Executives’ Decision Making in Australian Private Hospitals:

Margin or Mission?

A thesis submitted in (partial) fulfilment of the requirements for the degree

of Doctor of Business Administration.

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DECLARATION

I certify that except where due acknowledgement has been made the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of this thesis is the result of work which has been carried out since the official commencement date of the approved research program; and, any editorial work, paid or unpaid, carried out by a third party is acknowledged.

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ABSTRACT

This thesis examines decision making at executive level in Australian private hospitals by exploring the critical factors that influence these decisions and their interaction. It studies decision making as a social phenomenon, since individuals draw meaning from their own biographical and social environmental experiences. The researcher interpreted the constructed realities of the factors influencing executives’ decisions within the context of private hospitals - a field that is rarely examined through the lens of social research.

The majority of the literature reviewed on decision making in healthcare was concentrated mainly on natural sciences by studying the medical and clinical aspects of the decision, rather than on corporate strategic decisions. The other stream of research about the concept of decision making was found to be broad and general, often lacking the rigour of a specialised industry, such as private hospitals.

Historically, the business of healing the sick and improving human life has been dominated, in the hospital industry, by church and charitable missionary groups operating under the banner of ‘not-for-profit organisations’. The emergence of private arms of these organisations, the dominance of giant corporate healthcare providers, and frequent mergers and acquisitions has changed the face of private healthcare in general and private hospitals in particular. In the midst of this evolving sector, hospital executives remained
responsible for making decisions to deal with the legacy of the past, the needs of the present and the uncertainty of the future.

Using an Interpretivist research paradigm, the researcher conducted semi-structured and in-depth interviews with sixteen executive members who are experts in the industry and represent both sectors of the private hospital industry: private for-profit and private not-for-profit.

The data generated was transformed into technical accounts using an abductive research strategy (Blaikie, 1993). By adopting Schütz’s (1963) notion of first-order and second-order constructs, translation and interpretation of the data was conducted to move from lay concepts embedded within executives’ tacit, everyday language, into the researcher’s technical concepts.

Using Structuration Theory, that stressed the fundamental role of the human agent, the structure and their mutual dependence, the researcher moved beyond the interpretation of individuals’ meanings, to incorporate the structure as an entity that can be formed and reformed (Giddens, 1984). This notion, that Giddens (1984: 25) referred to as the “duality of structure”, strongly focused on the agents’ knowledgability whose actions are produced and reproduced across time and space.

The researcher interpreted social actors’ constructed meanings of these social phenomena in their work environment to form the elements of a two-dimensional decision making
model at organisational level, incorporating the present with the future and the internal with the external factors. On an individual level, three different approaches to decision making were identified, based on whether executives perceived the decision making phenomenon as intuition, as a reasoned process or as an expected outcome.

While being from a limited research sample, the findings of this study suggest that the paradox of mission / economic decisions restrained executives in the not-for-profit sector from strengthening their hospitals’ financial performance, putting at risk, therefore, their ability to achieve social dividends as a way to proclaim their mission. On the other hand, in the for-profit sector, shareholders’ dividends appeared to be a strong catalyst for attaining profit maximisation when making decisions. In both settings, the findings suggest that the role of stakeholder theory is questionable, particularly when executives remained hesitant to involve medical specialists, whom they considered to be major profit generators for private hospitals. This attitude appeared to be constant, despite the changes identified in executives’ individual approaches to decision making. However, early signs of shifts towards adopting more commercially and socially accountable decisions were apparent in not-for-profit and for-profit sectors respectively.

This study concludes with important contributions to the little known field of executives’ decision making in private hospitals. This contribution to knowledge is of practical value to executives who are currently in the private hospital sector or thinking of joining this industry. The decision making framework can also be adopted and tailored to other work contexts to guide executives’ business decisions in different industries.
The thesis sets out recommendations to assist executives in managing the different factors that interplay to form executives’ decisions. The importance of having a mission in business longevity and the integration, as opposed to alignment, of strategic goals with business operations when making executive decisions in private hospitals was highlighted. The implications for both sectors are described and recommendations for further research are suggested.
CHAPTER 1

INTRODUCTION

This study aims to reveal the underlying factors influencing decision making at the executive level in private hospitals, a field that has rarely been under the magnifying lens in business research. Most literature on decision making in healthcare focused on funding allocation and clinical decisions, such as decision making towards the patients’ end of life (Euthanasia), and recently the controversy surrounding the decision to introduce Gene therapy for the prevention and treatment of a number of diseases. Other decision making publications were broad in nature, lacking the depth of inquiry of an industry that is as complex as private hospitals with its two sectors: corporate for-profit and mission-based not-for-profit. Having two arms, the private hospital industry raises more questions about the role that each sector plays, particularly when the researchers’ experience, as well as the literature, particularly that both not-for-profit and for-profit private hospitals are in direct competition (Lyons, 2001).

The concept of decision making has been an area of interest for economists, sociologists and psychologists for many years. The literature reveals a significant body of knowledge about decision making analysing this social phenomenon at the individual (Kahneman
and Tversky, 1979), organisational (Simon, 1997; Tarter and Hoy, 1998) and social public levels (Richardson and Mckie, 2005). There is no shortage in the number of theories generated to address the human decision making process, which highlights contending perspectives and their implications for practice. Major empirical and theoretical studies encountered in the literature were searching for the “good” or “best” decision either by explaining (quantitative) or describing (qualitative) social phenomena (Sarantakos, 1998).

