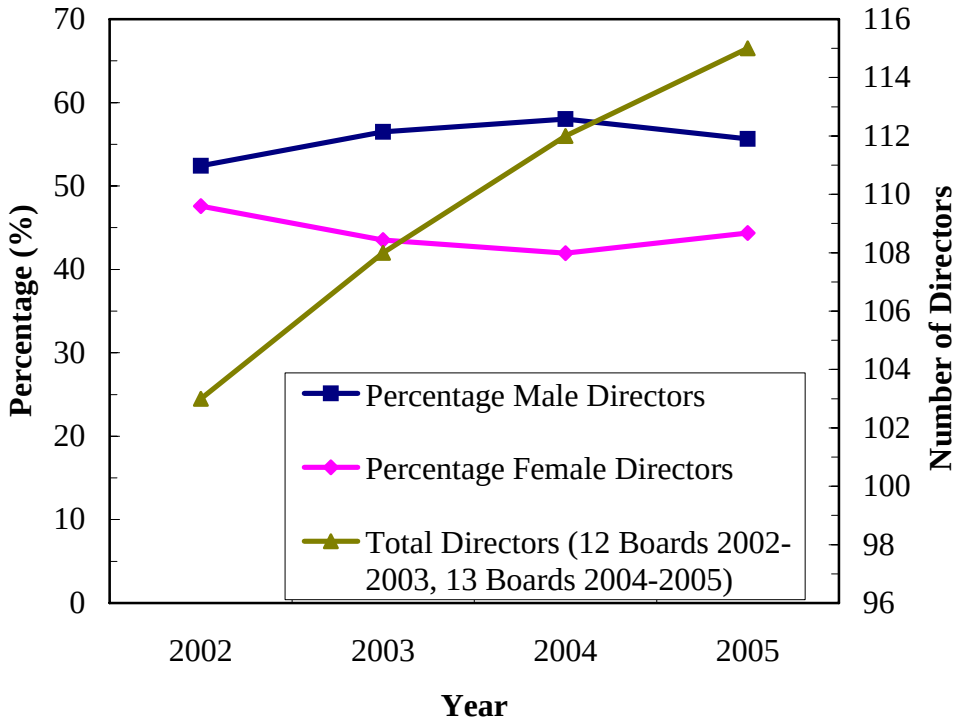


Figure 7.5 shows that the total number of directors serving on metropolitan health service Boards have increased and that the number of female directors has not yet reached 50 percent.

Figure 7.6 Chairs on metropolitan health service boards by gender.

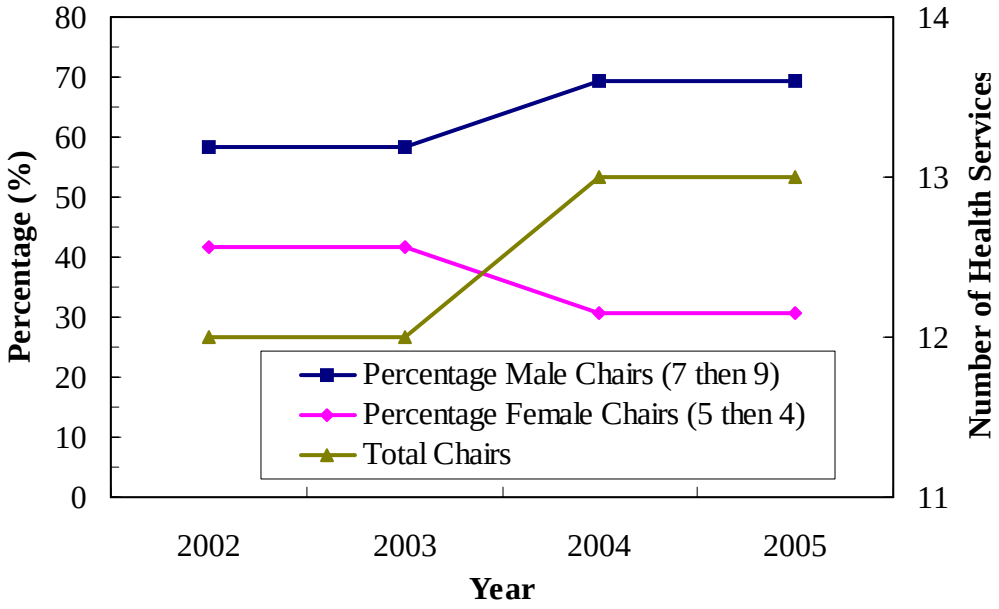


Figure 7.6 shows in 2004, due to one health service becoming two there was an increase by one Chair. It also reveals a decline in the number of women Chairs.

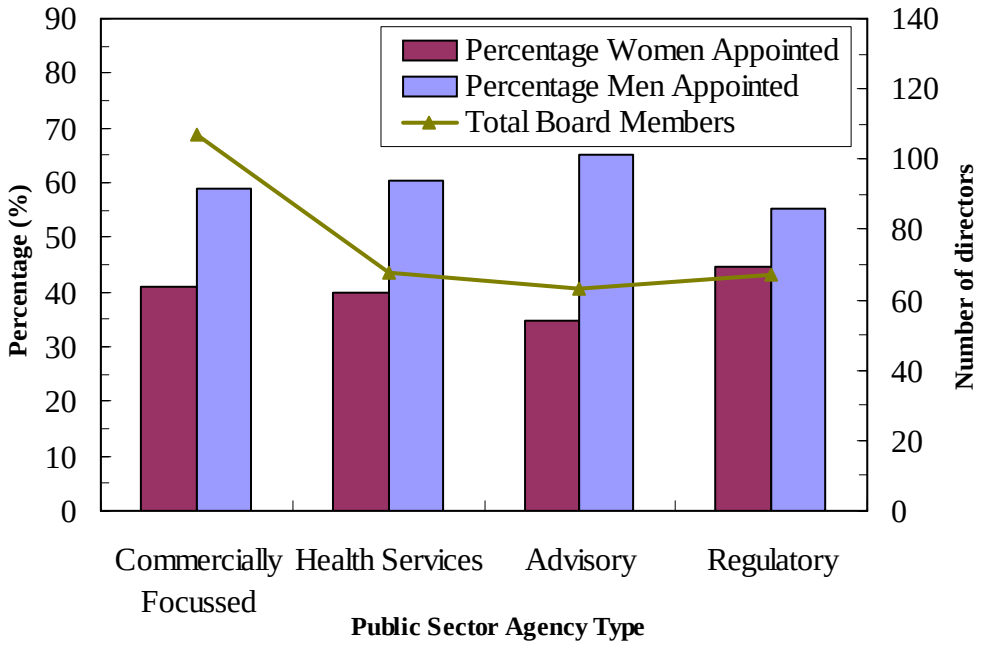
What is evident from this data is that the total number of directors for all health services has increased. There has also been slight rise in the number of women on Boards, with forty-nine of the one hundred and three directors in 2002 being female. In 2005, fifty-one of the one hundred and fifteen directors are female. It is interesting to note that in 2002, seven of the twelve health service Boards comprised of fifty and above percent women. The state government target of 40% representation was achieved in all years with nine of the thirteen agencies reaching this in 2005.

The figures for 2004 and 2005 indicate a level of stability. The total number of female Chairs has decreased from five of twelve in 2002 and 2003, to four of thirteen

in both 2004 and 2005. In 2005 the number of Boards with 50% and above women has been reduced to three of thirteen.

It can be argued that the participation of women on metropolitan Boards has improved (Office of Women's Policy, 2004). This led the researcher to compare the make-up of the metropolitan health service Boards with other public sector organisational types. Data from the *Public Accounts and Estimates Committee Report on Governance* (2005) is presented as Figures 7.7 and 7.8.

Figure 7.7 Appointments to public sector agency types by gender 2003-04.



Source: Adapted from the Public Accounts and Estimates Committee (PAEC) *Report on Corporate Governance in the Victorian Public Sector, 2005* (Exhibit 6:1 Number of women appointed to Boards of selected public sector agencies, 2003-2004:200-201)

Figure 7.7 shows the percentage of appointments to Boards of selected public sector agency types by gender where the female target is 40 percent and which is achieved by all except the Advisory type agencies.

Figure 7.8 Appointments as Chair to Victorian public sector agency types by gender 2003-04.

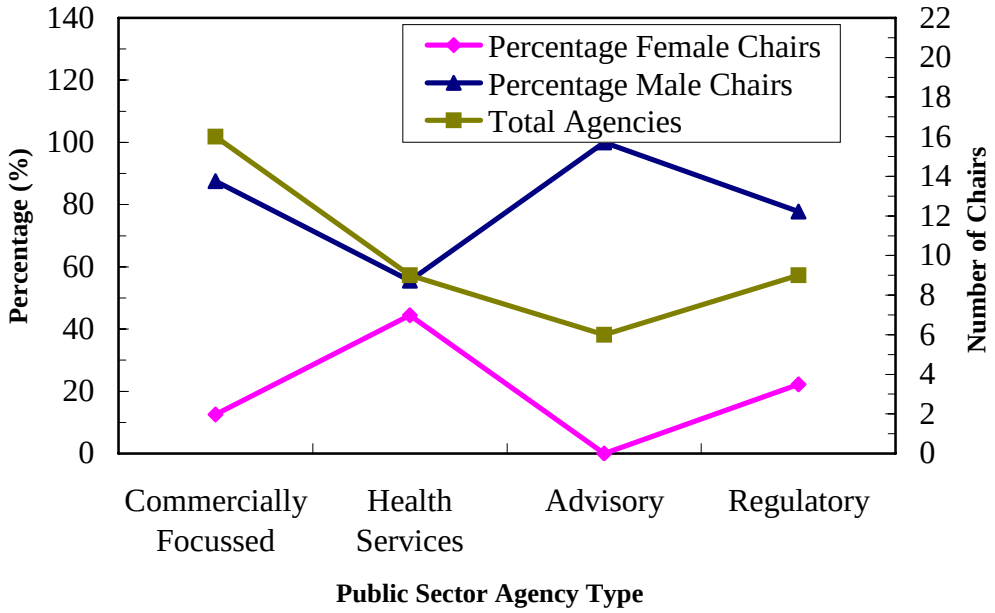


Figure 7.8 shows that approximately 40 percent of Chairs on public sector health service Boards are female.

Figure 7.8 reveals that in 2003 –2004, the government target of 40% female representation on public sector Boards was achieved on the *Commercially Focused*, *Health Services* and *Regulatory* Boards, but not the *Advisory Committee* Boards. The *Health Services* had the most women as Chairs and the *Advisory s* failed to have a woman in the role as Chair. It should be noted that in the four categories of the public sector, the agencies are 'selected'. That is, this table does not show all of the public sector agencies and in the instance of the Health Services, only eight of the possible twelve are presented. The ninth agency reported is a regional health service. It is not surprising to see that the *Nurses Board of Victoria* with 78% of the Board comprising of women, given that current *Australian Bureau of Statistics* figures indicate that nurses comprise over 90% of the national Health work force. Both *City*

West Water and *Peninsula Health* had over 50% of women on their Boards. *Essential Services* did not have any female directors during this period.

7.6 COMPOSITION, GENDER AND GOVERNANCE

The issue of gender balance has raised a number of questions regarding the lack of women on corporate Boards in the corporate governance literature. In a study of women directors in 2002 UK FTSE 100 companies, Sing and Vinnicombe stated that:

> Evidence shows that senior women do not easily gain access to the room…Explanations usually include women's lack of ambition, lack of experience and lack of commitment (2004:479).

It appears that the reason for the lack of women directors serving on corporate Boards is not easily explained and according to Singh and Vinnicombe (2004:479) the reasons given such as women's lack of ambition, experience and commitment has been 'disproved by research' and offer that social identity and social cohesion theories provide deeper insights into the reasons why women are poorly represented on Boards.

In his Canadian study on the views of women on the criteria for selection, Burke claimed that there were several key factors that included:

> … a flawed director process which places too much reliance on the "old boy network", difficulty in finding qualified women, few openings for new members and a reluctance to appoint women without previous experience (1997: 118).

Observations drawn from the empirical data from *HealthCo* and the trends presented of women represented on public sector Boards do not fully support Burke's claim. His claim that there is difficulty in finding 'qualified' women could be replaced with 'available women' as according to the DHS spokesperson those women available are often over subscribed. There is no supporting evidence to suggest that there is a reluctance to appoint women to Victorian public sector Boards without previous experience. This could be an area for future research.

According to Zweiggenhaft and Domhoff (1998), directors and the top executives of major corporations including government agencies are considered as 'elites' and that these elites are dominated by males. Equally, the Hansard Society Commission 1990:2, found that, 'the higher the rank, prestige or influence, the smaller the proportion of women'. While Conyon and Mallin (1997:116) reported 'strikingly low number of women in private sector Boardrooms', Ashburner (1995:117) reported 31.5% of the executive directors on Health Trust Boards are female and (27.9%) are non-executive. A current review of the representation of women serving on public sector health Boards in Victoria reveals that efforts to meet the labour government election promise for a target of at 40% of public sector Boards being made up of women is being achieved.

The argument that governance may be improved by having a broader representation of views was argued by Fondas and Sassalos, (2000). Singh and Vinnicombe (2004:481) claimed that governance is improved with women directors because women take their role more seriously and their 'sensitivity to other perspectives, as well as a more interactive and transformational management style' that creates a more open and productive environment. From the findings of their research Singh and Vinnicombe concluded that:

> …women can have something special to contribute to their Boards as women, with their different experiences, styles, responsibilities and voice on the Board (2004:486).

The researcher observed that rather than 'have something special to contribute' the women on the Board at *HealthCo* made worthy contributions at meetings. The notion that women on Boards may offer a 'special contribution' aligns with one of the external interviewees who believed from his own research and from his experience as a director and a Chair on various Boards that:

> *men and women process information differently and I've been fascinated by the research about the way men and women differently process accounting information. It found that women take a much wider range of considerations into account than men do. Males tend to focus on a much narrower range of factors. The literature is saying that women will make better decisions as bankers and auditors and so on as a consequence of human information processing differences.*

There was no evidence from the observations of the Board in this study to suggest that there were differences in the 'processing of information'. The researcher considered that overall, *HealthCo's* Board reflected a balance composition and range of skills and experience.

In establishing the relevance of Board composition and gender profiles in relation to the proportion of the users of the service and employees in the sector the researcher considered the findings of the employee profile from the *Staff Satisfaction Survey*. Despite a response rate of twenty-two percent, the gender profile of the 839 responses revealed that approximately 82% of the responses were from women as compared to approximately sixteen percent responses from males. This could indicate two possibilities. The first being that a significant percentage of *HealthCo's* workforce is made up of women and or that the female workers at *HealthCo* were more interested or made the effort to respond to the survey. The researcher also consulted the *Human Resources Department* to confirm the gender breakdown of staff at *HealthCo* and found that the gender split was approximately 70% female workers and 30% male workers. She was advised that there was a slight variation each year and therefore 70% was the 'approximate' figure. This figure is consistent with The Australian Bureau of Statistics (ABS) 2003 figures of 72.5% of all people employed in the health force industry being female. As such, she concluded that the dominance of women in the health sector was reflected in her response rate.

Table 7.3. Staff satisfaction survey: gender profiles

Gender	Actual Responses	Response Percentages (%)
Male	135	16.09
Female	686	81.76
Not provided	18	2.15
TOTAL:	**839**	**100**

The researcher consulted the literature to see comparisons between the make-up of the workforce specific to health care or hospitals was relevant to Board composition. Pfeffer examined the size, composition and function of Boards of directors in fifty-seven hospitals in the United States of America and found that:

The composition of the Board was determined partly by the socio-economic characteristics of the environment in which it operated, and again partly by the function it served (1973:362).

Similarly, Zald (1967) claimed that the organisation's location partly determined the composition of the Board, which is also determined by the available supply of prospective directors available to serve on the Board. In both cases, neither Pfeffer (1973) nor Zald (1967) discuss the importance of gender in Board composition and the emphasis is on function and ability to engage with the immediate environments and community they ultimately serve. This aligns with the perception of the Chair who said:

> *... it is important to attract people who have compassion for and a passion about our community. Ideally, I think every director should live in the region. They need to feel connected with the people and have a real understanding of their needs and lifestyles.*

She believed that this would provide them with the necessary knowledge and understanding of *HealthCo's* patients or 'users of the service. The researcher believed that despite differences in regional socio-economics or demographics and the diversity of Melbourne's population and the socio-economic mix of patients seen

in public hospitals made it difficult to argue for one perspective to reflect the users of any metropolitan health service.

The wording of the *Health Services Act* 1988 does not emphasise the need for gender equity. However, Section **65.T (3)** states that:

In making a recommendation under this section, the Minister must ensure that:

(a) the Board includes at least one person who is able to reflect the perspective of users of health services; and

(b) women and men are adequately represented.

Perhaps a better interpretation of Section **65.T** is that: (a) that one person be chosen who is able to reflect the perspective of the majority of users of the health service. The researcher was also reminded that those who serve on public health service Boards do so in terms of serving for the common good (Muetzelfeldt, 1994) rather than reflecting or representing that particular community.

It can be claimed from the investigation on governance in this study that the issue of Board composition and specifically gender is one worthy of further attention.