The literature review of decision making revealed a significant number of components and variables that interplayed to form the decision making phenomenon (Pearce, 1981; Parnell, 2003). The majority of the encountered research inquiries attempted to explore the nature of the relationships between executive decision making and one or more of the following factors: the firm’s performance, environmental circumstances, organisational structure, firm’s size, past experiences or executives’ attributes and diversity (Pearce, 1981; Ashmos, et. al, 1998; Drago, 1998; Martin, 1998; Miller, et. al, 1998; Eisenhardt, 1999; Suutari, 1999; Desai, 2000; Parnell, 2003).

The dominance of the Positivist research paradigm which imitates the methods of natural and physical sciences was apparent amongst decision making publications. Guba and Lincoln (1994: 109) described the ontology of the Positivist paradigm to be as follows:

An apprehendable reality is assumed to exist, driven by immutable natural laws and mechanisms. Knowledge of the “way things are” is conventionally summarized in the form of time-and context-free generalizations, some of which take the form of cause-effect laws.

When studying decision making using this paradigm, researchers are often challenged and limited in addressing or controlling all variables. For example, in their research on
400 executive decisions, Hough and White (2003) attempted to control a number of variables by studying 54 executive teams outside their usual work environment, using a simulated decision making environment. Nevertheless, the behavioural simulator model of research was associated with an inability to measure or to control executives’ cognitive skills providing in return another issue in the data generated (Hough and White, 2003).

A number of researchers such as Suutari (1999) and Parnell (2003) have limited the critical factors influencing decision making to the dilemmas resulting from the opposing views of the two schools of strategy; often overlooking other critical elements in the decision process such as chief executive officers’ leadership style, a firm’s size or organisational structure. Other studies such as environmental dynamism (Hough and White, 2003) were conducted unilaterally, by examining the relationship of only one specific component of strategy and decision making, without considering other elements that constitute the organisation as a whole.

After the naissance of the two founder schools of strategy (design and emergent) (Pearce, 1981; Richardson, 1994; Suutari, 1999), most recommended approaches to strategic decision making were rarely able to provide an original model. The suggested approach was often an expansion of an existing philosophical model, for example, a suggested alternative by Parnell (2003) was of balancing both models was no more than adding additional aspects to the strategic planning approach.

When strategic business decisions were explored in organisations, the focus was often on decision making at chief executive level in the for-profit organisations and at Board of
Directors level in the not-for-profit sector. Most research inquiries were general and conducted across several industries, which tended to provide practitioners with breadth of information lacking the depth of one specific industry.

Private hospitals are organisations offering acute healthcare services under the stewardship of a group of executive directors headed by a Chief Executive Officer (CEO). Decision making at this level is crucial and has a “ripple effect” on the clinical and financial performance of the organisation. Seldom were the studies in the literature that were performed at the executive level in for-profit or not-for-profit private hospitals. While administrative business decisions are traditionally made by hospital executives, medical specialists in private hospitals remained the primary advocates and decision makers for patients’ medical care, clinical needs and choice of hospitals (Willis, Young and Stanton, 2005). The controversy in the literature around non-medically trained executive members managing hospitals (Willis, et. al, 2005) and the volatility of the ownership of private hospitals (Wynne, 2001) triggered the researcher’s desire to illuminate this specialised field of the healthcare industry.

The word ‘business’ in healthcare often features negative connotations, particularly by frontline clinicians who are saving lives and witnessing death on a daily basis. In addition to meeting the clinical objectives through the provision of healthcare services, executives in hospitals are required to manage the financial aspect of these organisations and the economic imperatives associated with it. For the executive, the juggling act
between these “humanitarian” outcomes and financial returns remains an ongoing challenge.

In the last decade, mergers and acquisitions have occurred in both private hospital sectors, but have attracted more media attention in the for-profit sector. The consequences of private corporate entities purchasing and operating private hospitals for their shareholders were clearly highlighted in 2001, the Mayne Nickless experience and its subsidiary Health Care of Australia (HCoA) (AMA, 2001; Lyons, 2001).

In 1996, Mayne Health Corporation had acquired a large number of hospitals in Australia nationally and internationally. One of the strategies used by Mayne Health was to achieve an economy of scale by imposing uniformity of products and equipment on medical specialists across all their hospital groups. In 2001, the company was accused of turning away patients who attracted low subsidy from health insurances, a practice referred to as “cherry picking” (AMA, 2001). Allegations by the Australian Medical Association against the practice of Mayne Health attracted the nation’s media attention (Wynne, 2001; Bannerman, 2001a; Bannerman, 2001b; Mark, 2001). Mayne Health that started its business in non-health services, such as petrol and finance, was accused of selecting patients for profit generation (Bannerman, 2001b; Lyons, 2001; Mark, 2001). The business structure introduced by Mayne Health was seen to be compromising clinical care and medical specialists took their patients to other hospitals, which led to a decline in profit (Wynne, 2001). This approach ended up costing the company the sale of its private hospital portfolio in 2003.
The volatility of the private hospital market, its funding models and the diversity of its stakeholders, has left the researcher questioning the real factors driving private hospitals’ strategic decisions at executive levels. The presence of two sectors within the private hospital industry, for-profit and not-for-profit, further stimulated the researcher’s interest in exploring this industry under the magnifying lens of social research. Most of the not-for-profit private hospitals were mission based yet private, sharing similar management models to the corporate for-profit hospitals, but enjoying tax exempt status.

With changes in private hospitals’ operators, the sale of a number of private hospitals, the ageing generation of hospital founders and, the decrease in new members joining religious orders (Lyons, 2001), organisational vision and strategy has become questionable. In this environment, executive members are left managing private hospitals at their own discretion, making decisions that build or destroy the future of their organisations. Consequently, examining executive decision making under the spotlight of social research became of great importance. The researcher aims to gain deeper understanding of this social phenomenon by identifying and studying the critical factors underpinning executives’ decisions in private hospitals.

The findings of this current study could be of great value to new executives planning to start a career in private healthcare. The importance of executives’ decisions to the organisations’ financial viability and the longevity of businesses have been regularly highlighted in the literature.
Private hospitals are organisations delivering healthcare services with a variety of products ranging from child birth and treating acute illnesses, to caring for those with terminal disease. These “human” elements of the business managed in an increasingly economically conscious environment and the changes in ownership of private hospitals triggered the interest of the researcher to examine what really matters in this industry. This interest soon developed into a research question that formed the purpose of this social inquiry which is the desire to understand decision making at executive levels in private hospitals. The general prescriptive approach adopted by the literature fails to provide private hospital executives with the essential ingredients required to manage these specialised organisations strategically, in order to deliver healthcare services beyond today’s needs.

The primary motivation for this research topic was the need to fill the gap in the knowledge about the nature of executive decisions in private hospitals, and to provide practitioners with an enhanced and detailed view of the important aspects of managing private hospitals. The specific research objective is to explore the social phenomenon of decision making, at executive level, by identifying, understanding and explaining the factors that underpins these business decisions in Australian private hospitals. Understanding executives’ business decisions was best framed by unveiling the factors influencing their decisions as perceived by experienced executives in this field.
The ultimate questions that formulate the purpose of the research encompass the following:

1. What are the factors that influence executives’ decision making in Australian private hospitals?
2. Are these factors consistent amongst private hospitals regardless of the sector (for-profit or not-for-profit) in which they operate?
3. Does the interaction of these factors generate a decision with long term benefits for the organisation?
4. How can these findings be used to assist new executives in managing private hospitals for the long term?

This thesis aims to identify what really matters when making business decisions in private hospitals, by exploring the factors influencing decision making as perceived and interpreted by executives in private hospitals. The researcher aimed to illuminate this topic through the lens of executives who are experts in the private hospital industry.

This is an exploratory study to set the platform for further business research in this specialised field. Collis and Hussey (2003: 11) claimed that in exploratory research: “the research will assess which existing theories and concepts can be applied to the problem or whether new ones should be developed.” Recommendations will be presented in the form of a conceptual model that can be adopted by practitioners in the management of private hospitals. This model is of value to new executives who join the private hospital industry with no previous experience in this specialised area of healthcare.
This thesis adopts the Interpretivist research approach, in order to examine executive strategic decision making. By researching and interpreting the reality that private hospitals’ executives are experiencing in their governance on a daily basis, social scientific meanings will be developed. In his description of Interpretivist social science, Blaikie (2003: 15) added:

It is the everyday beliefs and practices, mundane and taken for granted, which have to be grasped and articulated by the social researcher in order to provide an understanding of these actions.

This research enquiry adopts a qualitative research strategy that aims to explore and to gain an understanding of the social phenomena by “examining and reflecting on perceptions” (Collis and Hussey, 2003: 13). The research data is generated using semi-structured in-depth interviews of research subjects who met the following criteria:

- Executive member;
- Currently working or have worked as an executive in private hospitals; and,
- Have more than 10 years’ experience in managing private hospitals.

Sixteen Australian private hospital executives have been interviewed, eight from each of the for-profit and not-for-profit sectors, in an effort to depict the factors underlying their decision making process.

The research inquiry is performed within the Interpretivist research paradigm in which social reality is constructed through the process of interpretation of the subjects (Sarantakos, 1998). The research strategy adopted was abductive which logic was described by Blaikie (2003: 25) as starting from the following:
The starting point is the social world of the social actors being investigated: their construction of reality, their way of conceptualizing and giving meaning to their social world, their tacit knowledge. This can only be discovered from the accounts which social actors provide. Their reality, the way they have constructed and interpreted their activities together, is embedded in their language.

The review of the literature revealed a number of factors influencing business decisions in general. These factors were used as a platform to build the critical factors influencing decision making in the private hospital context. In this research inquiry, themes were extracted from the generated primary data identifying the factors influencing executives’ decisions and exploring the interrelationship of these factors. The primary data was tabulated and critically analysed in light of the concepts found in the literature. By comparing and contrasting both the concepts identified in the literature and the ones generated by this study, the framework for executives’ decision making was developed.

This chapter (Chapter 1) introduced the reader to the research question of this study including its rationale and purpose. The following chapter (Chapter 2) presents a contextual background to cement the foundation of the research question. Chapter three provides an overview of decision making including definition, different theoretical and practical models and the interrelated factors influencing decision making as identified in the literature. Chapter four demonstrates the research methodology adapted to facilitate a greater understanding of the social phenomena under study. Chapter five presents the research findings of this study and the framework derived from the findings. Analysis of the findings and discussions are detailed in Chapter six, including the value of this
research to practitioners and implications for existing and future research. Chapter seven draws the thesis to a conclusion with a set of practical recommendations.
CHAPTER 2

CONTEXTUAL BACKGROUND

In the previous chapter, the rationale for researching the factors influencing executives’ decision making in private hospitals was highlighted. The objective of this chapter is to provide the contextual background of the study by presenting the ‘tapestry’ of time, place and industry dynamics of where this research is occurring. While setting the scene, the researcher provides a snapshot of private hospitals within the Australian healthcare system at present, reflecting on the past and forecasting the future. Clarifying the context of the research helps to better understand the role of the executive in these specialised organisations referred to as “private hospitals.”