7.7 STAFF PERCEPTIONS OF *HEALTHCO's* MISSION and VALUES

Given that the setting of the strategic direction of an organisation is said to be one of the Board's major roles in corporate governance, the researcher wanted to investigate the significance of the Mission and Values. That is, as a public sector health organisation, *HealthCo* required faith and support from its various stakeholders for additional financial and human resources, she wanted to see how and if staff

supported the Mission and Values. She also wanted to see if they were used as a strategic tool by the Board and management. Using a grounded theoretical approach, the researcher observed the drafting process of the Mission and Values. This lead to the development of questions as to whether the staff shared in the Board's significance of the Mission and Values in terms of job satisfaction and morale.

7.8 THE CONSULTATION PROCESS: DEVELOPING *HEALTHCO's* MISSION AND VALUES

As outlined in the *Health Services Act*, one of the primary tasks of the newly formed Victorian public health service - *HealthCo* was to set the strategic direction for the organisation, with both a strategic plan and a business plan to be submitted and approved by the Minister for Health within twelve months of operation. During an initial discussion with the CEO and the Chair the researcher was informed that prior to the merging of the campuses into one agency, the organisation had a reputation for having poor morale and a high turnover of staff. In setting the strategic direction for the new organisation *HealthCo*, the CEO wanted to prioritise the need to address morale and turnover. He claimed that one of the key goals was to change this culture and to create a healthcare agency that was regarded by existing and potential staff as "an employer of choice". That is, *HealthCo* would be recognised by its commitment to staff in providing a safe and satisfying work environment in which staff could realise their professional potential through career opportunities and development. This was endorsed by the Chair, who stated, *We want to attract the world's best and have a reputation for being the number one place to work and conduct research.*

In order to change the previous culture and create this reputation, both the CEO and Chair said that they believed that it was vital to consult with the staff so that they could have a genuine sense of involvement in the decision-making. They believed that the staff should be part of developing a Mission statement and nominate *HealthCo's* Values.

A total of nineteen staff consultation forums were conducted during October and November 2001. Over two hundred and fifty staff and a range of external stakeholders to *HealthCo* were involved. A key component of the consultation forums was to workshop a draft mission statement and a list of organisational values.

In the 19 sessions, the Mission and Values were workshopped. The drafts from all of the workshops were pooled and draft statements were prepared by the senior executive. *HealthCo's* Mission and Values have not been included in the discussion for the purposes of confidentiality. The researcher participated in Group 4 (refer column 'predominantly management').

All staff were then invited to attend consultation feedback sessions. Once again, the sessions were offered at different times and at different campuses to enable as many staff as possible to attend. Each session was in relation to one of the five strategic themes identified and staff could choose a session in which they were most interested or had specific expertise. Each of the groups had a mix of staff.

Table 7.4 Results of the staff consultation on the Mission and Values

GROUP	NUMBER IN GROUP	OVERALL IMPRESSION of:	WHAT NEEDED TO BE CHANGED or ADDED
1 (Composition = mostly medical & clinical services staff).	46	<u>Mission:</u> General acceptance of the concept. Wanted something more inspiring. Question its value when it is the funders, i.e. government and therefore the budget that really determines what happens in terms of quality or what is provided. <u>Values:</u> Too many. Should be a short & memorable list. 5 to be maximum. (gave suggestions)	Nothing in concept. Make more inspiring by additional terms such as *excellence*. A list of terms including *excellence* and *best practice*. Could be reduced to *Quality Care* as this embraces all of the other values. Quality care is dictated by funding and the political party.
2 research & teaching staff – including nurses	33	<u>Mission:</u> Positive response. Do not be all, must focus on what *HealthCo* wants to be. <u>Values:</u> Positive direction. Research and learning should be a value.	Embrace /promote teaching, learning & research into how *HealthCo* provides its service as this is integral to its existence. Interaction with the community. Pro-activeness. Evaluation of accountability. Additional terms including: law, morals and ethics. Foster life long learning for staff.
3 General mix all staff including admin	64	<u>Mission:</u> Indifferent. If the Mission statement is why *HealthCo* is in business it should not include concepts like	Not inspiring enough. Perhaps patronising. Need to include the promotion of health.

		teaching and education, as these are a means to an end. <u>Values:</u> Good although too many.	Reduce to 4 or 5 Additional terms suggested including *excellence.*
4 (Predominantly Management)	15	<u>Mission:</u> Too generic. Doesn't properly identify business outcomes. Confusing terminology. Needs to take charge of expectations. <u>Values:</u> Support proactively.	Should: be patient focussed. be simple and easy for everyone to read. focus on the key values (too many). More emphasis on partnerships. Staff development. Communication strategy to be put in place. Reward staff for coping with major change & for major achievements. Work together as equal partners.
5 (General mix including allied health)	28	<u>Mission:</u> Should be patient first. Maximise health outcomes. <u>Values:</u> Should reflect how to achieve rather than overall plan. Accountability to a range of stakeholders: patients, the community, and other providers.	Should be short & crisp and an inspiring concept. Responsive to the community it serves. Striving for *excellence.* Health promotion. Best practice measurement – national standards. Notion of equal partnerships.

Several of the comments in relation to the Mission such as, *too generic, indifferent* and the need to be *more inspiring* suggest that the Mission could be improved. Such comments were also received in relation to the values.

Following this staff consultation, the executive met and worked in with a management consultant and a final draft of *HealthCo's* Mission and Values was submitted to the Board for approval. It is interesting to note that the values were reduced to five and one of the values was changed to *excellence.* Formal acceptance and endorsement of the Mission and Values by the Board resulted in them being announced to the public at the Annual General Meeting and published in the 2000/01 Annual report.

In observing the process of staff involvement and consultation, the researcher made the following. [Memo: *Were the mission and Values on display at each of the campuses? Were they discussed by staff? Were the 250 views reflective of the entire staff? (approximately 4,000) Was there a link between a positive perception of HealthCo's Mission and Values and staff morale and job satisfaction?]*

Over the duration of her time at each of the campuses, the researcher conducted visual audits to see if the Mission and or Values were displayed for the staff and public to read. During each of the audits, the researcher would visit each floor, ward and department and look at walls and notice boards. She also visited the various tea and lunch rooms and spent time talking with staff asking them if they were aware of the Mission and Values and whether they had an impact on their attitude to their job. The researcher also canvassed the opinions of several patients and visitors to see if they were aware of them and if they believed that they reflected *HealthCo* in terms their perception of the staff.

Given the efforts put in by management with the development of the Mission and Values, the researcher was surprised to find that there was little promotion of them. Over the duration of her research, she found only two areas out of all the campuses where the Mission and Values were displayed. The majority of staff she spoke to were either not aware of the Mission and Values or did not believe they reflected the real culture of *HealthCo*. She also asked various patients and visitors to the hospital if they had seen or read *HealthCo's* Mission and Values. None of those asked had either seen or read them.

Based on this initial investigation, the researcher believed that there might have been a disparity in the perspective held by senior management, the Board and the staff regarding both the knowledge and understanding of *HealthCo's* Mission and Values. In order to test her assumption, she included three questions in the *Staff Satisfaction Survey* specific to the Mission and Values. The questions were

- I have read and understand *HealthCo's* Mission and Values (Q.16)
- I support *HealthCo's* Mission Statement and Values (Q.18)
- The practices and decisions made by the Board and management match the Mission Statement and Values (Q.21)

Table 7.5 shows the total responses to all questions from the lowest to the highest response rate.

Table 7.5 Response rates to all questions – lowest to highest *Staff Satisfaction Survey*

All responses sorted by response rate	***R:Total Ans***	
Question	**N**	*%ofT*
21. The practices and decisions made by the Board and management match the mission and values statements.	**798**	*95.57*
18. I support *HealthCo*'s Mission Statement and Values.	**801**	*95.93*
16. I have read and understand *HealthCo*'s Mission Statement and Values.	**804**	*96.29*
7. Our department achieves the best results possible for our resources.	**813**	*97.37*
1. It is clear what is expected of me in my position at *HealthCo*.	**814**	*97.49*
13. I feel that my work is valued by senior management.	**814**	*97.49*
24. I am aware of and can easily access *HealthCo* policies.	**815**	*97.60*
20. I value the benefits provided by *HealthCo* as well as my salary.	**816**	*97.72*
6. My ideas are well received and supported by my colleagues.	**818**	*97.96*
9. If I have any problems with my job, I feel that I can talk to my supervisor or manager.	**819**	*98.08*
11.*There aren't many career and/or promotional opportunities if I stay at *HealthCo*.	**819**	*98.08*
23. I get a real sense of achievement from my job.	**821**	*98.32*
8.* I believe that the facilities and equipment that we have to work with could be improved/updated.	**822**	*98.44*
15. *In my experience, staff are not given a clear picture of what is meant by quality and excellence.	**822**	*98.44*
25. Management recognises and rewards good performance and encourages workers to use initiative.	**822**	*98.44*
22. I see myself as an employee of the site where I am based rather than of *HealthCo*.	**823**	*98.56*
26. I believe that *HealthCo* maintains job security to the best of its ability.	**823**	*98.56*
5.* My supervisor/manager is not easy to communicate with.	**824**	*98.68*
14. My supervisor ensures I have access to all the technical information I need.	**824**	*98.68*
28. In my experience, people from different departments and sites are willing to help each other.	**824**	*98.68*
4. I get on well with my fellow workers.	**825**	*98.80*
10. I am proud to work for *HealthCo*.	**825**	*98.80*
12. I believe that I am well paid for what I do.	**825**	*98.80*
31. Overall, I am happy with my job.	**825**	*98.80*
2. I enjoy my job.	**826**	*98.92*
17. I believe that the responsibilities of my job are suitable for my qualifications and experience.	**826**	*98.92*
18. I believe that the organisation provides adequate time and opportunity for training for all staff.	**826**	*98.92*
30. In my view, staff are invited and encouraged to take part in decision-making processes.	**826**	*98.92*
26. I believe that management and the Board consider staff to be key stakeholders of *HealthCo*.	**827**	*99.04*
29. *I believe my opinions would have little impact upon decisions.	**827**	*99.04*
3. There is good teamwork in my department/area.	**828**	*99.16*

* Reversed questions

7.9 ANALYSIS of QUESTIONS 16, 18 and 21

Questions 16, 18 and 21 received the lowest response rate. Despite these questions having the worst response rate of the thirty questions asked (the lowest being question 21 with a total of 802 responses (of 839), the three questions received the highest level of comments with 24, 22 and 17 comments respectively.

In Question 16, *I have read and understand HealthCo's Mission Statement and Values* 186 staff had a neutral response and answered *neither agree* nor *disagree* representing 23%. A combined total of *strongly disagree* and *disagree* responses accounted for fifteen percent of the total. 410 staff *agreed* (51%) and 44 *strongly agreed* (5%). Thus, over fifty percent of the staff claimed to have read and understood the Mission and Values However, it is worth noting that 24 staff made separate comments stating that they had not seen, read or even knew what the Mission and Values were.

The responses for question 18 revealed that approximately 60% of the *staff agreed* or *strongly agreed* to support the organisational Mission and Values. 36% of the responses neither agreed nor disagreed and only a combined total of 3% disagreed or totally disagreed. Question 21 asked staff if they believed that the Board's practices and decisions matched the Mission and Values. A breakdown of the responses indicated that a little over half of the responses were *neither agree nor disagree* (54%). One third of the responses (combined) were *disagree* or *strongly disagree*. The remaining (17%) responses agreed that the Board's practices and decisions matched the Mission and Values.

There were also fifteen blank responses to for questions 16, 18 and 21. This indicates that an additional 15 staff were either unaware of or hadn't read or understood the Mission and Values. The researcher acknowledges that these responses cannot be said to be representative of the entire staff at *HealthCo.* However, they provide evidence to suggest that there is a disparity between the Board and Management's interpretation of the staff 's practical understanding and application of these organisational tools. In order for the Mission and Values to be adopted by the staff, further development and/or promotion is warranted.

Table 7.6 Qualitative Comments: Questions 16, 18 & 21

Number	Question	Comment
16	I have read and understand *HealthCo's* Mission and Values (24 comments in total)	*No I have not read it.* (8). No, no idea. I have not been given a statement to read. I don't know what it is. I don't know of this/these. *Did not know they existed.* *What does it say?* Can't recall reading it. *?? x2* *Can't remember.* Never seen statement. Not applicable x 2. *Have not seen or been able to access.* *Don't know what they are.* *Have not seen paperwork.*
18	I support *HealthCo's* Mission Statement and Values (22 responses in total)	What does it say? What is it? Can't recall reading. *Sometimes.* *? x 2.* *Can't remember.* *Never seen statement x 2.* *Not familiar with.* *Not applicable x 2.* *I'm just not sure they work!* *Not read x 2.* *I have not been given a statement to read, I don't know what it is & they are.* *Do not know (2) of this/these.* *No, no idea.* *Have not seen.* *Have not seen paperwork.*
21	The practices and decisions made by the Board and management match the Mission Statement and Values (17 responses in total)	*They have monetary interests only.* *Who knows? What does it say?* *I am not aware.* ?? x 3. *No comment?* *Not applicable x 2* *Not read.* *Have not been studied, unable to comment.* *I have not been given a statement to read. I don't know what it is. Don't know.* *No, no idea.*

7.10 ORGANISATIONAL MISSION AND VALUES: THE LITERATURE

An abundance of management literature on organisational Mission and Values has emerged over the past decade (Bart and Tabone 1998). Fundamentally, Mission statements and publicised organisational values are considered as the primary tools for setting the strategic direction, objectives and the identity of the organisation. They are said to represent the 'formal declarations of an organisation's specific and long term objectives' Bart and Tabone (1998:1). Bain and Company (1994) proclaimed the mission statement as the pre-eminent universally used management tool. Claims that they are critical to the success of an organization have been made by Pearce and David (1987); Collins and Porras (1991). Leuthesser and Kohli (1997:59) have labelled them as the 'starting points' of organisational identity and Bart and Tabone (1998) referred to them as organisational 'cornerstones'.

In contrast, Leonard (2000) labelled them as 'paper tigers'. Smith, Heady, Carson and Carson (2001) claimed that despite the plethora of academic literature, there is little empirical evidence to support their merit in terms of organisational performance and that much of what is written on Mission statements is commercially focused and specific to private or "for-profit" organisations (Bart and Tabone, 1998).
There are a range of definitions on what a Mission statement is and what it should contain. Pearce offered that a Mission is:

> A broadly defined but enduring statement of purpose that distinguishes the organization from others of its type and identifies the scope of its operations in product (service) and market terms (1982:15).

The place of the mission statement is regarded as significant in the non-profit sector, with these organisations reliant on the generosity of the community and others to provide the vital financial and voluntary human resources to enable their programs and services to be delivered. Brown, Yoshioka and Munoz described the mission as:

> … more than a statement or a symbol; it is a tool that provides a clear, compelling statement of purpose that is disseminated both internally and externally. Increasingly mission statements are recognised as a strong management tool that can motivate employees and keep them focused on the purpose of the organisation. Often times, the mission statement attracts clients, donors, funders, employees, and volunteers to a non-profit organisation (2004:28).

Hence in the majority of non-profits, particularly in the health sector they are regarded as the 'core' (Angelica, 2001: Glasrud, 2001) or the 'bottom line' of organisations (Sawhill and Williamson, 2001: Sheehan, 1996). Despite the structural governance and accountability differences between non-profit and public sector entities, a public health service can be said to have more in common with its non-profit counterparts, as despite receiving government funding for its operational costs, it too is heavily reliant on the faith and goodwill of its diverse stakeholders. That is, in order to attract possible voluntary support and financial donations or sponsorship, the health service must be respected and trusted by its community for being seen to provide the best possible healthcare with its limited resources.

There have been several empirical studies addressing the link between organisational performance and mission statements in healthcare organizations, (Gibson, Newton and Cohran, 1990; Bart and Tabone, 1999). It has also been claimed that it is essential to have the involvement of staff in creating a Mission statement in the healthcare industry because of the:

> … diverse characteristics of the healthcare market make it essential for employees on all levels to not only have a clear understanding of what they are trying to achieve, but also a feeling of support and involvement in determining the mission (Forehand, 2000:267).

The diverse characteristics of the healthcare market and its workforce have been acknowledged and discussed in Chapter 3. This research observed the process of developing *HealthCo's* organisational Mission and Values and the attitude of staff toward them. The researcher did not attempt to critique the worthiness of the Mission and Values, rather, observe and record how staff perceived them. Hitt (1990) described the Mission and Values as the 'soul of the organisation' and that they should provide direction for decision-making and action. Whilst not being conclusive, the findings from this study indicate that more communication between the Board and management to staff was required in order for *HealthCo's* Mission and Values to become the 'soul' and influence with decision-making and action.

7.11 SUMMARY

In this chapter, a range of mixed data sources were presented to reveal some emerging themes on governance in relation to Board composition, gender and staff

perceptions of the Mission and Values. The literature was also consulted after analysis of the data in the traditions of grounded theory. The researcher was surprised to find that there was little to emerge on ethics and this will be discussed in the concluding chapter along with an overview of the key emergent issues.

CHAPTER 8 DISCUSSION AND CONCLUSIONS

8.1 INTRODUCTION

Corporate governance has been under the academic and public spotlight over the past decade, and organisational reform in both the private and public sectors has accelerated the need for investigation into governance operations. This study has broadened the existing knowledge and understanding of governance processes and practices. This knowledge has been dominated by research based on economic theoretical models. This study provides a social construction of governance based on active engagement and observation at *HealthCo*. As stated by Charmaz:

> Through sharing the worlds of our subjects, we come to conjure an image of their constructions and of our own (2000:529).