This chapter aims to set the scene for this research study, by shedding light onto the private hospital industry with its two sectors: private for-profit and private not-for-profit. Furthermore, a narrative of the researcher’s journey to date in this industry will be presented to provide more insight into the research context. This insider view is of particular value when adopting the abductive research strategy to explore the social actors’ interpretation of the social phenomena under study. This approach is supported in the literature by scholars such as Blaikie (2003: 25) who stated: “Hence, the researcher
has to enter their ‘social actors’ world in order to discover the motives and reasons that accompany social activities.”

2.1 Overview of the Australian Healthcare System

The healthcare system in Australia is funded by federal and individual state government and supported by private health insurance. The national health insurance scheme known as Medicare, is funded by the federal government and can be accessed by all Australians. The Medicare system funds visits to general medical practitioners and partially contributes to limited specialised healthcare services (Willis, et. al, 2005). In addition to Medicare, the government supports public hospitals and the Pharmaceutical Benefits Scheme (PBS) that subsidises a large number of pharmaceutical drugs (ABS, 2004).

However, the public healthcare system alone could not be viable in Australia without the support of the private health system. In fact, the Australian Bureau of Statistics (2006) showed that four in ten patients requiring hospital services in Australia were admitted to private hospitals, achieving 30 percent of all hospital occupied days. To be privately health insured, individuals pay a premium to private health insurers who reimburse private healthcare providers for the cost of treatment on behalf of their members. Other patients who are also classified as ‘private’ include the war veterans or their widows, and individuals under a compensation arrangement such as the Traffic Authority Commission work cover (Productivity Commission, 1999). Furthermore, a limited number of patients, referred to as ‘self insured’, choose to pay costs directly to a private hospital in order to access private healthcare services.
The private healthcare system provides the community with the ability to access specialised and private health services through bypassing the long waiting lists of patients waiting for treatment in the public healthcare sector. When admitted to a private hospital, other benefits may encompass prime accommodation facilities and the choice of the medical specialist (Productivity Commission, 1999). The definition of a private hospital, as identified by the Productivity Commission (1999:10), lay in the following key distinguishing features: “It is privately owned and managed; it charges for services rendered; and it offers patients the choice of doctor.”

The majority of private hospitals are funded by private health insurers who reimburse these hospitals for the services rendered to their privately insured members. Government’ funding is available to private hospitals that have contracts with the government, to provide a limited number of services to public patients and to war veterans and war widows/widowers through the Department of Veterans’ Affairs (DVA) (Productivity Commission, 1999).

The number of privately insured members in the community plays an integral role in determining the market size of private hospitals. In the last decade, the federal government introduced new incentives to encourage people to take up private health insurances. An example is the 30 percent rebate through tax relief on health insurance premium and lifetime health cover program for people joining private health insurance at a younger age (PHIAC, 2004; Willis, et. al, 2005). These initiatives tend to boost the
number of privately insured community members who will potentially be treated in private hospitals. While the definition of private hospitals in Australia is uniform, the ownership of these organisations is more diverse.

2.2 Ownership of Private Hospitals in Australia

In Australia, private hospital operators provide approximately 30 percent of the available hospital beds nationally and treat close to four in every 10 patients (Gee, 2007). This private ownership is mainly classified into two categories: private for-profit and private not-for-profit (Productivity Commission, 1999). The private for-profit sector encompasses 167 hospitals and contributes 56 percent of private hospital beds, whereas the not-for-profit private sector owns 118 hospitals which covered 44 percent of private beds (ABS, 2006). Whilst the former is operated by commercial groups usually floating on the stock market and paying dividend to shareholders, the latter is run by religious and charitable entities governed by volunteer board members and benefited from a tax exempt status. Private not-for-profit organisations were often referred to in the literature as the “third sector” (Lyons, 2001:110), with social and community responsibilities articulated in their mission statements and their raison d’être as was originally set by the religious orders who founded them. Lyons (2001:110) best described the development of this “third sector” in Australia and the stimulus for its formation in the following paragraph:

The first and perhaps most important stimulus was religious belief. There are several ways in which religion stimulated the formation of non profit organisations. At one level, it stimulated people to act out particular components of their beliefs, to organise relief for the poor, for example. It also led people, particularly those who had committed their lives to their religious faith, to maintain and expand the organisational presence of their religion and to ensure its growth into the future. Finally, there were those whose beliefs focused on the
great battle between good and evil and predisposed them to see enemies of their faith all around, usually in the followers of other faiths. They formed the core of sectarianism that played a central role in shaping Australia’s third sector.

The majority of these organisations are considered as religious and charitable groups (Willis, et. al, 2005), working for the good of the community by ‘healing the sick and helping the poor’, yet maintain a private status. Expanding the Church’s ministry through the provision of healthcare services was the key objective of many hospital founders and generally summed up in their mission statement. Hospitals in this category are qualified as non-for-profit organisations by the Australian Taxation Office (ABS, 2006) and therefore are tax exempt. In contrast with private for-profit hospitals, where the profit is distributed as dividends to shareholders, the returns in not-for-profit private hospitals are reinvested into the organisation and society.

In general, private not-for-profit hospitals are governed by a Board of Directors. The Board is responsible for the mission and strategic directions of the organisation. The Board, elected by religious members, appoints a Chief Executive Officer who in turn recruits a team of executives to lead and manage the hospital. The organisational structure adopted is similar to the conventional structure used to run corporate businesses, which Lyons (2001: 126) refers to it as the “corporate management model”. Private for-profit hospitals’ management model is comparable to the private not-for-profit, except that the Board is elected by shareholders to whom they pay financial dividends, rather than religious members whose surplus is reinvested in the organisation and society.
Over the years, with not-for-profit hospitals’ founding members diminishing in numbers, private corporate groups investing in for-profit hospitals, and funding sources and methods changing, the gap between the humanitarian and commercial aspect of healthcare has increased. These structural changes in the private hospital industry create a need to gain a closer look at this specialised field. Private hospitals remain operating yet under different owners or management models. In the last decade, for example, the industry has witnessed several changes in for-profit private hospitals’ ownership, with more than 50 for-profit private hospitals bought and sold by different large corporations. Other mergers have occurred to a lesser extent in the not-for-profit sector. These mergers are contributing to the changing nature of the private hospital industry from small independent businesses to large corporate entities (Productivity Commission, 1999). As a result, the private sector has been playing an important role within the overall healthcare system in Australia (Willis, et. al, 2005).

2.3 Contribution of Private Hospitals to the Australian Healthcare System

Healthcare services provided by private hospitals in Australia range from acute hospitals and day facilities (532 hospitals and day facilities in total) to mental health and rehabilitation hospitals (94 hospitals) (ABS, 2006). The size and the significance of acute private hospitals’ contribution to the Australian healthcare system warrants separate analysis of the characteristics of this industry and its role in comparison with similar healthcare services in the public sector.
Recent publications based on the Australian Bureau of Statistics and the Australian Institute of Health and Welfare, such as in Gee (2007), have demonstrated the broad similarities in the mix of services offered in the private healthcare sector compared to the public healthcare sector in Australia. These similarities were particularly in the casemix, a system that group hospital patients who have similar characteristics into the same group (Ferguson, 2004: 319), and complexity of medical procedures performed, as well as the increasing number of patients treated who were aged between 65 and 85 years of age (Gee, 2007). While public hospitals received their funding from the allocated federal and state government budgets, the majority of private for-profit and not-for-profit hospitals were financed by investors and religious entities respectively. A small number of private hospitals operating in Australia are also community-based and mutual society hospitals.

With the exception to occasional research grants or trials by government bodies and private health funds, all capital investment including facility development, equipment purchase, staff education and development and research were financed by private owners or business operators. Private hospitals are reimbursed by private health insurers only after their privately insured member receives treatment at the hospital (Willis, et. al, 2005).

The increase in outlays as a result of escalating costs of advancement in technology, increased clinical governance scrutiny and tighter rebates from the private health insurance. This in turn, put more pressure on executives to generate more income. For
example, an Australian Bureau of Statistics report (2006) showed that private hospitals have invested $322 million in capital assets including construction work. These high expenditures ran the risk of commercial imperatives taking priority in shaping executives’ decisions to recoup their costs and to ensure high internal rate of return on their investment.

The remaining section of this chapter will present the context in which private hospitals operate, by shedding light onto the elements that impact on their revenue and expenditure.

2.4 Revenue of Private Hospitals

The income of private for-profit and not-for-profit hospitals depends mainly on the number of privately insured patients who access their services. The percentage of privately insured members in the community tends to be a critical factor in determining the business viability and sustainability of private hospitals. The greater the number of privately insured people in the community, the more private hospitals’ activities are likely to increase, thereby generating more revenue in the form of reimbursement from health insurances. The role of private health insurance is best described as beneficial for “people who want to use doctors and private hospitals of their choice” (Clinton, 2004: 18). The federal government recognised the significant contribution of private hospitals to the healthcare system and assisted this sector in maintaining a good market size by introducing new incentives to boost the private health insurance coverage rate (Willis, et. 
al., 2005). For example, in January 1999, the introduction of the federal government 30 percent private health insurance rebate increased the number of privately insured patients. As a result, the majority of private hospitals have shown higher activity levels during this period, reflecting the growth in the overall privately insured numbers. Figure 1 illustrates private health insurance rate in Australia over a decade and the significant increase in coverage rate after the government initiative in 1999, as reported by the Private Health Insurance Administration Council (2004). For better accuracy in the insurance rate, the private insurance cover for hospitals has been separated in this graph from private insurance cover for other ancillary health services such as dental and physiotherapy.

**Figure 1** Private health insurance coverage.

![Graph of private health insurance coverage from December 1992 to December 2004 in Australia.](image)

Source: PHIAC (2004)

More privately insured people meant more potential business for both public and private hospitals. Budgetary constraints have also encouraged public hospitals to admit private
patients, in order to attract additional funding from private health insurers thus competing against other private hospitals in treating privately insured patients (Productivity Commission, 1999).