The world of the subjects at *HealthCo* was constructed by the researcher who employed a range of predominately traditional qualitative methods based on numerous interactions. The techniques included: prolonged observation and engagement with the Board and senior managers, observation and participation in a range of activities at the three campuses of the organisation, personal interviews, discussions and electronic interchange with a diverse range of internal and external stakeholders. The study also employed some quantitative approaches that included; a staff satisfaction survey that included questions on governance as a means of canvassing and assessing the opinions of a large and diverse workforce. A submission to an external body was used to capture how several of the key personnel at *HealthCo* – the CEO, the Chair, the Senior Finance Officer and the Human

Resource Manager, perceived the agency's governance functions and operations. Other data was extracted and incorporated into the research from Annual Reports, *the Health Services Act 1988*, and a range of information sources from the *Department of Human Services*.

The personal interviews, discussions and questionnaires given to the Board and staff provided the substantive data. The researcher's fieldwork and observations were used to develop questions and to assist the researcher in the coding and categorisation of the data.

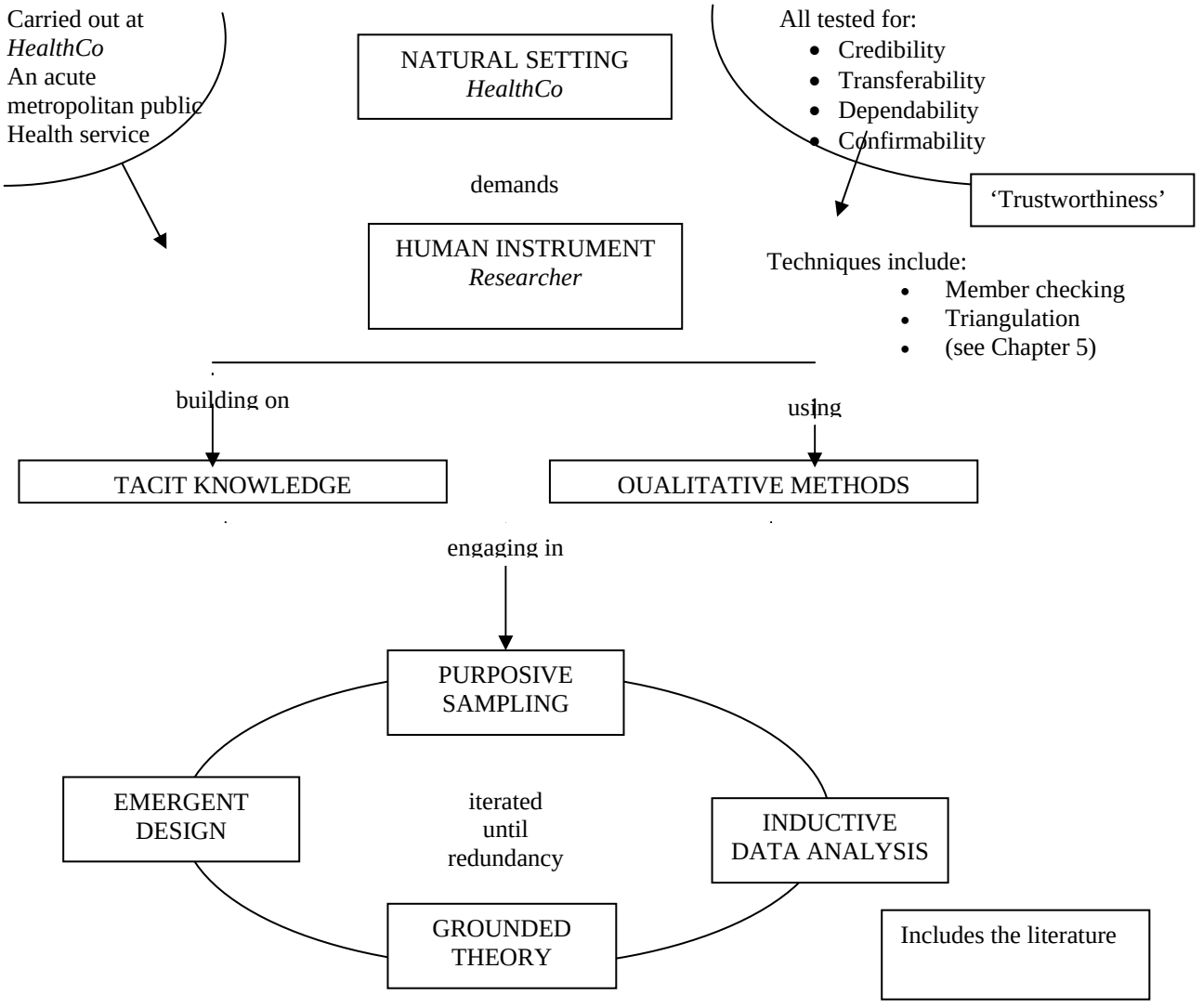
Each of the data sources were individually analysed and coded. Codes were then identified and sorted into categories. Data was then sorted from all sources into each of the emerging categories before fusing like data until the researcher had reached theoretical saturation (Glaser and Strauss, 1967). A range of academic literature was then 'progressively assessed' for its relevance to the study (Dick, 2002) and the major issues raised in the data checked for similarities and differences in the literature. Recognised qualitative techniques such as: member checking and triangulation ensured trustworthy, valid and reliable data.

In this final chapter, a synthesis of the key issues to emerge in the data is presented, along with a discussion of relevant corporate governance and management literature. Given that the study was purposely limited to one organisation *HealthCo*, the aim was to capture how governance is practiced and understood within this particular context.

8.2 CONSTRUCTING GROUNDED THEORY: CORPORATE GOVERNANCE IN *HEALTHCO*

Naturalistic inquiry was the methodological approach applied by the researcher. As part of the description of the processes used in this type of inquiry, the researcher used Lincoln and Guba's (1985) *Flow of Naturalistic Inquiry* to illustrate the processes used to construct grounded theory. A further adaptation has been included to describe the outcomes of the application of this methodology by describing each of the elements in this approach.

Figure 8.1 The construction of a grounded theoretical perspective of corporate governance in a public health agency using a naturalistic inquiry



Source: Adapted from Figure 4.1 The flow of Naturalistic Inquiry, p.90.

In this adapted version, the actual mapping of the research processes is shown. That is, the context and setting for the study along with the techniques for establishing trustworthiness.

The sampling framework was purposeful with all participants chosen for their relevance to the inquiry. The design of the study was emergent as questions and concepts were explored after concurrent inductive data analysis that identified repeated themes for further investigation. These themes were coded and categorised by the researcher and after reiteration and further explorations via additional questions, were identified as theoretical concepts once no further insights could be gained. This was when the researcher believed that the themes had been fully explored and no further or additional information was gained. This final stage is referred to as 'theoretical saturation'.

After completing these stages, this research identified the following theoretical constructs of governance.

8.3 COMPONENTS OF CORPORATE GOVERNANCE

The six categories of *Corporate Governance* (as adapted from the NSW *Corporate Governance in Better Heath Practice Guide,* 1999) were used to categorise the collective findings from the data sources. *Corporate Governance* was the first category to be analysed. Participants in the study claimed that corporate governance cannot be easily defined. This is consistent with the literature that describes governance as complex and as presented in Chapter 2 has a variety of definitions.

The following elements were reported by the directors to be key components or requirements of governance:

- direction, control and accountability
- principles and codes
- statutory or legal jurisdiction
- ethical behaviour
- Board composition and make-up
- setting the direction of the organisation
- strategic thinking
- decision-making
- compliance
- knowledge of roles and responsibilities
- accountability to a range of stakeholders including the community
- has a Board that acts as a caretaker and is responsible to staff and all stakeholders

The second category *Health Service Delivery and Policy* provided the context of the study – the health service industry. The remaining four categories: *Committee Structure, Composition, Meetings* and *Board and CEO Relationships* allowed for a closer insight into governance as a process at *HealthCo.* These categories are not context specific as in the case of *Health Service Delivery and Policy.*

The areas of each category are shown in the second column of Table 8.1. A summary of the researcher's findings from the total responses is shown in column three, with areas of weakness or uncertainty in column four.

Table 8.1 Six categories of governance in the public health sector

Category	Areas in relation to questions from appraisals	Findings	Comments/areas of uncertainty and or weakness
Corporate Governance	Roles and responsibilities of directors, planning, goals, objectives, 'vision', fiduciary duties and accountability, statutory and legal compliance, understanding of need for confidentiality, transparency – e.g. reporting in *Annual Report*, ethical behaviour and leadership, overseeing/supporting management decisions, evaluation of management performance review of Board performance.	High understanding of roles & responsibilities. High understanding of corporate strategy, planning, vision. Board works as a team. Appropriate structure to achieve *HealthCo's* purpose and goals. Self-Rating of performance = high. * Ethical behaviour is assumed	No written position description for Chair No disciplinary policy for directors No established set of criteria for evaluation of director's performance *No ethical code of conduct
Health Service Delivery and Policy	knowledge of: broader healthcare industry, 'competitors' – includes other healthcare services - both public and private. Policy and how any changes may affect *HealthCo.* The service's facilities and maintenance needs and the demographic and health profile of the community/population it services.	Have identified that not a great deal of knowledge in this area especially in terms of *HealthCo's* current physical facilities and problems such as maintenance. Board do not discuss the idea of other healthcare services as competitors. Branding of private health provider discussed at staff planning day.	Other health services not considered 'competitors'. Poor knowledge of hospital facilities/maintenance – this is seen as a 'management' rather than a Board issue. CEO wants to brand *HealthCo* – this includes logos and stationery etc, as he believes this will make the health service more competitive against new 'private' health provider.
Board's Committee Structure	Is the structure appropriate or is there a need to change? Is there a statement of purpose for each committee? Do directors serve on at least one committee,	Basis of a good committee structure and all directors serving on at least one or more committees. Minutes of meetings and liaison	Committee structure appears to work at committee level. High representation of management on committees. One committee failed to develop a statement of purpose

	Are minutes of committee meetings provided sufficiently and adequately for full Board meetings? Is there effective liaison with key stakeholders (staff, community, contractors, employer associations etc)?	with key stakeholders appears sound.	and took over twelve months to convene a meeting. This was never questioned by other Board members or flagged to be an issue of concern. Reports from sub-committee meetings one of the last of the agenda items at Board meetings and are often rushed through because of the length taken by the Finance report that is always the second item on the agenda.
Board meetings	Adequacy of timing for supply of agenda and other reading materials for meetings, participation in meetings, teamwork, ability to ask questions, Chair's ability to run effective meetings.	High attendance rate and participation in meetings and pre-reading of all materials supplied for meetings. Chair competent in position of running meetings yet does not keep time for agenda items. Finance reports always dominate and cause other items to be reduced.	Several Board members claimed that the agenda and other reading materials are often posted out too late to allow for adequate reading and preparation for meetings. Observations support this, as researcher noticed several Board members opening sealed document packages at the start of several meetings. Teamwork not evident.
Board CEO Relationships	Relationship between directors and CEO (trust), Relationship with Chair. Delegation of authority to CEO. Evaluation of CEO's performance and remuneration. Access to on going education and training for directors.	High respect, credibility and level of trust in CEO. Strong rapport with Chair. CEO has necessary delegated authority to manage *HealthCo.* Little knowledge of any education or training programs for directors.	(Is there a list of criteria for measuring performance?) The Board Appraisals were the only form of discussion regarding performance. Some directors indicated the need for ongoing training & education given the 'complexity' of the industry.

8.4 EMERGING ISSUES

Based on the findings presented in Table 8.1, the dominant issues that emerged in this study indicated that:

- There may be an assumption that directors fully understand their roles and responsibilities (that is, despite stating knowledge directors not aware of any job descriptions for the role or any performance measurement).
- There seems to be a lack of training, education and specific resources available to directors to assist them in better understanding their roles.
- The distinction between the role of senior managers and the Board is somewhat blurred.
- Equal representation of women on public sector bodies regarded as desirable but appears difficult to achieve/maintain.
- With a focus on compliance, it would appear that the financial reporting dominates Board meetings and limits the actual time spent on discussion of the issues arising from the sub-committee reports.
- The acceptance and understanding of the organisational Mission and Values by all staff requires further development. That is, the perception of the Board and management of how staff perceive the organisational Mission and Values does not appear to match.
- Ethics is an assumed component of governance in this particular setting. That is, there was an overall assumption that because it is a public health organisation all parties operate on the notion of 'the common good'. Ethical decision-making was seen to be in the hands of the medical staff and a 'clinical governance' issue.

A comprehensive discussion of the emerging issues was presented in Chapters 6 and 7.

One significant issue to emerge during the course of this study was that whist ethical behaviour 'is the cornerstone of effective corporate governance' (NSW Health and HSA of NSW, 1999: 7) there was a lack of discussion or evidence as to how this is to be demonstrated or measured. It seemed that the ethical behaviour of directors was 'assumed' by their appointments, with one of the requirements for the selection criteria being 'provide ethical and effective leadership' (refer *Health Services Act,* 1998, S65. Whilst this is stated in the Act, there are no specific indicators relating to ethics.

The researcher observed that ethical discussions appeared limited to the domains of the *Quality Committee* and this discussion tended to focus on the prioritisation of services and treatment for patients. It appeared that on most parts, ethical decisions regarding patient care was determined by the clinicians rather than management or the Board. Such decisions were seen to be a 'clinical' governance issue. This was supported by the researcher's observations at Board meetings and diarised notes that no major ethical discussions on patient treatment or care occurred. This excluded general comment issues such as ambulance bypass or ward closures due to staff shortages. Observations made from social interactions with the directors as individuals and collectively at dinners and retreats revealed a genuine concern that funds be equitably spread according to the needs of the community. The Directors felt that this was often difficult to achieve with limited financial resources.

The responses given by the external governance practitioners on the place of ethics in governance were consistent in that ethics was determined by individual values and that ethics formed part of a broader social understanding that to be appointed as a Director, one must have the appropriate reputation.

The researcher also noted that *HealthCo* did not have a 'Code of Conduct' that is a recommended as a fundamental instrument to assist in the promotion and understanding of the expected organisational behaviour at all levels.

Despite this, an overview of the combined data sources revealed that whilst the governance structure at *HealthCo* could be considered sound, there are clearly components of corporate governance that may be improved or are in fact 'assumed', such as ethics. Training and education for Board directors was also considered valuable in promoting better governance at *HealthCo.*

8.5 EVALUATING THE WORTHINESS OF THE STUDY

As discussed in Chapter 4, Glaser and Srauss (1967) established four criteria in order to evaluate the worthiness of grounded theory. In summary the four key terms of the criteria are: *fit, understandability, generalisability,* and *control*. Partington's (2000:93) interpretation of the criteria has been adopted by the researcher who questioned her grounded theory on corporate governance and its ability to: *fit* in the real world, *work* across a range of *contexts*, and be *relevant* to the people concerned and readily *modifiable.*

According to Locke (2001), the real test of grounded theory is its pragmatic use. That is, how useful it is not only to social scientists but also to a more general audience or the 'layman' who may wish to engage with the theory on a practical level. The researcher agrees with the original Glaser and Strauss criteria and of the interpretations of these criteria given by Parkington and Locke. This is her synopsis of how the study met the criteria.

(1) Engagement with the diverse parties involved in the governance of a large public health sector agency was based in a real life context. It therefore met the criteria of being able to 'fit' as it is part of the real world of governance. It was neither a contrived nor controlled investigation, rather an account of corporate governance as it actually was.

(2) The theoretical framework could easily be adopted by a range of parties, not limited to social scientists as it provided specific details about the methods used to collect and analyse the data. It is therefore adaptable and clearly workable.

(3) Despite the specific location of this research - a metropolitan acute health service, it is not contextually limited because the theoretical framework can be applied to other areas of organisational and management research. That is, the governance structure was not unique and could be described as a typical public sector governance structure. Also, as outlined in one of the key data sources – Board Appraisal 1, five of the six categories used to discuss the emerging issues can be considered relevant to any governance context, as *Health Service Delivery and Policy* specific to the

healthcare industry. Rather than a prescriptive formula, it provided clear guidelines and protocols about the processes required to undertake such a study.

(4) The theory offered a means of enhancing or improving governance as a process. For example, it highlighted that the time spent on financial reporting dominated meetings and compromised other areas such as the sub-committee reports. This left little time to deal with 'clinical governance' issues that may be revealed through the *Quality Committee* reports. Given that clinical governance 'is now highly placed on the agendas of all health service Boards in Australia' (Chapter 3, p.73), there was little evidence to suggest that the Board actually dealt with clinical governance decision-making issues. It also revealed that there is a need to promote the Mission and Values if they are to be considered as effective strategic tools for governance.

This research acknowledged that an observational study of a Board is not unique. However, what distinguishes this study from the others is that it incorporated a variety of data not only based on the observation of the Board, but also incorporated a range of data sources, samples and techniques based on the original principles of grounded theory (Glaser and Strauss 1967) and 'creatively' adapted to the social context in which it is based Charmaz (2000). The researcher explored the literature after her direct experiences of governance and looked for similarities and differences with the emerging issues and themes she had discovered. Thus the literature was not omitted, but only 'delayed' so that the theory was formed by the actual research, not formed by the literature (Chamberlain, 1995).

The researcher aimed to examine and provide a theoretical framework on corporate governance in an acute public health organisation that could have practical application not limited to this one area and or limited as an academic exercise. That is, by the provision of a detailed narrative of all of the processes and subsequent examples of the coding and categorisation of the data, this theoretical journey could be understood by a range of parties, not limited to an academic audience.

As explained by Locke:

> Grounded theory acknowledges its pragmatist philosophical heritage in insisting that a good theory is one that will be practically useful in the course of daily events, not only to social scientists, but also to laymen. In a sense, a test of good grounded theory is whether or not it works 'on the ground' so to speak (Locke, 2000:59).

In essence, the analysis of the data was in the three stages outlined by Locke (2001). Firstly, the data and codes of one item or source of data were compared to another and categories were allocated to constant or unique issues or themes. These categories were then integrated or linked with like or similar recurrent themes. In the third and final stage 'theoretical saturation' (Glaser and Strauss 1978) was reached and the researcher was able to settle on the theoretical components to write about the research.

8.6 TENSIONS IN USING GROUNDED THEORY

Whilst this thesis argued for a grounded theoretical approach to research corporate governance, it acknowledged that there are 'tensions' involved in undertaking this approach (Locke, 2001: 84). Immersion in and with the data is a fundamental aspect of the process. However, at times the researcher was 'overwhelmed' by the sheer volume of the data and the time required to assign meaning with the numerous codes and memos from the many sources collected. The difficulty in the separation of immersion and analysis is not easy and any researcher who plans to undertake a grounded theoretical study must create time to step away and allow the analytic processes to occur. In the later phases of the study and whilst writing her interpretation of the data, the researcher found that it was useful to discuss some of the emerging issues with colleagues as recommended by Glaser and Strauss (1967).

8.7 CONTEXT

Our understanding of any phenomena is based on our knowledge of what and where the event is happening – the context. It is the contextual boundary that limits the study to the one place at one point in time. In this study, *HealthCo* is the context and despite providing detailed guidelines and findings on corporate governance from the data collected in the context of one public sector health services provider, this thesis acknowledges some limitation, but considers that there may be a range of variables common to like organisations.

These variables include: changes in government policy and the changeover of directors at the expiration of their terms; the impact of organisational restructure and subsequent management changeovers- with an emphasis on the bottom line, and demographic changes in the population creating increased or decreased funding or access to services and treatment. However, the researcher has supplied the, 'who, what, when, and where' approach to enable another researcher to construct a similar inquiry. Given that the mission of grounded theory is to extend existing knowledge rather than duplicate what already exists, this study is not limited by its context. The grounded theoretical orientation used in this study is a variation of the original (Glaser and Strauss (1967) and subsequent (Glaser (1994) and Strauss and Corbin (1990) epistemological approach. It supports Charmaz (2000:510) that grounded theory application should not be 'rigid or prescriptive' and grounded theory methods 'flexible' and 'heuristic'.

8.8 LIMITATIONS OF THE STUDY

Despite the literature on governance being wide in range and spread across many disciplines (Turnbull, 1997), the primary area of focus of governance research has been on the economic performance of Boards. Initially, this was seen as a possible limitation, as there seemed a lack of appropriate theoretical models to allow for a more holistic examination of governance. This initially perceived limitation was turned into one of the strengths of the research, the development of a grounded theoretical approach to add to the existing knowledge base on governance.

One of the more obvious limitations is that this study provided an insight into the governance mechanisms and arrangements in one public health sector body.

Although the research examined public sector governance per se, this research does not claim to provide a definitive and comprehensive account of all public sector governance.

The study was also limited by time constraints and the overall availability of key participants given their existing professional time commitments. For example, individual interviews were cancelled or cut short as directors and other senior executives chose to respond to other more urgent duties. In general, the researcher had limited access to the directors and despite most of the directors indicating an interest in the research, few were ever available for follow-up discussions or interviews. Despite attending all Board meetings and several retreats the researcher felt that she was not privy to all of decision-making that may have occurred, as she was aware that many 'urgent' decisions were made by telephone or electronic communication.

Goulding presented the advantages and strengths of undertaking a grounded theoretical approach but also pointed out the limitations in relation to the time required to do so. She said:

> In order to fully utilise the method, there must be recognition that it is time-consuming, often frustrating and because of the nature of the method, often takes the research in a number of different directions before a plausible theory starts to emerge. This requires patience, an open mind and flexibility (1998:58).

The study was ambitious in that it attempted to include a diverse range of voices in the inquiry. This was extremely time-consuming and difficult to achieve, however, the researcher persevered with 'an open mind and flexibility'. Another limitation or 'frustration' was the lack of consistency and access to key personnel. That is, the agency was in what appeared to be a state of constant organisational restructure. Despite the general consensus of the importance of the study, the researcher recognised that it was quickly pushed aside by matters considered more urgent. One of the major criticisms of emergent research is that it may be a label for 'ad hoc' or 'sloppy' research that lacks detailed and 'precise' planning and execution (Descombe: 2003:126-128). The researcher acknowledges that emergent inquiry cannot be 'precisely planned' and thus requires a high level of disciplined thinking to create and recreate opportunities to access rich and insightful data. There is a need for risk-taking and determination to follow through with ideas in areas that may not have been questioned and explored. The researcher must be able to react spontaneously and be prepared to seize on research opportunities as they present themselves. This may involve following up on an unplanned interview or asking for organisational involvement to undertake a task that may add to an already heavy workload.

In establishing a study based on observing company directors at work or 'managerial elites', Winkler (1987:135) emphasised that 'researchers are liable to underestimate the time, effort and risk involved'. In this study, the researcher was accustomed to cancelled or rescheduled meetings as the 'managerial elites' that she dealt with had, at times, higher organisational priorities. Cairncros, Ashburner and Pettigrew (1991) identified the time demands of directors in the United Kingdom's National Health service (NHS) were well in excess of the 'prescribed' time commitments.

Williamson (1994) posited that governance in health services may take greater demands of its directors than their counterparts in the private sector.

In the initial proposal for this study, there was an overall plan of the length of time and the type of data sources required. These details were essential components of the candidature process and also required by *HealthCo*, however, the researcher was aware of the difficulty in 'precisely' plotting all that may be required ahead of time given the multiple realities and how these realities interacted to shape, influence and in some cases change the direction and possible outcome of the study (Lincoln and Guba, 1985, p. 41). An example of this is in the design and implementation of the *Staff Satisfaction Survey*. This survey created an opportunity to formally gather the perceptions of governance of over 3000 employees. Equally, the submission written in response to the *Public Accounts and Estimates Committee*, emerged from the researcher seeing the notice in *The Age* newspaper and initiating the response and involvement from both the CEO and Chair. This opportunity provided an external framework from which to examine governance at *HealthCo*. That is, it was external to the questions posed by the researcher. It also gave the researcher the opportunity to spend more time with the CEO and the Chair as they contributed to the submission.

The study could be said to be limited by the need for anonymity. That is, some of the artefact and other materials such as the organisational Mission and Values and exerts from Annual Reports could not be published in the thesis. The researcher believed that this limited the discussion on these key areas of corporate governance.
The researcher was not dissuaded by the lack of research available to guide her, rather challenged to undertake an empirical study of such magnitude.

> Because research on Boards and directors is still in its infancy, there are few theoretical, empirical, or methodological guideposts to assist the optimistic yet wary researcher through the prescriptive minefield (Pettigrew, 1992:169).

The researcher concurs with Pettigrew regarding the as she faced the minefield of undertaking a study of governance in a complex setting. This research revealed that corporate governance can be viewed through a range of theoretical lenses and academic disciplines. However, grounded theory provides a viable model to view, analyse and possibly assess governance.

8.9 RECOMMENDATIONS FOR FUTURE INQUIRY

As has been stated previously this thesis did not attempt to evaluate or measure the performance of the Board or *HealthCo* as an organisation, however, after completing the data analysis and consulting the literature as is customary in a grounded theoretical approach, the researcher found the work on Hospital Board Effectiveness Kovner (1990) as a useful approach. Kovner outlined a range of issues such as Board composition and the need to monitor individual and Board performance by setting clear guidelines and objectives based upon their specific roles and responsibilities.

By applying Kovner's levels of behaviour, from 'failing to effective Boards' the researcher rated *HealthCo* as an effective Board based on her observations of the Board's interaction with management and the community (see shaded text Table 8.2).

Table 8.2 Levels of governance performance for hospital boards

Behavior	Failing Boards	Acceptable Boards	Effective Boards
Integrate decision making	Hospital makes decisions only in crisis	Segmented decision making	Integrated decision-making
Support Management	No support	Supports management so long as no bloc Opposition	Backs management contribution to hospital objectives
Focus and Energize the Board	No agenda	No measurable objectives	Evaluates performance relative to objectives set in advance
Benefit the Community	Not considered	Assumed	Defines population served and assesses and influences hospital to improve health status and contain costs.

Source: Adapted from Kovner (1990) *Improving Hospital Board Effectiveness: an Update*, Frontiers of Health Service Management 6:3, pp.17.

From the analysis of the data collected and from the researcher's observations *HealthCo* can be described as being an Effective Board because they appear to have *integrated decision-making*, with the Board *backing management contribution to hospital objectives* and *defines the population served and assesses and influences hospital to improve health status and contain costs.*

An example of the 'integrated decision-making' was presented in Chapter 7 (see Table 7.10). The integration of the decision-making on the organisational Mission and Values included staff forums with managers and this was then presented to the Board for discussion and review at a Board retreat. The researcher believed that the Board backed management's contributions to *HealthCo's* objectives and witnessed this directly at Board meetings with the endorsement of the CEO and other senior

management reports and proposals. The terms of reference for both the *Quality* and *Population and Primary Care Committee's* included defining and doing a needs based analysis of the health status of *HealthCo's* population. That is, a priority listing of the major diseases and treatments of the population they serviced and a cost analysis according to resources allocated. Both committees were also active in ways to promote health and preventative programs, such as immunisation and screening of potential diseases.

Kovner's categorisation of governance performance for Hospital Board's could provide a useful framework to assist future research in governance and or Board performance. It could also be adapted for use in other organisations, particularly in the public or community sectors

8.10 CONCLUDING REMARKS

This thesis has attempted to investigate the broad concept of corporate governance in the context of the Victorian public health sector. It does not claim to have found the solution to the possibility of failed governance, or to have created a best practice model of governance. The aim of the researcher was to reveal actual organisational governance in order to enhance what is known about governance as a practice. It also offered a constructivist conceptual paradigm for further governance inquiry.

Despite this being the end of the thesis, it is not the end of the discussion on corporate governance. It is a small step in perhaps opening up governance to assist in a more general understanding of what governance may actually mean. It is an invitation to

academics, practitioners and or stakeholders to take up the challenge. The thesis ultimately argues that governance as a social construction has not only one human face (McGregor 2000), rather many faces and voices that ultimately shape the governance of any organisation.

Carver (1997) contended that ultimately, hospitals hold the power of life and death. This thesis advocates that it is rather the governance of hospitals and the people that govern them that really hold this power as they are responsible for the allocation of resources. As such, this thesis offers an insight into the complex world of governance in a public health organisation. It aims to assist in providing a greater understanding of broad and diverse concept labelled corporate governance

As stated by Abetz (2003:1)

> …Corporate governance s should not be viewed as a goal to be attained...rather, it is a journey that requires vigilance, constant review, and ongoing consideration.

The researcher now invites others to take the vigilant journey of consideration and investigation into the complex world known as corporate governance. With dedicated vigilance and consideration, governance can be reviewed and further improved.

Appendix 1

Copy of Selection Criteria for appointment to Victorian public health service Boards

http://www.health.vic.gov.au/governance/mphs-guidelines2008.pdf

Appointments to boards of Metropolitan Public Health Services –

Guidelines and information for applicants

Background

The Minister for Health, the Hon Daniel Andrews MP, is seeking applications from suitably qualified and experienced persons for appointment as directors on the boards of metropolitan public health services. Those interested must have a commitment to excellence in public health care and the skills and expertise to contribute to the governance of a complex, major health care organisation.

Boards of directors are responsible to the Minister for setting the strategic directions of public metropolitan health care services within the framework of government policy. They are accountable for ensuring that the metropolitan public health services:

- are effective and efficiently managed
- provide high quality care and service delivery
- meet the needs of the community
- meet financial and non-financial performance targets.

Metropolitan Public Health Services in Victoria

The public hospital sector represents a significant part of the health care system in Victoria. The total budget allocated by the Department of Human Services to metropolitan public health services in 2007-08 is approximately $3.9 billion, which represents over 40% of the State outlays on health and community services. There are 13 metropolitan public health services, as listed at the end of this document. The overall budget managed in 2007-08 by each metropolitan public health service ranges in size from approximately $50 million to over $600 million.

Metropolitan public health services do not operate in isolation from other parts of the health care system. They provide a complex range of services through direct service delivery across acute, sub-acute, aged care, mental health and primary health program areas. Through service networks and partnerships, services are extensive and there are growing links with other health providers such as general practitioners, community health centres, aged and extended care services and other community service providers. Metropolitan public health services promote the integration of services across program areas to improve service quality, efficiency and accessibility.

Boards of Metropolitan Public Health Services

The board of directors of a metropolitan public health service is accountable to the Minister for Health for the governance of the organisation. The board is responsible for setting the strategic directions of the metropolitan public health service as well as general oversight of operations and financial control.

Each metropolitan public health service has a Chief Executive Officer who is responsible to the board for the implementation of the board's policy decisions; providing advice where sought by the board; proper day to day management of the resources of the metropolitan public health service; and reporting on the metropolitan public health service's performance.

The functions of the board are prescribed by the *Health Services Act 1988 section 65S*. In broad terms, the role and functions of the board of a metropolitan public health service are to:

- provide effective and ethical leadership and provide integrity for the organisation
- monitor and be accountable for the performance of the metropolitan public health service (including throughput, quality, waiting lists, and hospital solvency, liquidity and viability)
- oversee the management by the Chief Executive Officer and monitor his/her performance
- develop, review, change and approve strategic plans for the metropolitan public health service
- develop plans, strategies and budgets to ensure accountable and efficient provision of health services by the metropolitan public health service and the long term financial viability of the entity, overseeing a planned approach to commitments and expenditure and the management of risk
- establish and maintain effective systems to ensure that health services meet the needs of the communities served by the metropolitan public health service and that the views of users of health services are taken into account in planning, review and improvement of services
- ensure that high quality, effective services are provided by the metropolitan public health service and that effective and accountable systems are in place to monitor and continuously improve the quality and effectiveness of health services, address problems in a timely manner and foster innovation
- develop arrangements with other health care agencies and health service providers to enable effective and efficient service delivery and continuity of care
- facilitate health research and education.

Metropolitan public health services obtain the major share of its income from the State in exchange for an undertaking to provide health services. Increasingly the focus is on outcomes rather than to prescribe inputs. Metropolitan public health services are encouraged to use best business practice in their operations, foster innovation in clinical care and service delivery, and to respond to the output funding environment (including Casemix funding) by introducing responsible management systems, which devolve budget responsibility and foster initiatives to improve performance. This is demonstrated in the annual Statement of Priorities, a signed agreement between the Minister for Health and individual board chairpersons.

Terms and conditions for appointment of directors

Metropolitan public health services are established under the *Health Services Act 1988* and are governed by a board of directors usually comprising nine persons appointed by the Governor in Council on the recommendation of the Minister for Health. The *Health Services Act 1988* provides for board directors to hold office for not more than three years from the date of appointment.

Existing directors are eligible for reappointment and must reapply using the formal application process. They should be aware that reappointment is not automatic and that they cannot expect to be reappointed as a right. Board directors must not serve more than nine consecutive years. The positions currently being advertised will be appointed from 1 July 2008.

Short-listed applicants may be interviewed and assessed to ensure that they have the necessary qualifications, skills and experience for the position and that they are able to commit adequate time to the appointment. Applicants will also be required to provide information on whether they are current members of any other government bodies. Applicants should be aware that, if appointed to a board of directors, they are expected to attend, as a minimum, 75% of meetings of the board held during the year, and that they are expected to make a significant contribution to the board.

Assessing applicants

The government is committed to ensuring that there is strong governance and accountability of the board for the performance of the organisation and delivery of health services. Each metropolitan public health service needs a balanced board, which has the right mix of relevant skills, knowledge, attributes and expertise to be effective and achieve its objectives. This includes skills and expertise relating to the governance of health services, and ability to represent the views of the community.

It is government policy that government boards and committees reflect the composition of the Victorian community, including the representation of women, indigenous Victorians, Victoria's culturally diverse community and young Victorians.

The capacity of the applicant to effectively contribute time to the workload and demands of board and committee membership will also be a factor in the final selection process. It is important that applicants clearly identify any conflicts of interest that may arise if appointed to a board, and specify how these conflicts will be managed.

Staff will not be appointed to the board. As a general rule, individuals with other pecuniary interests in the organisation will not be appointed. For example contractors providing goods or services, or where the individual's personal/professional interests are directly affected by strategic decisions of the board.

Selection criteria

Applicants must address the following Selection criteria as part of their application:

1. Possession of significant expertise or qualifications that would be advantageous to the governance of health services, within the following disciplines:

    - corporate management
    - finance/audit
    - law
    - human resources
    - capital management
    - strategic information technology
    - risk management
    - clinical governance

2. Capacity to reflect the views of the community and users of health services, including demonstrated community participation and representation.

3. Continuing high levels of performance in their fields of endeavor.

4. Integrity and a high standing in the community.

5. Appreciation or understanding of the broader policy context and issues surrounding the delivery and planning of public health services.

6. Good working knowledge and understanding of accountability relationships and corporate governance, including the separation of governance and management, and the roles, duties and obligations of non-executive directors.