Both the public and the private healthcare sectors are facing the burden of increased healthcare costs at times when budgetary constraints from the government and private health insurances are getting tighter. Private hospitals are of particular interest as they are private businesses attracting a different funding scheme based on the negotiated agreed funding with private health insurers. This is also known as third party funding. The number of specialist consultants who refer patients to private hospital services also contribute to the funding of private hospitals. This complex arrangement was best described by the Productivity Commission (1999: 21) in this statement:

First, doctors and health funds both often act as agents for the patient. Second, responsibility for choosing the product – primarily assumed by the doctor – is separate from responsibility for paying for it – primarily the role of the health fund on behalf of its contributors.

This third party funding arrangement for the provision of private healthcare services will be covered in more detail in the following section.

### 2.4.1 Private Hospitals’ Funding Models

Negotiations between private health insurers and individual private hospitals are formalised under separate Hospital Purchaser Provider Agreements (HPPAs). Under this contract, private health insurers have the final say in determining the amount to be paid to
a hospital for the type of care that the patient received in a private hospital. Only war veterans and war widows/widowers are eligible to receive free private hospital treatment by the Department of Veterans’ Affairs (DVA) through the Repatriation Private Patient Scheme (RPPS) (Productivity Commission, 1999). The other group of patients who are entitled to free treatment in private hospitals are those covered by a form of compensation scheme. The two common compensation schemes in Australia are workers’ compensation, which covers workplace injuries and third party motor insurance, which covers individuals with motor vehicle injuries. A minority group of patients (nine percent of overall private hospitals’ activities in Australia) are self-paying, which means they pay private hospitals directly for the healthcare services received (Productivity Commission, 1999). Regardless of the type of insurance, the share of total benefits paid to private hospitals has shown, over the years, a declining trend reaching an overall decrease of eight percent in 2005-2006 compared to 1999-2000 (Gee, 2007).

In the last two decades, private hospitals witnessed a significant change in the funding models from private health insurers. Per Diem (per day) funding has been gradually replaced with case payment (per admission). In the past, the hospital funding was based on the number of days (per day) the patient spent in hospital. This arrangement was slowly replaced with an agreed lump sum of money (per admission) that is paid to private hospitals based on the patient’s diagnosis or treatment regardless of the patient’s length of stay in hospital or the consumables used during hospitalisation. Only prosthetic implantable devices which usually remain in the patient’s body after discharge from hospital attracted a separate rebate.
2.4.2 Medical Specialists’ Role in Private Hospitals

Since running a financially viable private hospital was totally dependent on the number of people using the service, ensuring high activity levels became a necessity for private hospital operators. The more patients the hospital admits, the more the financial benefit. However, these patients are admitted under the discretion of medical specialists (who recommend treatment in their preferred private hospital). Despite the patient being the recipient of the service, the medical specialist has a major role in patients’ selection of the private hospital in which the treatment is undertaken.

In the public sector, medical specialists are employed by the hospital in which they work (Willis, et. al, 2005). However, with the exception of certain areas such as Intensive Care Units and Emergency Departments where specialists can be employed by the hospital, the majority of medical specialists in the private sector, are accredited by the hospital and possess the right to offer specialised clinical care to their patients in more than one private hospital. They apply for accreditation through the credential process of each private hospital, which grants them admitting rights. Medical specialists usually follow a fee-for service scheme (Willis, et. al, 2005). They tend to receive payment for their services using the government Medicare scheme and through private health insurers (Duckett, 2005). Occasionally, patients pay medical specialists additional “out-of-
pocket” payments should the medical consultation or operating fees exceed the specialists’ Medicare scheduled reimbursement.

While this section gave a snapshot of the revenue streams of private hospitals, the following section provides more details of costs and overheads.

2.5 Expenditure of Private Hospitals

Service provision in private hospitals necessitates ever increasing expenditure particularly related to the following categories which will be discussed in the next section: Healthcare workforce, compliance with government and industry policies and advancements in technology.

2.5.1 Healthcare Workforce

Private hospitals are healthcare service providers offering a place of treatment thus enabling medical specialists and other health professionals to deliver patient care. “Hospitals are in the business of curing the acutely ill” stated Mintzberg (1997: 12) when summarising the service offered by the hospital industry. They act as “vectors” providing medical specialists and patients with all the resources required for the provision of healthcare services. The top priority and responsibility of private hospitals was ensuring the availability of adequate levels of staff, including highly specialised nurses and skilled technicians. Labour costs account for approximately 70 to 80 percent of the total industry costs including salaries, superannuation and payroll tax (Duckett, 2005).
Increasing salaries and costs of recruitment to attract staff have also been ongoing financial burdens, particularly with the increase shortage and casual employment in nursing and allied health staff (Duckett, 2005). The paradigm shift towards casualisation of the healthcare workforce has been the focus of an Australian study, comparing this phenomenon between the public and the private sectors (Lumley, Stanton and Bartram, 2004). Using combined qualitative and quantitative research methods, this study showed that in both sectors, casualisation provided high level of work performance and quality of patient care (Lumley, et al., 2004: 33). The sample of this study was selected from one public (300 beds) and one private (120 beds) hospitals, non-comparable in size which limits the ability to present the findings as representative of each hospital’s relevant sector.

Other expenditures in private hospitals are related to the provision of patients’ facilities that meet government standards, such as operating theatres and patients’ accommodations. Furthermore, capital equipment, surgical instruments and devices, pharmaceuticals and other medical consumable items were provided by private hospitals.