7. Demonstrated strategic thinking, planning and leadership skills, and experience at high-level decision-making.

8. Experience in effective consultation and collaboration with stakeholders.

In assessing the criteria, consideration will be given to board composition and ensuring correct balance.

Capacity to commit adequate time

The government is committed to supporting the balance between work and family, and establishing 'family-friendly' work environments. It is important that applicants are aware of the time commitment involved in discharging the duties of being a board director. Applicants should be aware that, if appointed to a board of directors, they are expected to attend, as a minimum, 75 per cent of meetings of the board held during the year.

Board directors are part-time non-executive directors. Generally, board meetings occur monthly and there may be additional extraordinary meetings or board functions which directors are expected to attend. Each board has several subcommittees that meet monthly and directors would be expected to participate on some of these, including potentially occupying the role of Chair of a subcommittee.

As well as time for direct attendance, time should be allowed for reading and preparatory work to ensure that directors are fully informed and able to add value to the board's decision making processes.

Declaration of private interests

In accordance with government policy, all applicants must complete a Declaration of Private Interests to the satisfaction of the Minister. This provides for disclosure of pecuniary interests or other private interests, which could conflict with the proper performance of directors' duties.

In selecting suitable candidates as directors on boards of metropolitan public health services, directors should recognise their obligations and abide by the Directors' Code of Conduct issued by the State Services Authority. In so doing, directors are required to carefully examine issues scheduled for discussion by the board and identify any perceived or actual conflict of interest that may arise. Should this be the case, the director must disclose the conflict of interest, withdraw from board deliberations and abstain from voting on the matter. The director should also discuss with the Chair any situation where they are unsure if a conflict, whether actual or perceived, may exist.

Applicants with a background in financial management should disclose in their declaration of private interests if they have had or are currently engaged in consultancy work with professional financial services organisations providing audit, tax and advisory services to health services in Victoria. In addition, any applicants who have provided other high level advice or management services should include details of that involvement which can be considered as part of their application. This information is used to ensure that selected candidates can be appointed to boards where they have limited or no conflicts that would affect their ability to contribute to the work of the board.

The information provided in this declaration will be held and reviewed by the department in accordance with the *Information Privacy Act 2000*. Any declarations provided by short-listed applicants who are not appointed to a Board will be returned to the individual. Applicants should refer to the sample Declaration of Private Interests form for an understanding of the information required.

The appointment of individuals, including the reappointment of any current board directors, is subject to the satisfactory completion of a current Declaration of Private Interests.

Probity checks

It is essential that appointees to government bodies have records of personal, professional and commercial integrity, and that the public sector is seen as maintaining high standards in this area. In accordance with government policy, applicants will be required to consent to the conduct of formal probity checks. These probity checks will consist of a criminal record check Australia wide by Victoria Police, an Australian Securities and Investments Commission disqualification register check, and a National Personal Insolvency Index check conducted through the Insolvency and Trustee Service Australia.

All applicants are required to provide a completed *Consent to Check and Release National Police Record*. Applicants holding a police certificate provided within the last 12 months may provide a certified copy of this instead of completing the consent form. Applicants should refer to the sample *Consent to Check and Release National Police Record* form for an understanding of the information required.

The appointment of individuals, including the reappointment of any current board directors, to a board is subject to the satisfactory completion of the formal probity checks detailed above.

Referee reports

Referee reports are an important part of the selection process and will be obtained for all short-listed applicants. On the Application Form applicants are asked to nominate three referees who can discuss the application in relation to the key selection criteria and responsibilities of the position.

Remuneration

Remuneration will be paid at rates determined by the Governor in Council. Generally, remuneration payments will only be made to the appointee in their personal capacity through the metropolitan public health service's payroll system. Under no circumstances will payment be made on invoice. The government is not prepared to sanction payments that could be construed as tacitly supporting tax minimisation arrangements.

Public sector employees are only eligible for remuneration in certain circumstances. Public sector employees include people employed in the service of the State of Victoria by:

- a government department
- statutory body, instrumentality
- public bodies such as public hospitals and community health centres
- local government
- employees of universities and schools are also considered public sector employees for the purposes of remuneration.

Short-listed applicants who are public sector employees will be required to provide a copy of their current job description and a letter from their employer indicating:

- approval for the employee to undertake the position

- that there is no material conflict of interest for the person to be appointed. In the event that the conflict is trivial, the extent of this should be described, together with any procedures which may be adopted to manage the perceived conflict

- that the board duties are outside the individual's functions as a public sector employee in their substantive position and that the work involved in the appointment can be, and will be, performed in the employee's own time.

Short listed applicants that fall into this category will be notified by the department and provided with the relevant instructions to complete this requirement.

Metropolitan Public Health Services

Information on each of the metropolitan public health services can be found at the following websites:

Metropolitan Public Health Service	Website	Corporate office location
Austin Health	www.austin.org.au	Heidelberg
Bayside Health	www.baysidehealth.org.au	Prahran
Dental Health Services Victoria	www.dhsv.org.au	Carlton
Eastern Health	www.easternhealth.org.au	Box Hill
Melbourne Health	www.mh.org.au	Parkville
Northern Health	www.nh.org.au	Preston
Peninsula Health	www.peninsulahealth.org.au	Frankston
Peter MacCallum Cancer Institute	www.petermac.org	East Melbourne
The Royal Children's Hospital	www.rch.org.au	Carlton
The Royal Victorian Eye and Ear Hospital	www.rveeh.vic.gov.au	East Melbourne
The Royal Women's Hospital	www.thewomens.org.au	Parkville
Southern Health	www.southernhealth.org.au	Clayton
Western Health	www.wh.org.au	Footscray

Further information about the Victorian health care system and the Department of Human Services can be found at www.health.vic.gov.au and www.dhs.vic.gov.au. An interactive map of the metropolitan public health services is at www.health.vic.gov.au/maps/index.htm.

Checklist for Applicants

All Applicants must provide the following documentation in order to maximise consideration of their application

1. A completed and signed Application Privacy Form, using the form provided.

2. A completed typed and signed Curriculum Vitae Summary Form, using the form provided. Additional Curriculum Vitae information may be provided as an attachment to the form. (Please note this form must be typed and signed by hand).

3. A signed statement addressing each of the eight Selection criteria, as listed on page 3 of this guide.

4. A completed Declaration of Private Interests form using the form provided.

5. A completed, signed and witnessed Consent to check and release National Police Record form using the form provided. Applicants should attach a copy of photo I.D. such as a current driver's licence or passport. No payment is required with this form.

All applicants are required to provide a completed Application Privacy Form, Curriculum Vitae Summary Form, Declaration of Private Interests form and Consent to check and release National Police Record form. These are available at www.health.vic.gov.au/governance/appointments.htm or from the Applications Officer at the Department of Human Services on 03 9096 9058.

Please note that short-listed applicants who are public sector employees will be required to provide a letter from their employer as noted in the above section on 'Remuneration'.

Expressions of interest, marked 'In Confidence', enclosing the *Application Form*, *Curriculum Vitae Form* and required supporting documentation should be received at the following address by **5pm** on **Friday 1st February 2008**. Late applications cannot be accepted.

Applications to Dental Health Services Victoria should be addressed as follows:

Applications Officer
Level 12, 50 Lonsdale Street
Melbourne 3000

All OTHER Applications are addressed as follows:

Applications Officer
Governance and Accountability
Access and Metropolitan Performance Branch
Department of Human Services
GPO Box 4057
MELBOURNE 3000

Due to new building security procedures, hand delivered applications **cannot** be accepted. Applications must be posted to the above address in a clearly addressed envelope.

Appendix 2

Copy of interview schedule – external governance professionals

External Interview questions: ***Corporate Governance***

PhD Candidate: Maree Fitzpatrick, Faculty of Business and Law, Victoria University,
Contact details via email: maree.fitzpatrick@vu.edu.au

Commence with a brief overview of your background – specifically related to expertise/interest in Corporate Governance.
(e.g. corporate lawyer, accountant, CEO of an organisation, have served on a number of boards, academic) * can include mix

1. What is your definition of Corporate Governance?

2. Does Corporate Governance differ between private and public sector organisations?
   How?
   Why?

3. What is the relationship between Corporate Governance and ethics? What is it?

4. How do we separate our personal ethics from Boardroom decisions? Is this difficult?

5. What is *good* Corporate Governance? What are the key elements?

6. How can *good* Corporate Governance be achieved and sustained?

7. A 1998 international survey found that in Australia, the emphasis is on conformance/compliance as opposed to performance. Do you agree? Is this good – ie does it promote /ensure *good* governance?

8. Is Corporate Governance necessary? Why? Can we be *over* governed?

9. There are claims that good Corporate Governance gives an organisation a competitive advantage? Is this really the case? How? Why? Why not?

10. What do you understand the terms *transparency* and *accountability* to mean?

11. Are they realistic achievable? How/Why/Why not?

12. How does an organisation demonstrate transparency yet maintain confidentiality?

13. How do organisations best manage risks?

14. Are external auditors the best protective mechanism for Boards?

15. There are numerous international corporate governance principles and codes. Are they useful?

Appendix 3

Copy of Board Self-Appraisal Questionnaire

BOARD SELF APPRAISAL QUESTIONAAIRE
(please tick most appropriate response)

Corporate governance	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1 .The role, responsibilities and objectives of the board are clearly stated and well understood by board members.	❑	❑	❑	❑	❑
2. The corporate plan of the organisation is regularly reviewed to ensure it remains consistent with the direction the board wishes to take.	❑	❑	❑	❑	❑
3. The board and management are successfully communicating the organisation's corporate strategies at all levels within the organisation.	❑	❑	❑	❑	❑
4. The board ensures that the corporate strategies of the organisation are regularly monitored and reviewed.	❑	❑	❑	❑	❑
5. The vision and strategies for the organisation guide the board's decision making.	❑	❑	❑	❑	❑
6. The board regularly reviews the performance of management.	❑	❑	❑	❑	❑
7. Finances and other resources of the Organisation are well controlled through the finance and audit committees of the board.	❑	❑	❑	❑	❑
8. The board ensures that there is an effective and efficient management and control system in place to see that its plans and decisions are implemented.	❑	❑	❑	❑	❑
9. The board and management maintain effective communication with the Minister on important issues.	❑	❑	❑	❑	❑
1 0. The board and management maintain effective communication with the Director-General on important issues.	❑	❑	❑	❑	❑
11. A strong sense of coordination and team work underpins boardroom behaviour and decision making.	❑	❑	❑	❑	❑

Corporate governance (continued)	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
12. Board members comply with legal and other statutory requirements imposed upon them.	❑	❑	❑	❑	❑
13. Board members understand the prescribed functions of Health Service boards as detailed in the Health Services Act 1988.	❑	❑	❑	❑	❑
14. Board room conflicts of interest are effectively avoided.	❑	❑	❑	❑	❑
15. Board members stay abreast of issues and trends which could affect the strategic or business plan of the organisation.	❑	❑	❑	❑	❑
16. Board members understand the necessity for maintaining confidentiality in the conduct of board business.	❑	❑	❑	❑	❑
17. Board members understand that self interest comes second to the interests of their organisation.	❑	❑	❑	❑	❑
18. Board members understand that the role of the board as a whole is one of governing rather than managing the organisation.	❑	❑	❑	❑	❑
19. Board members understand the difference between the board's policy-making role and the role of management to manage.	❑	❑	❑	❑	❑
20. The board is able to clearly communicate its concerns, expectations and ideas to the CEO.	❑	❑	❑	❑	❑
21. Board members understand the essential characteristics of good governance.	❑	❑	❑	❑	❑
22. The board has endorsed a formal fraud control strategy for the organisation.	❑	❑	❑	❑	❑
23. The board details its corporate governance practices in its annual report as an effective way of providing operational transparency for the organisation.	❑	❑	❑	❑	❑

Corporate governance (continued)	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
24. The board has been successful in establishing, through management, effective and regular liaison with:					
• the community	❑	❑	❑	❑	❑
• staff	❑	❑	❑	❑	❑
• employee associations	❑	❑	❑	❑	❑
25. The board and management have been successful in establishing regular liaison with the local community.	❑	❑	❑	❑	❑
26. The board has put systems in place to assign accountabilities of board members, committees and auditors for monitoring management.	❑	❑	❑	❑	❑
27. Board members have a clear understanding of the core business of the organisation and the key measures of performance.	❑	❑	❑	❑	❑
28. Board members have a clear understanding of the by-laws of the Health Service.	❑	❑	❑	❑	❑
29. The board has access to sources of of expert advice.	❑	❑	❑	❑	❑
Health service delivery & policy	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
30. The board ensures, through management, that the quality of service delivery is continually monitored and improvements made where necessary.	❑	❑	❑	❑	❑
31. The board ensures that it is continually kept aware of the health status of its community and changes in demography.	❑	❑	❑	❑	❑
32. The board ensures there is an appropriate balance between prevention, early intervention, curative, rehabilitative/palliative care.	❑	❑	❑	❑	❑
33. The board ensures it is kept abreast of any changes in major health policies.	❑	❑	❑	❑	❑
34. The board monitors the impact which these changes may have on their organisation.	❑	❑	❑	❑	❑

The Board's committee structure	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
35. The board receives sufficient, appropriate and timely information from the following committees, or their equivalents:					
• finance & audit committee	❑	❑	❑	❑	❑
• quality committee	❑	❑	❑	❑	❑
• community committee	❑	❑	❑	❑	❑
• population committee	❑	❑	❑	❑	❑

Board composition	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
36. The range of qualifications and experience that individual board members bring to the board enhances its ability to govern.	❑	❑	❑	❑	❑

Board meetings	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
37. The board ensures it has been provided with meeting agendas, accompanied with the necessary information far enough in advance of the scheduled meetings to:					
• be adequately prepared	❑	❑	❑	❑	❑
• make sure the agenda enables board business to be dealt with efficiently	❑	❑	❑	❑	❑
• make sure there is sufficient time for discussion of issues requiring major decisions	❑	❑	❑	❑	❑
38. Board meetings are conducted in a way that encourages contributions from all board members, constructive participation and timely decision making.	❑	❑	❑	❑	❑
39. The frequency of scheduled board meetings is appropriate in order to address the business of the organisation effectively.	❑	❑	❑	❑	❑
40. The most effective way of finalising decisions of the board is by consensus rather than formal vote.	❑	❑	❑	❑	❑

Board CEO relationships	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
41. The board's communication with management, through the CEO, is open, honest and based on mutual respect.	❑	❑	❑	❑	❑
42. The board has ensured that the CEO has sufficient delegated authority to manage the Organisation.	❑	❑	❑	❑	❑
43. The board is satisfied that steps have been taken to develop members skills and update their knowledge by:					
• the provision of a comprehensive and informative orientation program for new board members	❑	❑	❑	❑	❑
• access to continuing education and training programs	❑	❑	❑	❑	❑
• suggestions for improving the board's performance	❑	❑	❑	❑	❑

comments/suggestions for improving the board's performance
(include an additional page if necessary)

Thank you.

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Appendix 4

Director's Self-Appraisal

BOARD GOVERNANCE WORKSHOP QUESTIONNAIRE (Part 1)

Directors' Self-Rating Procedure

You are being asked to rate your knowledge, performance, and understanding of the various criteria for members of the health service board of directors.
All the ratings will be collected and tabulated and the results will be presented for full board discussion.
Most questions ask you to rate your level of information or knowledge on a low-high scale. If you rate your knowledge above average, for example, you might give yourself a 6, 7, or 6 or even higher on any given question. If you have any doubts about any area or feel you're still learning, you might give yourself a 4, 3 or 2. Please be candid as you answer these questions about your own board knowledge (*please circle most appropriate response*).
A few questions may require brief comments. Use examples where it will help explain your comment.

1. Rate your knowledge of and familiarity with the organisation on whose board you serve, regarding services, key personnel, corporate mission, goals and objectives.

1 2 3 4 5 6 7 8 9 10

2. How well do you understand your own responsibilities as a board member?

1 2 3 4 5 6 7 8 9 10

3. Rate your relationship with other directors.

1 2 3 4 5 6 7 8 9 10

4. Rate your knowledge of the health care industry compared to other hospital board members nationwide.

1 2 3 4 5 6 7 8 9 10

5. Rate your understanding of the Health Service competitors in the marketplace.
1 2 3 4 5 6 7 8 9 10

6. Rate your involvement in the process of overseeing management recommendations for corporate goals and objectives.

Never 1 2 3 4 5 6 7 8 9 10 Always

7. Rate your knowledge of the hospitals' physical facilities, for maintenance or replacement.

1 2 3 4 5 6 7 8 9 10

8. Rate your attendance at board and committee meetings.

1 2 3 4 5 6 7 8 9 10

9. Rate your participation in board meetings.

1 2 3 4 5 6 7 8 9 10

10. Rate your reading of minutes and other information prior to board and committee meetings.

Never 1 2 3 4 5 6 7 8 9 10 Always

11. Rate your willingness to keep board and committee discussions out of non-policy management operating issues.

Never 1 2 3 4 5 6 7 8 9 10 Always

12. Are there any real or potential conflicts of interest in your services as a member or officer of the board?

Yes ☐ No ☐

13. **What do you feel are your strongest areas of knowledge, experience, and competence? (*Mark all that apply by placing a tick in the box/es*)**
   - ☐ **Advertising and promotion**
   - ☐ **Consumer wants and habits**
   - ☐ **Employee relations**
   - ☐ **Energy**
   - ☐ **Engineering**
   - ☐ **Environmental issues**
   - ☐ **Financial management**
   - ☐ **Governmental affairs (local)**
   - ☐ **Governmental affairs (state and national)**
   - ☐ **Investments**
   - ☐ **Legal**
   - ☐ **Management information systems**
   - ☐ **Materials management**
   - ☐ **Medicine**
   - ☐ **Marketing**
   - ☐ **New product or service introduction**
   - ☐ **Planning**
   - ☐ **Real Estate**
   - ☐ **Technology**

14. Are there any areas of expertise that the board or CEO are not properly using to get the greatest benefit from your board service?