### 2.5.2 Compliance with Government and Industry Policies

A number of federal and state government legislations and industry policies regulate private hospitals (Willis, et al., 2005). While licensing is granted by the state government, the Commonwealth is responsible for the declaration of private hospitals in order to be eligible to receive payment from private health funds. Other federal legislation include
legislation covering relationships between private hospitals, medical practitioners and health funds; and, legislations aimed at the members of health insurance providers to encourage the uptake of private insurance (Productivity Commission, 1999). The main areas of conduct that are governed by the state government licensing include planning and building criteria (e.g. location and bed numbers), staffing arrangements, facilities and equipment, maintenance, improvements, records and registries, reporting and notification (Productivity Commission, 1999). A number of key federal government legislations that impact the private hospital industry include policies related to expenditure, such as the Pharmaceutical Benefits Scheme and Medicare, and other initiatives in relation to private health insurance including the introduction of lifetime health cover and tax incentives.

These legislations aim to provide access to private healthcare services, decrease the burden on the public system and ensure a fair distribution across the nation. There are other industry policies to maintain and to improve the quality of healthcare services. The Australian Council on Healthcare Standards (ACHS), for example, is one of the key bodies responsible for monitoring quality of services and thereby granting accreditation for hospitals who meet the ACHS standards. Established in 1974, ACHS is an independent not-for-profit organisation comprising government, professional colleges, industry bodies in health and consumers. The ACHS determines the standards for assessment, evaluation and accreditation of healthcare organisations. The process is conducted by qualified surveyors following generally, a framework. The most common framework in private hospitals is known as the ‘Evaluation and Quality Improvement Program’ (EQUIP). The ACHS EQUIP process involves meeting the following
standards which are grouped under the functions of clinical, support and corporate as per Table 1 (ACHS, 2006).

**Table 1** Lists of quality standards by category

<table>
<thead>
<tr>
<th>CLINICAL</th>
<th>SUPPORT</th>
<th>CORPORATE</th>
</tr>
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<tbody>
<tr>
<td>Continuum of Care</td>
<td>Quality Improvement and Risk Management</td>
<td>Leadership and Management</td>
</tr>
<tr>
<td>Access</td>
<td>Human Resource Management</td>
<td>Safe Practice and Environment</td>
</tr>
<tr>
<td>Appropriateness</td>
<td>Information Management</td>
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</tr>
<tr>
<td>Effectiveness</td>
<td>Population Health</td>
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<td>Safety</td>
<td>Research</td>
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<td>Consumer focus</td>
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<td>Support</td>
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The accreditation status gained by the hospital after an on site review increases stakeholders’ confidence and trust in the quality of outcomes delivered and organisational performance. Experts in the industry such as the Private Hospital Association, which represent its members noted that private hospitals are exposed to higher accreditation status (Gee, 2007) compared to public hospitals. These mandatory requirements necessitate more funding to be allocated to areas such as research, information technology, work environment and teaching and development. These funds enable private hospitals to achieve and maintain industry standards, and the ongoing costs associated with accreditation. In addition to the increase in legislative requirements as noted earlier, the adoption of new technologies played a significant role in escalating healthcare costs which will be discussed in the next section (Herbert, 2004).
2.5.3 Advancements in Technology

The Australian Bureau of Statistics (2006) showed that private hospitals in Australia witnessed a 4.9 percent increase in capital expenditure between the financial years 2004-05 ($6,144m) and 2003-04 ($5,859m). The capital expenditure invested in private hospitals was shown to exceed $330m (ABS, 2006). The major non-labour cost components in private hospitals are related to pharmaceutical, medical and surgical supplies, repairs and maintenance and investment in capital expenditure (Productivity Commission, 1999). Investment in capital expenditure increases according to advancements in technology (Willis, et. al, 2005). Adopting new medical technologies requires a significant capital investment that is difficult to achieve without favourable activity levels and positive net profit. In Australia, more than 16 percent or $ 64.32m of private hospitals’ expenditure in the financial year 2004-05 (APHA, 2005) was spent on acquiring new equipment, which was driven by developments in technology. Further increases in equipment cost in the vicinity of 63 percent or $19.26M were forecasted for the financial year 2005-06 compared to 2003-04 (APHA, 2005). On the other hand, the increase in the population aged 65 years and over has resulted in frequent hospitalisation of this group, requiring more complex treatment and longer lengths of stay in hospital. The associated costs with longer life and more complex diseases associated with older age is expected to rise with the percentage of this group increasing in Australia from 13 percent in 2004 to 27 percent and 31 percent in 2010 (ABS, 2006). In 2003-04, the Australian Institute of Health and Welfare statistics showed that this age group represented 35 percent of all private hospital admissions.
Investing in expensive technology often becomes a competitive advantage for private hospitals and can attract media attention positioning these organisations as the leaders in their field. Aside from the marketing benefits, the clinical advantages of excessive technology applications in healthcare remains a controversial issue (Herbert 2004; Thomas, 1995). Suppliers selling expensive capital equipment to healthcare providers tend to produce large amounts of statistical data to demonstrate operational efficiencies and optimal clinical outcome when using their product. This often leads to excessive use of technology with outcomes that could be questionable in evidence based practice. A report from the Productivity Commission (1999) has demonstrated the importance of service utilisation and the use of new technologies in rising healthcare costs. Warnings are often noted in the literature reviewed advising healthcare managers to focus on “changing technology” and to refrain from investing in capital that could become obsolete with a new and more effective treatment on the market (Smith, et.al, 1994: 36).