Yes ☐ No ☐

Comments:

_____

_____

15. Rate your overall performance as a member of this board.

Unsatisfactory 1 2 3 4 5 6 7 8 9 10 Satisfactory

Appendix 5

Board performance appraisal

Board Appraisal (part 2)

This questionnaire asks you to evaluate your health service board. All ratings will be collected and tabulated and the results will be presented for discussion.

1. **The board periodically reviews the mission statement and corporate objectives to determine both current and future direction of the institution.**

Never 1 2 3 4 5 6 7 8 9 10 Always

2. **The board understands and accepts its responsibility for reviewing the appropriateness of long-range planning and corporate strategy.**

Never 1 2 3 4 5 6 7 8 9 10 Always

3. **The board assists management to review its short and long range planning assumptions as they relate to economic, political and market projections.**

Never 1 2 3 4 5 6 7 8 9 10 Always

4. **The board periodically studies the institution's competitive position in its market by assisting management to review comparative trends and data concerning similar organisations.**

Never 1 2 3 4 5 6 7 8 9 10 Always

5. **Does the management information system for the organisation allow for sophisticated planning techniques?**

No ☐ **Yes** ☐

6. **Does the board regularly refer to approved goals, objective, and plans to guide its decision making process?**

No ☐ **Yes** ☐

7. **Is there an understanding and acceptance that the organisation is managed and led by the CEO, sho serves at the pleasure of the board?**

No ☐ **Yes** ☐

8. **Does the board understand its need for a succession plan for the position of CEO that includes how people will be identified, reviewed, and selected – whether internally or externally?**

No ☐ **Yes** ☐

9. **Does the board have a succession plan for itself, in terms of how board members are identified, reviewed and selected?**

No ☐ **Yes** ☐

10. Does the board have a written conflict of interest policy that reviews annually and board member's business that does business with the health service?

No ☐ **Yes** ☐

11. Other than their board service, are there any services that are sold to the institution by members of the board?

None 1 2 3 4 5 6 7 8 9 10 Many

12. Has the board's structure been designed to help the institution achieve its purposes and goals?

No ☐ **Yes** ☐

13. Does the board have an adequate range of expertise and board experience to make it effective?

No ☐ **Yes** ☐

14. Are the majority of directors devoting adequate time to their board responsibilities?

No ☐ **Yes** ☐

15. Should the board consider changes in its bylaws concerning any of the following:

Board size?

No ☐ **Yes** ☐

Age Composition?

No ☐ **Yes** ☐

Sex composition?

No ☐ **Yes** ☐

Geographical composition?

No ☐ **Yes** ☐

Tenure in office?

No ☐ **Yes**☐

Compensation?

No ☐ **Yes** ☐

Membership on boards or competing organisations?

No ☐ **Yes** ☐

16. Should the committee system be reviewed and revised?

No ☐ **Yes** ☐

17. Do all committees have written statements of purpose?

No ☐ **Yes** ☐

18. Do all board members serve on at least one committee?

No ☐ **Yes** ☐

19. How would you rate the chairperson's ability to run effective meetings?

Low 1 2 3 4 5 6 7 8 9 10 High

20. Does the chairperson of the board have a written position description and personal specifications?

No ☐ **Yes** ☐

21. How would you rate the board's ability to focus on substantial policy matters as opposed to minutiae and administrative details?

Low 1 2 3 4 5 6 7 8 9 10 High

22. Does a specific committee (ie executive compensation, audit, or personnel) have a responsibility for evaluation of the CEO's performance and compensation?

No ☐ **Yes** ☐

23. Does the board have a list of specifications for board membership?

No ☐ **Yes** ☐

24. Does the board do a strengths and weaknesses audit to pinpoint areas of expertise that it lacks?

No ☐ **Yes** ☐

25. Does the board have a disciplinary policy for board members?

No ☐ **Yes** ☐

26. Does it have a plan to get rid of non-contributing board members?

No ☐ **Yes** ☐

27. Does the board understand and accept its fiduciary accountability in areas of financial performance?

No ☐ **Yes** ☐

28. Does the board regularly get financial information and data that are understandable, timely and useful?

No ☐ **Yes** ☐

29. Does the board feel there is adequate opportunity to discuss trends in the organisation's financial performance?

No ☐ **Yes** ☐

30. Does the board have an approved audit policy, and does it review the implementation of auditor's recommendations?

No ☐ **Yes** ☐

31. Does the board annually approve and select outside auditors?

No ☐ **Yes** ☐

32. Does the board have a written policy and procedure for CEO evaluation and compensation?

No ☐ **Yes** ☐

33. Does the board have an established set of performance standards of criteria that allow for periodic evaluation of a director's performance?

No ☐ **Yes** ☐

34. Does the board understand the art of asking penetrating pertinent questions?

No ☐ **Yes** ☐

35. Does the board have an educational development policy with annual time requirements for all directors?

No ☐ **Yes** ☐

36. Does the CEO have the necessary authority to manage the organisation?

No ☐ **Yes** ☐

37. Does the board understand the need to ensure that the institution is understood and appreciated by its publics?

No ☐ **Yes** ☐

38. Do board members share market information or perspectives from their outside worlds with the organisation's CEO?

No ☐ **Yes** ☐

39. Do board members occasionally request additional financial information for their own edification or clarification?

No ☐ **Yes** ☐

40. How would you rate the credibility and trust between the board and the CEO?

Low 1 2 3 4 5 6 7 8 9 10 High

41. How would you rate the advance information materials you receive for board meetings?

Low 1 2 3 4 5 6 7 8 9 10 High

Appendix 6

Staff satisfaction survey

46651

HealthCo

STAFF QUESTIONNAIRE

CLASSIFICATION DETAILS: *Office use only*

(Please tick the most appropriate response - one only - for each question using a blue or black pen and provide a written answer if needed):

I am employed at *HealthCo* as a(n):

- O administration officer
- O allied health practitioner
- O cleaner
- O executive
- O food services provider
- O hospital medical officer
- O medical officer (full time)
- O medical officer (visiting)
- O nurse
- O patient support services
- O research (medical)
- O research (non-medical)
- O security/maintenance worker
- O technical advisor (IT support)
- O other (please describe below)

I work at: O one site only; O more than one site; or O on all sites.

My employment at *HealthCo* is: O full-time; O part-time; O casual; or O other.

I have been at *HealthCo* for:
O up to 12 months; O 1-3 years; O 3-5 years; O 5-10 years; or O 10+ years.

My age is: O under 20; O 20 - 24; O 25 - 35; O 36 - 44; or O 45+ years of age.

I am: O Male; or O Female.

I am from an: O English speaking background; or a O non-English speaking background.

Please now turn the page to complete the questionnaire

46651

IN RELATION TO YOUR CURRENT JOB:

(Please tick the choice that best matches your response to each of the following statements)

	Strongly Disagree	***Disagree***	***Neither Agree nor Disagree***	***Agree***	***Strongly Agree***
1. It is clear what is expected of me in my position at *HealthCo.*	○	○	○	○	○
2. I enjoy my job.	○	○	○	○	○
3. There is good teamwork in my department/area.	○	○	○	○	○
4. I get on well with my fellow workers.	○	○	○	○	○
5. My supervisor/manager is not easy to communicate with.	○	○	○	○	○
6. My ideas are well received and supported by my colleagues.	○	○	○	○	○
7. Our department achieves the best results possible for our resources.	○	○	○	○	○
8. I believe that the facilities and equipment that we have to work with could be improved/updated.	○	○	○	○	○
9. If I have any problems with my job, I feel that I can talk to my supervisor or manager.	○	○	○	○	○
10. I am proud to work for *HealthCo.*	○	○	○	○	○
11. There aren't many career and or promotional opportunities if I stay at *HealthCo.*	○	○	○	○	○
12. I believe that I am well paid for what I do.	○	○	○	○	○
13. I feel that my work is valued by senior management.	○	○	○	○	○
14. My supervisor ensures I have access to all the technical information I need.	○	○	○	○	○
15. In my experience, staff are not given a clear picture of what is meant by quality and excellence.	○	○	○	○	○
16. I have read and understand *Health*Co Mission Statement and Values.	○	○	○	○	○
17. I believe that the responsibilities of my job are suitable for my qualifications and experience.	○	○	○	○	○
18. I support *HealthCo* Mission Statement and Values.	○	○	○	○	○
19. I believe that the organisation provides adequate time and opportunity for training for all staff.	○	○	○	○	○
20. I value benefits provided by *HealthCo* as well as my salary.	○	○	○	○	○
21. The practices and decisions made by the Board and management match the mission and values statements.	○	○	○	○	○
22. I see myself as an employee of the site where I am based rather than of *HealthCo.*	○	○	○	○	○
23. I get a real sense of achievement from my job.	○	○	○	○	○
24. I am aware of and can easily access *HealthCo* policies.	○	○	○	○	○
25. Management recognises and rewards good performance and encourages workers to use initiative.	○	○	○	○	○
26. I believe that *HealthCo* maintains job security to the best of its ability.	○	○	○	○	○
27. I believe that management and the Board consider staff to be key stakeholders of *HealthCo.*	○	○	○	○	○
28. In my experience, people from different departments and sites are willing to help each other.	○	○	○	○	○
29. I believe my opinions would have little impact on Board decisions.	○	○	○	○	○
30. In my view, staff are invited and encouraged to take part in decision-making processes.	○	○	○	○	○
31. Overall, I am happy with my job.	○	○	○	○	○

Once again, thank you for your time. Your opinions are valued.

Appendix 7

Health Services Act 1988 (version 14)

Extracts: (*Table of Contents, Purpose, Commencement and Definitions*)

http://www.dhs.vic.gov.au

Appendix 8

Health Services Governance Act 2000

http://www.dhs.vic.gov.au

Health Services (Governance) Act 2000

Act No. 39/2000

TABLE OF PROVISIONS

Victoria

No. 39 of 2000

Health Services (Governance) Act 2000†

[Assented to 6 June 2000]

The Parliament of Victoria enacts as follows:

1. ***Purpose***

The main purpose of this Act is to amend the **Health Services Act 1988** to facilitate the disaggregation of certain health care networks and the re-organisation of public health care agencies in the metropolitan area.

2. ***Commencement***

(1) Subject to sub-section (2), this Act comes into operation on a day to be proclaimed.

(2) If this Act does not come into operation before 1 July 2001, it comes into operation on that day.

3. ***Principal Act***

No. 49/1988.

In this Act, the **Health Services Act 1988** is called the Principal Act.

4. ***Definitions***

(1) In section 3 of the Principal Act **insert** the following definition—

' **"metropolitan health service"** means—

(a) a metropolitan health service listed in Schedule 5; or

(b) premises occupied by a metropolitan health service listed in Schedule 5—

as the case requires;'.

(2) In section 3 of the Principal Act in the definition of "former agency"—

(a) after paragraph (a)(vii) **insert**—

"(viii) by force of section 195 of this Act; or";

(b) after paragraph (b) **insert**—

"or

(c) a metropolitan hospital designated in an Order under section 215;".

(3) In section 3 of the Principal Act in the definition of "public hospital"—

(a) after paragraph (b) **insert**—

"(ba) except in Division 4 of Part 3, a metropolitan health service; or";

(b) in paragraph (c) for "or by a metropolitan hospital" **substitute** ", by a metropolitan hospital or by a metropolitan health service".

(4) In section 3 of the Principal Act in the definition of "successor agency" in paragraph (a) after "former agency" **insert** "(whether for all purposes or for the purposes of a trust in relation to a former agency)".

(5) In section 3 of the Principal Act in the definition of "trust"—

(a) in paragraph (a) after "amalgamated" **insert** "at any time";

(b) after paragraph (b) **insert**—

"(ba) a body the incorporation of which is cancelled by force of section 195; or";

(c) after paragraph (c) **insert**—

"; or

(ca) a metropolitan hospital designated in an Order under section 215—".

5. ***Governor in Council may amend Schedule 5***

After section 8(3) of the Principal Act **insert**—

"(4) The Governor in Council, by Order published in the Government Gazette, may amend Schedule 5 by—

(a) adding the name of a metropolitan health service; or

(b) removing the name of a metropolitan health service; or

(c) amending the name of a metropolitan health service.".

6. ***Core objects***

After section 24(2) of the Principal Act **insert**—

"(2A) If the Secretary directs a metropolitan health service to amend or alter its core objects, the metropolitan health service must amend or alter its core objects accordingly.".

7. ***Directions of Secretary***

In section 42(1) of the Principal Act—

(a) in paragraph (e) after "facilities" **insert** ", services, equipment or supplies";

(b) in paragraph (f) for "or services" (where twice occurring) **substitute** ", services, equipment or supplies";

(c) after paragraph (f) **insert**—

"(fa) the extent to which and the conditions on which a hospital is required to obtain or purchase facilities, services, equipment or supplies provided by another hospital or another person or body;".

8. ***New Division 9B inserted***

After Division 9A of Part 3 of the Principal Act **insert**—

"Division 9B—Metropolitan health services

65P. ***Incorporation***

Each metropolitan health service, by operation of this Act—

(a) is a body corporate with perpetual succession; and

(b) shall have an official seal; and

(c) may sue and be sued in its corporate name; and

(d) is capable of purchasing, taking, holding, selling, leasing, taking on lease, exchanging and disposing of real and personal property; and

(e) is capable of doing and suffering all acts and things which bodies corporate may by law do or suffer.

65Q. ***Metropolitan health services do not represent Crown***

A metropolitan health service does not represent, and shall not be taken to be part of, the Crown.

65R. ***Objects of metropolitan health services***

(1) Subject to section 184, the objects of a metropolitan health service are the objects approved by the board of the metropolitan health service and the Secretary.

(2) Section 24 applies to the amendment or alteration of the objects of a metropolitan health service.

65S. ***Board of directors***

(1) There shall be a board of directors of each metropolitan health service.

(2) The functions of the board of a metropolitan health service are—

(a) to monitor the performance of the metropolitan health service;

(b) to oversee the management of the metropolitan health service by the chief executive officer;

(c) to monitor the performance of the chief executive officer of the metropolitan health service;

(d) to develop strategic plans for the operation of the metropolitan health service;

(e) to develop plans, strategies and budgets to ensure accountable and efficient provision of health services by the metropolitan health service and the long term financial viability of the metropolitan health service;

(f) to establish and maintain effective systems to ensure that the health services provided meet the needs of the communities served by the metropolitan health service and that the views of users of health services are taken into account;

(g) to ensure effective and accountable systems are in place to monitor and improve the quality and effectiveness of health services provided by the metropolitan health service;

(h) to ensure that any problems identified with the quality and effectiveness of health services are addressed in a timely manner and that the metropolitan health service strives to continuously improve quality and foster innovation;

(i) to develop arrangements with other health care agencies and health service providers to enable effective and efficient service delivery and continuity of care;

(j) to establish the organisational structure, including the management structure, of the metropolitan health service;

(k) to appoint a person to fill a vacancy in the position of chief executive officer;

(l) to establish a Finance Committee, an Audit Committee and a Quality Committee and other committees to assist it in carrying out its functions;

(m) to facilitate health research and education;

(n) any other functions conferred on the board by or under this Act.

(3) The board of a metropolitan health service has such powers as are necessary to enable it to carry out its functions, including the power, subject to section 24, to make, amend or revoke by-laws.

65T. ***Directors***

(1) The board of a metropolitan health service shall consist of not less than 6 and not more than 9 persons appointed by the Governor in Council on the recommendation of the Minister.

(2) The Governor in Council, on the recommendation of the Minister, may appoint one of the directors of the board to be the chairperson of the board.

(3) In making a recommendation under this section, the Minister must ensure that—

(a) the board includes at least one person who is able to reflect the perspectives of users of health services; and

(b) women and men are adequately represented.

(4) In considering a recommendation for the purposes of sub-section (3)(a), the Minister must give preference to a person—

(a) who is not a registered provider within the meaning of the **Health Services (Conciliation and Review) Act 1987**; and

(b) who is not currently or has not recently been employed or engaged in the provision of health services.

(5) The **Public Sector Management and Employment Act 1998** does not apply to a director of a board of a metropolitan health service in respect of the office of director.

65U. ***Terms and conditions***

(1) A director of a board of a metropolitan health service holds office for the term, not exceeding 3 years, specified in the instrument of appointment and is eligible for re-appointment.

(2) A director of a board of a metropolitan health service must not serve more than 3 consecutive terms as director of that board.

(3) A director of a board is entitled to be paid—

(a) reasonable expenses incurred in holding office as a director of the board; and

(b) such remuneration as is specified in the instrument of appointment.

65V. ***Removal and resignation***

(1) A director of a board of a metropolitan health service may resign by writing signed by that person and delivered to the Governor in Council.

(2) The Governor in Council, on the recommendation of the Minister, may remove a director, or all directors, of a board from office.

(3) The Minister must recommend the removal of a director of a board from office if the Minister is satisfied that—

(a) the director is physically or mentally unable to fulfil the role of a director of a board; or

(b) the director has been convicted or found guilty of an offence, the commission of which, in the opinion of the Minister, makes the director unsuitable to be a director of a board; or

(c) the director has been absent, without leave of the board, from all meetings of the board held during a period of 6 months; or

(d) the director is an insolvent under administration within the meaning of the Corporations Law.

65W. ***Disclosure of interest***

(1) If a director of a board of a metropolitan health service has a direct or indirect pecuniary interest in a matter being considered, or about to be considered, by the board, the director, as soon as practicable after the relevant facts come to the director's knowledge, must disclose the nature of the interest at a meeting of the board.

(2) The person presiding at the meeting must cause the declaration to be recorded in the minutes of the meeting.

(3) A director who has a conflict of interest in a matter—

(a) must not be present during any deliberations on the matter; and

(b) is not entitled to vote on the matter.

(4) If a director votes on a matter in contravention of sub-section (3)(b), his or her vote must be disallowed.

(5) This section does not apply in relation to a matter relating to the supply of goods or services to the director if the goods or services are, or are to be, available to members of the public on the same terms and conditions.

65X. ***Procedure of board***

Subject to this Part, the procedure of a board of a metropolitan health service is in the discretion of the board.

65Y. ***Immunity***

(1) A director of a board of a metropolitan health service is not personally liable for anything done or omitted to be done in good faith—

(a) in the exercise of a power or the discharge of a duty under this Act; or

(b) in the reasonable belief that the act or omission was in the exercise of a power or the discharge of a duty under this Act.

(2) Any liability resulting from an act or omission that would but for sub-section (1) attach to a director of the board of a metropolitan health service attaches instead to the metropolitan health service.

65Z. ***Validity of acts or decisions***

An act or decision of a board of a metropolitan health service is not invalid by reason only of—

(a) a defect or irregularity in or in connection with the appointment of a director of the board; or

(b) a vacancy in the directorship of the board.

65ZA. ***Advisory committees***

(1) The board of a metropolitan health service—

(a) must appoint at least one community advisory committee; and

(b) must appoint a primary care and population health advisory committee; and

(c) may appoint such other advisory committees as it determines.

(2) The board of a metropolitan health service must appoint its community advisory committee and its primary care and population health advisory committee within 6 months after the establishment of the metropolitan health service.

(3) The board of a metropolitan health service must include in its report of operations under Part 7 of the **Financial Management Act 1994**, a report on the activities of its advisory committees.

65ZB. ***Community advisory committee***

(1) Subject to this section, a community advisory committee consists of such number

of members as the board of the metropolitan health service determines.

(2) The board of a metropolitan health service must ensure that the persons appointed to a community advisory committee are persons who are able to represent the views of the communities served by the metropolitan health service.

(3) In appointing persons to a community advisory committee, a board must give preference to a person—

(a) who is not a registered provider within the meaning of the **Health Services (Conciliation and Review) Act 1987**; and

(b) who is not currently or has not recently been employed or engaged in the provision of health services.

(4) The board of a metropolitan health service must appoint a person to fill a vacancy in the membership of a community advisory committee within 3 months after the vacancy arises.

65ZC. ***Primary care and population health advisory committee***

(1) Subject to this section, a primary care and population health advisory committee consists of such number of members as the board of the metropolitan health service determines.

(2) A board of a metropolitan health service must ensure that its primary care and population health advisory committee consists of persons who between them have the following knowledge and expertise—

(a) expertise in or knowledge of the provision of primary health services in the areas served by the metropolitan health service;

(b) expertise in identifying health issues affecting the population served by the metropolitan health service and designing strategies to improve the health of that population;

(c) knowledge of the health services provided by local government in the areas served by the metropolitan health service.

(3) The board of a metropolitan health service must appoint a person to fill a vacancy in the membership of its primary care and population health advisory committee within 3 months after the vacancy arises.

65ZD. ***Guidelines of Secretary***

The Secretary may publish guidelines relating to the composition, role, functions and procedure of advisory committees.

65ZE. ***Procedure of advisory committees***

Subject to any guidelines of the Secretary, the procedure of an advisory committee of a metropolitan health service is in its discretion.

65ZF. ***Strategic plans***

(1) The board of a metropolitan health service must at the direction of the Minister and at the time or times determined by the Minister, prepare and submit to the Minister for approval a strategic plan for the operation of the metropolitan health service.

(2) A strategic plan must be prepared in accordance with the guidelines established by the Minister from time to time.

(3) The Minister may—

(a) approve a strategic plan; or

(b) approve a strategic plan with amendments; or

(c) refuse to approve a strategic plan.

(4) The board of a metropolitan health service must advise the Minister if it wishes to exercise its functions in a manner inconsistent with its approved strategic plan.

65ZG. ***Annual meetings***

(1) The board of a metropolitan health service must ensure that the chief executive officer convenes an annual meeting of the metropolitan health service to be held on or after 1 July and on or before 31 October (or, if the Secretary in writing approves a later date, on or before that later date) in each year.

(2) Nothing in sub-section (1) requires an annual meeting of a metropolitan health service to be held before the metropolitan health service has been a metropolitan health service for 12 months.

(3) The chief executive officer of the metropolitan health service must cause notice of the annual meeting to be published in a newspaper circulating generally in the area where the metropolitan health service is situated giving notice—

(a) of the date, time and place of the meeting; and

(b) that the meeting is open to the public.

(4) At each annual meeting of a metropolitan health service, the board—

(a) must submit the report of operations and financial statements prepared in accordance with Part 7 of the **Financial Management Act 1994**; and

(b) must report on the health services provided to the community in the preceding year and on health services proposed to be provided in the following year; and

(c) must report on such other matters as are prescribed.".

9. ***Confidentiality***

(1) After section 141(3)(ga) of the Principal Act **insert**—

"(gb) the giving of information to or by a person, or a person in a class of persons, designated under sub-section (5) in the course of carrying out support functions designated under sub-section (5); or".

(2) After section 141(4) of the Principal Act **insert**—

"(5) For the purposes of sub-section (3)(gb), the Governor in Council, may by Order published in the Government Gazette designate—

(a) a person, or a class or classes of persons, employed or engaged by—

(i) a public hospital or denominational hospital; or

(ii) a multi-purpose service; or

(iii) a community health centre; and

(b) support functions carried out or to be carried out by those persons.".

10. ***New section 157G inserted***

After section 157F of the Principal Act **insert**—

"157G. ***Supreme Court—limitation of jurisdiction***

It is the intention of section 226 to alter or vary section 85 of the **Constitution Act 1975**.".

11. ***New Part 9 inserted***

After Part 8 of the Principal Act **insert**—

'PART 9—TRANSITIONAL PROVISIONS RELATING TO METROPOLITAN HEALTH SERVICES

Division 1—Preliminary

179. ***Definitions***

In this Part—

"instrument" includes a document and an oral agreement;

"liabilities" means all liabilities, duties and obligations, whether actual, contingent or prospective;

"property" means a legal or equitable estate or interest (whether present or future and whether vested or contingent) in real or personal property of any description;

"rights" means all rights, powers, privileges and immunities, whether actual, contingent or prospective.

180. ***Extra-territorial operation***

It is the intention of the Parliament that the operation of this Part should, as far as possible, include operation in relation to the following—

(a) land situated outside Victoria, whether in or outside Australia;

(b) things situated outside Victoria, whether in or outside Australia;

(c) acts, transactions and matters done, entered into or occurring outside Victoria, whether in or outside Australia;

(d) things, acts, transactions and matters (wherever situated, done, entered into or occurring) that would, apart from this Part, be governed or otherwise affected by the law of the Commonwealth, another State, a Territory or a foreign country.

Division 2—Establishment of metropolitan health services

181. *Order establishing a metropolitan health service*

(1) The Governor in Council, by Order published in the Government Gazette may, on the recommendation of the Minister, establish a metropolitan health service.

(2) If an Order is made under sub-section (1)—

(a) a new metropolitan health service with the name specified in the Order comes into existence; and

(b) Schedule 5 is amended by the addition of the name of the new metropolitan health service in the appropriate alphabetical position.

182. ***Establishment of first board***

(1) Despite section 65T, the board of a metropolitan health service that comes into existence under an Order under section 181 consists of the persons (being not less than 6 and not more than 9) named in the Order.

(2) For the purposes of Division 9B of Part 3, the Order under section 181 constitutes the instrument of appointment of the directors of the board and may include terms and conditions of appointment.

183. ***Appointment of first chief executive officer***

(1) The Governor in Council, by Order published in the Government Gazette, may on the recommendation of the Minister, appoint a person to act as the first chief executive officer of a metropolitan health service established by Order under section 181.

(2) The Order may specify the period (being not more than 6 months) of appointment and the terms and conditions of appointment of the chief executive officer.

(3) If a person is appointed to act as chief executive officer of a metropolitan health service under sub-section (1)—

(a) the person is deemed to have been appointed by the board of the metropolitan health service; and

(b) the appointment is deemed to be approved by the Secretary under section 25.

184. ***First by-laws of metropolitan health service***

(1) The Governor in Council, by Order published in the Government Gazette, may on the recommendation of the Minister, specify the by-laws of a metropolitan health service established by Order under section 181.

(2) The by-laws must specify the objects including the core objects, of the metropolitan health service.

(3) By-laws of a metropolitan health service specified in an Order under sub-section (1) have effect as if made by the board of the metropolitan health service and approved by the Secretary under section 24.

185. ***Limited period to make Orders***

An Order under this Division may not be made after the day that is 12 months after the date of commencement of the **Health Services (Governance) Act 2000**.

Division 3—Establishment of community health centres

186. ***Order establishing a community health centre***

(1) The Governor in Council, by Order published in the Government Gazette may, on the recommendation of the Minister, establish a community health centre.

(2) The Order must specify the area served by the community health centre.

(3) If an Order is made under sub-section (1)—

(a) a new community health centre with the name specified in the Order comes into existence; and

(b) the community health centre is deemed to be an association incorporated under the **Associations Incorporation Act 1981**; and

(c) the community health centre is deemed to be an agency registered under Division 2 of Part 3; and

(d) the community health centre named in the Order is deemed to be declared under section 45 to be a community health centre; and

(e) the area specified in the Order is deemed to be declared under section 45 to be the area served by the community health centre.

187. ***Establishment of first board of management***

(1) Despite section 46, the board of management of a community health centre that comes into existence under an Order under section 186 consists of the persons named in the Order.

(2) The Order under section 186 is deemed for the purposes of Division 6 of Part 3 to be the instrument of appointment of the members of the board of management and may include terms and conditions of appointment.

(3) A member of the board of management may be appointed under the Order until the day that is 12 months after the date of commencement of the **Health Services**

(Governance) Act 2000 or for a lesser period specified in the Order.

188. ***First rules of community health centre***

(1) The Governor in Council, by Order published in the Government Gazette, may on the recommendation of the Minister, specify the rules of a community health centre established by Order under section 186.

(2) The rules of a community health centre specified in an Order under sub-section (1) have effect as if made and approved under the **Associations Incorporation Act 1981**.

(3) An Order under sub-section (1) may incorporate the model rules under the **Associations Incorporation Act 1981** subject to any variations specified in the Order.

189. ***Limited period to make orders***

An Order under this Division may not be made after the day that is 12 months after the date of commencement of the **Health Services (Governance) Act 2000**.

Division 4—Appointment of administrator

190. ***Appointment of administrator***

(1) The Governor in Council, on the recommendation of the Minister, may appoint an administrator for a metropolitan hospital.

(2) The appointment may be for such period and subject to such terms and conditions as are specified in the instrument of appointment.

(3) On the appointment of an administrator to a metropolitan hospital under this section—

(a) the directors of the board of the metropolitan hospital cease to hold office; and

(b) the chief executive officer of the metropolitan hospital goes out of office; and

(c) sections 40E, 40F and 40G cease to apply in relation to the board of that hospital and continue not so to apply during the period of appointment of the administrator.

(4) Section 61 does not apply to the appointment of an administrator under this Division.

(5) Sections 61 and 62 do not apply to a metropolitan hospital for which an administrator has been appointed under this Division.

(6) The Governor in Council, on the recommendation of the Minister, may at any time revoke the appointment of an administrator and if necessary appoint a new administrator for a metropolitan hospital.

191. ***Functions of administrator***

(1) The functions of an administrator of a metropolitan hospital are—

(a) to carry out the functions of the board of the metropolitan hospital; and

(b) to facilitate the transfer of property, rights and liabilities of a metropolitan hospital to another agency or other agencies or to the Crown under this Part.

(2) An administrator of a metropolitan hospital appointed under this Division has and may exercise all the powers and functions and is subject to all the duties of the board of the metropolitan hospital under, and comprises that board for the purposes of, this Act and the by-laws of the metropolitan hospital.

192. ***Direction of Secretary***

An administrator appointed under this Division is subject to the direction of the Secretary in the exercise of the administrator's functions and powers and the performance of the administrator's duties under this Division.

Division 5—Transfer of property, rights and liabilities of metropolitan hospitals on cancellation of incorporation

193. ***Definitions***

In this Division—

"transferring hospital", in relation to an Order under section 181, means a metropolitan hospital the incorporation of which is cancelled under the Order;

"effective date", in relation to an Order under section 181, means the date specified in the Order to be the effective date of that Order;

"new health service", in relation to an Order under section 181, means the metropolitan health service which comes into existence under that Order;

"old instrument" means an instrument subsisting immediately before the

effective date of an Order under section 181—

(a) to which a transferring hospital was a party; or

(b) that was given to or in favour of a transferring hospital; or

(c) that refers to a transferring hospital; or

(d) under which—

(i) money is, or may become, payable to or by a transferring hospital; or

(ii) other property is to be, or may become liable to be, transferred to or by a transferring hospital;

"**transferred hospital employee**" means a person who, by reason of section 204(1), is regarded as being employed by a new health service with effect from the effective date of an Order under section 181.

194. ***Cancellation of incorporation of metropolitan hospital***

(1) If the Minister recommends to the Governor in Council the establishment of a metropolitan health service by Order under section 181, the Minister may also recommend to the Governor in Council that the Order cancel the incorporation of a metropolitan hospital.

(2) If the Minister recommends the cancellation of the incorporation of a metropolitan hospital, the Governor in Council may

provide for the cancellation of the incorporation in an Order made under section 181.

195. ***Transfer from metropolitan hospital to metropolitan health service***

If an Order is made under section 181 cancelling the incorporation of a metropolitan hospital, then on a date specified in the Order—

(a) the incorporation of the metropolitan hospital to which the Order relates is cancelled; and

(b) Schedule 3 is amended by the omission of the name of that metropolitan hospital; and

(c) the directors of the board of the metropolitan hospital go out of office; and

(d) the chief executive officer of the metropolitan hospital goes out of office.

196. ***New metropolitan health service to be successor in law***

On the coming into existence of a metropolitan health service under an Order under section 181 which also cancels the incorporation of a metropolitan hospital—

(a) all property and rights of the transferring hospital, wherever located, vest in the new health service; and

(b) all liabilities of the transferring hospital, wherever located, become liabilities of the new health service; and

(c) the new health service becomes the successor in law of the transferring hospital; and

(d) on and from the effective date of the Order, the transferring hospital must, for the purposes of any trust in relation to that hospital, be taken not to have had its incorporation cancelled and the new health service must be taken to be the same body as the transferring hospital for those purposes.

197. ***Substitution of party to agreement***

Where, under section 196, the rights and liabilities of a transferring hospital under an agreement vest in, or become liabilities of, a new health service—

(a) the new health service becomes, on the effective date of the Order, a party to the agreement in place of the transferring hospital; and

(b) on and after the effective date of the Order, the agreement has effect as if the new health service had always been a party to the agreement.

198. ***Old instruments***

(1) Each old instrument (including an instrument made under an Act) has effect and continues to have effect according to its tenor on and after the effective date of an Order under section 181 as if a reference in the instrument to a transferring hospital were a reference to the new health service.

(2) Without limiting the effect of sub-section (1), on and from the effective date of an

Order under section 181, an instrument creating a trust in relation to—

(a) a transferring hospital to which the Order relates; or

(b) a former agency of which such a transferring hospital is the successor agency—

has effect and continues to have effect according to its tenor as if the trust were in relation to the new health service.

199. ***Proceedings***

If, immediately before the effective date of an Order under section 181, proceedings (including arbitration proceedings) to which a transferring hospital was a party were pending or existing in any court or tribunal, then, on and after the publication of the Order, the new health service is substituted for the transferring hospital as a party to the proceedings and has the same rights in the proceedings as the transferring hospital had.

200. ***Interests in land***

Without prejudice to the generality of this Division and despite anything to the contrary in any other Act or law, if, immediately before the effective date of an Order under section 181, a transferring hospital is the registered proprietor of an interest in land under the **Transfer of Land Act 1958**, on and after that date—

(a) the new health service is to be taken to be the registered proprietor of that interest in land; and

(b) the new health service has the same rights and remedies in respect of that interest as the transferring hospital had.

201. ***Amendment of Register***

The Registrar of Titles, on being requested to do so and on delivery of any relevant certificate of title or instrument, must make any amendments in the Register that are necessary because of the operation of this Division.

202. ***Taxes***

No stamp duty or other tax is chargeable under any Act in respect of anything effected by or done under this Division or in respect of any act or transaction connected with or necessary to be done by reason of this Division, including a transaction entered into or an instrument made, executed, lodged or given.

203. ***Evidence***

(1) Documentary or other evidence that would have been admissible for or against the interests of a transferring hospital if an Order had not been made under section 181, is admissible for or against the interests of the new health service.

(2) Division 3A of Part III of the **Evidence Act 1958** continues to apply with respect to the books of account of a transferring hospital and to entries made in those books of account before the effective date of an Order under section 181.

(3) In sub-section (2), **"books of account"** has the same meaning as in Division 3A of Part III of the **Evidence Act 1958**.

204. ***Transfer of hospital employees to new health service***

(1) A person who, immediately before the effective date of an Order under section 181, was an employee (other than the chief executive officer) of a transferring hospital is to be regarded as—

(a) having been employed by the new health service with effect from that date; and

(b) having been so employed on the same terms and conditions as those that applied to the person, immediately before that date, as an employee of the transferring hospital; and

(c) having accrued an entitlement to benefits, in connection with that employment by the new health service, that is equivalent to the entitlement that the person had accrued, as an employee of the transferring hospital immediately before that date.

(2) The service of a transferred hospital employee as an employee of the new health service is to be regarded for all purposes as having been continuous with the service of the employee, immediately before the effective date of the Order under section 181, as an employee of the transferring hospital.

(3) A transferred hospital employee is not entitled to receive any payment or other benefit by reason only of having ceased to be an employee of the transferring hospital because of this Division.

(4) A certificate purporting to be signed by the chief executive officer of the new health service certifying that a person named in the certificate was, with effect from the effective date of the Order under section 181, employed, by virtue of this section by the new health service is admissible in evidence in any proceedings and is conclusive proof of the matters stated in it.

205. ***Future terms and conditions of transferred employees***

Nothing in section 204 prevents—

(a) any of the terms and conditions of employment of a transferred hospital employee from being altered by or under any law, award or agreement with effect from any time after the effective date of the Order under section 181; or

(b) a transferred hospital employee from resigning, or the termination of a transferred hospital employee's employment, at any time after the effective date of the Order in accordance with the then existing terms and conditions of the employee's employment by the new health service.

Division 6—Transfer of property, rights and liabilities before cancellation of incorporation of metropolitan hospital

206. ***Definitions***

In this Division—

"**effective date**", in relation to an Order under section 208, 214 or 215, means

the date specified in the Order to be the effective date of that Order;

"**former hospital property**" means property, rights or liabilities of a metropolitan hospital that, under this Division, have vested in, or become liabilities of, a metropolitan health service or community health centre;

"**old instrument**" means an instrument subsisting immediately before the effective date of an Order under section 208—

(a) to which a transferring hospital was a party; or

(b) that was given to or in favour of a transferring hospital; or

(c) that refers to a transferring hospital; or

(d) under which—

(i) money is, or may become, payable to or by a transferring hospital; or

(ii) other property is to be, or may become liable to be, transferred to or by a transferring hospital;

"**staff transfer date**" in relation to a list referred to in section 220 means the date fixed by the Minister under section 219 as the staff transfer date for the purposes of that list;

"**transferred hospital employee**" means a person who, by reason of section 221 is regarded as being employed by a

metropolitan health service or a community health centre with effect from the relevant staff transfer date;

"**transferring hospital**", in relation to an Order under section 208, means the metropolitan hospital specified in the Order.

207. ***Division to prevail***

If there is any inconsistency between this Division and Division 9A of Part 3, this Division prevails to the extent of the inconsistency.

208. ***Transfer Order***

(1) The Governor in Council, by Order published in the Government Gazette, may, on the recommendation of the Minister—

(a) allocate to a metropolitan health service such of the property, rights and liabilities of a metropolitan hospital as are specified in the Order; or

(b) allocate to a community health centre such of the property, rights and liabilities of a metropolitan hospital as are specified in the Order.

(2) Without limiting sub-section (1), an Order under that sub-section may allocate property, rights and liabilities by reference—

(a) to a campus of a metropolitan hospital or other place; or

(b) to a class or category of property, rights or liabilities; or

(c) to a combination of paragraphs (a) and (b).

209. ***Property rights and liabilities transferred to metropolitan health service or community health centre***

If an Order is made under section 208, then on the effective date of the Order—

(a) all property and rights of the transferring hospital specified in the Order vest in the metropolitan health service or community health centre specified in the Order; and

(b) all liabilities of the transferring hospital specified in the Order become liabilities of the metropolitan health service or community health centre specified in the Order; and

(c) the metropolitan health service or community health centre specified in the Order becomes the successor in law of the transferring hospital in relation to the property, rights and liabilities specified in the Order.

210. ***Substitution of party to agreement***

If, under section 209, the rights and liabilities of a transferring hospital under an agreement vest in, or become liabilities of, a metropolitan health service or community health centre—

(a) the metropolitan health service or community health centre becomes, on the effective date of the relevant Order under section 208, a party to the agreement in place of the transferring hospital; and

(b) on and after the effective date of the relevant Order under section 208, the

agreement has effect as if the metropolitan health service or community health centre had always been a party to the agreement.

211. ***Proceedings***

If, immediately before the effective date of an Order under section 208, proceedings relating to former hospital property (including arbitration proceedings) to which a transferring hospital was a party were pending or existing in any court or tribunal, then, on and after the effective date of the relevant Order, the metropolitan health service or community health centre specified in the Order is substituted for the transferring hospital as a party to the proceedings and has the same rights in the proceedings as the transferring hospital had.

212. ***Interests in land***

Without prejudice to the generality of this Division and despite anything to the contrary in any other Act or law, if immediately before the effective date of an Order under section 208, a transferring hospital is, in relation to former hospital property, the registered proprietor of an interest in land under the **Transfer of Land Act 1958**, then on and after that date—

(a) the metropolitan health service or community health centre specified in the Order is to be taken to be the registered proprietor of that interest in land; and

(b) the metropolitan health service or community health centre specified in the Order has the same rights and

remedies in respect of that interest as the transferring hospital had.

213. ***Old instruments***

(1) Each old instrument relating to property rights and liabilities of a metropolitan hospital that, under this Division, have vested in, or become liabilities of, a metropolitan health service or community health centre has effect and continues to have effect according to its tenor on and after the effective date of the relevant Order under section 208 as if a reference in the instrument to the transferring hospital were a reference to the metropolitan health service or community health centre specified in the Order.

(2) This section does not apply to an instrument creating a trust to which section 214 or 215 applies.

214. ***Trusts in respect of metropolitan hospitals existing on 31 July 1995***

(1) The Governor in Council, by Order published in the Government Gazette, may, on the recommendation of the Minister, designate a metropolitan health service as the successor of a metropolitan hospital existing on 31 July 1995 and designated in the Order, for the purposes of any trust in relation to that metropolitan hospital.

(2) The Minister must not recommend the designation of a metropolitan health service or metropolitan hospital under sub-section (1) unless the Minister is satisfied that the metropolitan health service is the appropriate successor for the metropolitan hospital having regard, where relevant, to the

campuses operated or to be operated by the metropolitan health service.

(3) On and from the effective date of an Order under this section, an instrument creating a trust in relation to—

(a) a metropolitan hospital designated in the Order; or

(b) a former agency of which the metropolitan hospital is the successor agency—

has effect and continues to have effect according to its tenor as if the trust were in relation to the metropolitan health service designated in the Order as the successor of the metropolitan hospital.

(4) On and from the effective date of an Order under this section, a metropolitan health service designated in the Order must, for the purposes of any trust in relation to a metropolitan hospital designated in the Order, be taken to be the same body as that metropolitan hospital.

(5) This section has effect despite anything to the contrary in sections 65D and 65F.

215. ***Trusts in respect of metropolitan hospitals created on or after 1 August 1995***

(1) The Governor in Council, by Order published in the Government Gazette, may, on the recommendation of the Minister, designate a metropolitan health service as the successor of a metropolitan hospital created on or after 1 August 1995 and designated in the Order, for the purposes of any trust or class or category of trusts specified in the

Order in relation to the metropolitan hospital.

(2) The Minister must not recommend the designation of a metropolitan health service or metropolitan hospital under sub-section (1) unless the Minister is satisfied that the metropolitan health service is the appropriate successor for the metropolitan hospital having regard, where relevant, to the campuses operated or to be operated by the metropolitan health service.

(3) On and from the effective date of an Order under this section, an instrument creating a trust specified, or in a class or category specified, in the Order in relation to a metropolitan hospital designated in the Order has effect and continues to have effect according to its tenor as if the trust were in relation to the metropolitan health service designated in the Order as the successor of the metropolitan hospital.

(4) On and from the effective date of an Order under this section, a metropolitan health service designated in the Order must, for the purposes of any trust specified, or in a class or category specified, in the Order in relation to a metropolitan hospital designated in the Order, be taken to be the same body as that metropolitan hospital.

(5) This section has effect despite anything to the contrary in sections 65D and 65F.

216. ***Amendment of the Register***

The Registrar of Titles, on being requested to do so and on delivery of any relevant certificate of title or instrument, must make any amendments in the Register that are

necessary because of the operation of this Division.

217. ***Taxes***

No stamp duty or other tax is chargeable under any Act in respect of anything effected by or done under this Division or in respect of any act or transaction connected with or necessary to be done by reason of this Division, including a transaction entered into or an instrument made, executed, lodged or given.

218. ***Evidence***

(1) Documentary or other evidence that would have been admissible for or against the interests of a transferring hospital if an Order had not been made under section 208, is admissible for or against the interests of the metropolitan health service or community health centre specified in the Order.

(2) Division 3A of Part III of the **Evidence Act 1958** continues to apply with respect to the books of account of a transferring hospital and to entries made in those books of account before the effective date of an Order under section 208, whether or not they relate to former hospital property.

(3) In sub-section (2), **"books of account"** has the same meaning as in Division 3A of Part III of the **Evidence Act 1958**.

219. ***Staff transfer date***

(1) The Minister, by notice published in the Government Gazette, may determine a date that is to be the staff transfer date for the purposes of a list under section 220.

(2) The Minister may give more than one notice under this section in respect of a metropolitan hospital.

220. ***List of staff***

(1) Before the relevant staff transfer date, the Secretary must prepare a list of employees (other than the chief executive officer) of a metropolitan hospital who are to become employees of a metropolitan health service or community health centre on that date.

(2) The list may specify the employees—

(a) by name or position; or

(b) by class or category; or

(c) by reference to a campus of a metropolitan hospital or other place; or

(d) by any combination of paragraphs (a) to (c).

(3) The list must specify the metropolitan health service or community health centre which on the staff transfer date is to become the employer of each employee specified on the list.

(4) Nothing in this section prevents a person specified on a list as an employee of a metropolitan hospital from resigning or being dismissed at any time before the relevant staff transfer date in accordance with the terms and conditions of his or her employment.

221. ***Transfer of staff***

(1) A person listed as an employee of a metropolitan hospital in a list prepared under section 220 who was such an employee

immediately before the relevant staff transfer date is to be regarded as—

(a) having been employed by the metropolitan health service or community health centre specified in the list with effect from the staff transfer date; and

(b) having been so employed on the same terms and conditions as those that applied to the person, immediately before the staff transfer date, as an employee of the metropolitan hospital; and

(c) having accrued an entitlement to benefits, in connection with that employment with the metropolitan health service or community health centre, that is equivalent to the entitlement that the person had accrued, as an employee of the metropolitan hospital immediately before the staff transfer date.

(2) The service of a transferred hospital employee as an employee of the metropolitan health service or community health centre is to be regarded for all purposes as having been continuous with the service of the transferred hospital employee, immediately before the relevant staff transfer date, as an employee of the metropolitan hospital.

(3) A transferred hospital employee is not entitled to receive any payment or other benefit by reason only of having ceased to be

an employee of a metropolitan hospital because of this Division.

(4) A certificate purporting to be signed by the chief executive officer of the metropolitan health service or community health centre certifying that a person named in the certificate was, with effect from the relevant staff transfer date, employed, by virtue of this section by the metropolitan health service or community health centre named in the certificate is admissible in evidence in any proceedings and is conclusive proof of the matters stated in it.

222. ***Future terms and conditions of transferred employees***

Nothing in section 221 prevents—

(a) any of the terms and conditions of employment of a transferred hospital employee from being altered by or under any law, award or agreement with effect from any time after the relevant staff transfer date; or

(b) a transferred hospital employee from resigning, or the termination of a transferred hospital employee's employment, at any time after the relevant staff transfer date in accordance with the then existing terms and conditions of his or her employment by the metropolitan health service or community health centre.

223. ***Abolition of metropolitan hospital***

(1) An administrator appointed under Division 4 in respect of a metropolitan hospital may recommend to the Minister that the

incorporation of that metropolitan hospital be cancelled.

(2) If a recommendation is made under sub-section (1) and the Minister is satisfied that as far as practicable the property, rights and liabilities of the metropolitan hospital have been transferred to another agency or other agencies, the Minister may recommend to the Governor in Council that the incorporation of the metropolitan hospital be cancelled.

(3) The Governor in Council, on a recommendation under sub-section (2), may by Order published in the Government Gazette, cancel the incorporation of a metropolitan hospital.

(4) If an Order is made under this section, then on the date specified in the Order—

(a) the incorporation of the metropolitan hospital to which the Order relates is cancelled; and

(b) Schedule 3 is amended by the omission of the name of the metropolitan hospital.

224. ***Effect of Order***

(1) On the cancellation of the incorporation of a metropolitan hospital under section 223—

(a) all property and rights of the metropolitan hospital, wherever located, vest in the Crown; and

(b) all liabilities of the metropolitan hospital, wherever located, become liabilities of the Crown; and

(c) the Crown becomes the successor in law of the metropolitan hospital in respect of that property and those rights and liabilities; and

(d) this Division applies as if any reference—

(i) to an Order under section 208 were a reference to an Order under section 223; and

(ii) to former hospital property were a reference to property, rights and liabilities vested in the Crown under this sub-section; and

(iii) to a metropolitan health service were a reference to the Crown.

(2) This section does not apply to a trust.

Division 7—General

225. ***Validity of things done under this Part***

Nothing effected by this Part or suffered under this Part—

(a) is to be regarded as placing any person in breach of contract or confidence or as otherwise making any of them guilty of a civil offence; or

(b) is subject to compliance with or is to be regarded as placing any person in breach of or as constituting a default under any Act or other law or any provision in any agreement, arrangement or understanding including, without limiting the generality of the foregoing, any

provision prohibiting, restricting or regulating the assignment or transfer of any property or right or the disclosure of any information; or

(c) is to be regarded as fulfilling any condition which allows a person to exercise a power, right or remedy in respect of or to terminate any agreement or obligation; or

(d) is to be regarded as giving rise to any remedy for a party to a contract or an instrument or as causing or permitting the termination of any contract or instrument because of a change in the beneficial or legal ownership of any property, right or liability; or

(e) is to be regarded as causing any contract or instrument to be void or otherwise unenforceable; or

(f) is to be regarded as frustrating any contract; or

(g) releases any surety or other obligee wholly or in part from any obligation.

226. ***Operation of provisions not subject to review***

Nothing done under Division 2, 3, 5 or 6 or section 190 gives rise to any cause or right of action or application before any court or tribunal.

227. ***Application of property cy-pres not affected***

(1) Nothing in section 198(2) in relation to an Order under section 181 affects the operation of—

(a) an order of a court for the application of property cy-pres made before the effective date of that Order; or

(b) a scheme or authority for the application of property cy-pres sanctioned or given by the Attorney-General under the **Charities Act 1978** before the effective date of that Order.

(2) Nothing in section 214 or 215 in relation to an Order under section 214 or 215 affects the operation of—

(a) an order of a court for the application of property cy-pres made before the effective date of that Order; or

(b) a scheme or authority for the application of property cy-pres sanctioned or given by the Attorney-General under the **Charities Act 1978** before the effective date of that Order.

228. ***Application to trusts whenever created***

The amendments made to this Act by the **Health Services (Governance) Act 2000** apply with respect to a trust (within the meaning of section 3(1)) in relation to a body, whether the trust was created before, on or after the commencement of section 11 of that Act.

229. ***Saving of quality assurance bodies***

(1) This section applies to a committee, council or other body established by one or more metropolitan hospitals and declared to be an approved quality assurance body under section 139.

(2) The Minister, by notice published in the Government Gazette, may declare that a

designated committee, council or body to which this section applies is to be taken to be a body established by a designated metropolitan health service.

(3) On the publication of a notice under sub-section (2)—

(a) the notice has effect according to its tenor; and

(b) the declaration of the designated committee, council or body under section 139 continues to have effect and may be revoked in accordance with that section.

(4) This section has effect despite anything to the contrary in the by-laws of the designated metropolitan health service.'.

12. ***New Schedule 5 inserted***

After Schedule 4 of the Principal Act **insert**—

" **SCHEDULE 5**

METROPOLITAN HEALTH SERVICES

".

13. ***Amendment of Mental Health Act 1986***

After section 120A(3)(g) of the **Mental Health Act 1986 insert**—

"(ga) the giving of information to or by a person, or a person in a class of persons, designated under section 141(5) of the **Health Services Act 1988** in the course of carrying out support functions designated under that provision; or".

NOTES

† *Minister's second reading speech—*

Legislative Assembly: 4 May 2000

Legislative Council: 24 May 2000

The long title for the Bill for this Act was "to amend the **Health Services Act 1988** to facilitate the disaggregation of certain health care networks and the re-organisation of public health care agencies in the metropolitan area and for other purposes."

Constitution Act 1975:

Section 85(5) statement:

Legislative Assembly: 4 May 2000

Legislative Council: 24 May 2000

Absolute majorities:

Legislative Assembly: 23 May 2000

Legislative Council: 25 May 2000

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