2.6 Private Hospitals’ Market

The private health industry cannot be studied in isolation without a reference to the economic implications of an aging population in Australia (DEST, 2001). A reflection on this topic by (Clinton, 2004: 10) revealed the following:

The Australian population is ageing progressively due to low fertility and increasing longevity. By 2051, the proportion of the population over the age of 65 years will double to over 25%.
It has been argued that the increase in the ageing population creates a financial burden on the healthcare system (Clinton, 2004; Productivity Commission, 2005). Prolonging life, particularly related to research and advances in technologies, is also experienced by the private hospital industry (Productivity Commission, 1999). The additional requirements of this ageing population for a longer length of stay in hospital, due to complications and slower recovery time, are examples of variables that are escalating healthcare costs.

Other market changes that the private hospital industry has witnessed in the last decade included a significant number of acquisitions / mergers, and the increase in corporate entities operating these organisations. The concept of managed care (third party administration and financial management of healthcare costs) which has turned “medicine into a business” in America (Bruhn, 2005: 311) has aroused opposition in Australia (Marcus, 2000: 1). As noted earlier, the most significant example in the history of Australian private hospitals was the case of Mayne Health that attracted media attention at the beginning of this century. Mayne Health, which operated 60 private hospitals in Australia, did not take long to exit the private hospital industry by selling all hospitals in its portfolio. Many reasons have attributed to this divestment including allegation of only admitting patients who attracted high subsidies from private health insurers and what was referred to in the media as ‘cherry picking’ (AMA, 2001; Lyons, 2001).

Several mergers and acquisitions of private hospitals have occurred after the sale of Mayne Health, increasing in this way the number of corporate entities owning private
hospitals. Recent experience showed that a new business model to healthcare is emerging with a real estate company owning the land and the facility and a different operator managing private hospitals.

The past and present market changes in the private hospital industry triggered the researcher’s interest in gaining better understanding of executives’ strategic decision making in private hospitals, in light of the changing face of the future of private healthcare which will be covered in the next section.

2.7 Future of the Private Hospital Industry

When forecasting the future of private healthcare, technology acquisition and private health insurance rates tend to be two of the key driving forces for revenue and expenditure in this industry. As noted earlier in this chapter, the increased percentage of privately insured members in the community is a critical factor in the viability and sustainability of private hospitals. On the other hand, ongoing investment in major technology often at medical specialists’ request impacts significantly on the private hospitals’ financial bottom line.

The question that emerges is how will these two elements shape the private healthcare industry in the future? Will the healthcare system be witnessing more robotic surgery and sophisticated prosthetic devices as a result of advancement in technology; or will diseases become more complex with an aging population and conventional treatment
become the optimal option? How will the variation in the private health insurance rate impact on the private healthcare industry? And, how will hospital executives manage their businesses to adapt to the different scenarios created by these two interacting forces? The complexity of the private healthcare industry and environmental forces will lead to more than one possibility. Based on potential changes in these driving forces over time, the researcher is forecasting four possible shifts in industry structure. When making business decisions, remaining focused on overall structural conditions can avoid gravitation to one element in the structure (Porter, 2008). Scenario construction will be used in the next section to explore the variations and implications of these forces and the different plausible futures of the private not-for-profit healthcare industry.

2.7.1 Rationale for Selecting Scenarios as a Forecasting Tool

Scenario building has been chosen as the method of choice to forecast the long term horizon of the private healthcare industry. According to Makridakis, et. al. (1998: 472), “A major purpose of scenarios is to challenge conventional thinking and avoid extrapolation into the future in a linear fashion.” However, to predict a plausible future every scenario needs to be anchored in the past. From the past and the present the future emerges seamlessly (Heijden, 1996).

A review of the past and the present has indicated the significance of medical technology acquisition, and health insurance coverage for private hospitals. Past trends have shown that health insurance membership rates are not linear, with the government reacting by
introducing a new initiative, each time the rate declines, to boost the insurance rate (as illustrated in Figure 2). The latest of these initiatives include: the federal government 30 percent rebate on private health insurance premium that was initiated in January 1999 and, second, the lifetime health cover launched 1 July 2000, that encourages the take up of private health insurance earlier in life by recognising the time the person has been privately insured and keeping health insurance rates lower throughout life.

**Figure 2**  Review of health insurance coverage (June 1971 – December 2004)

Source: PHIAC (2005)

Following the trend in the past, the future of the health insurance coverage is anticipated to have periods of high and low coverage, with the federal government interfering to boost private health insurance when the rates are at their lowest. Although it is not possible to predict the percentage of future technology acquisition by private hospitals, advancements in technology in the last decade have shown its increasing role in healthcare delivery, through the changes in modalities and practices adopted by medical specialists in the provision of clinical care. For example, minimally invasive radiological
procedures have been gradually replacing conventional open surgery in the treatment of a large number of diseases. What is mostly unknown is how quickly private hospitals will adopt new medical technology in an ever changing socio-economic environment and volatile health insurance rates.

To consider the long term implications of medical technology and health insurance coverage, alternative scenarios are built to illustrate how the private hospital industry will look, with changes in these fundamental structural forces. Demonstrating the impact of these strong forces on the structure is best pictured in form of different scenarios giving the reader more dramatic and real possibilities that could occur in the unknown future of private hospitals.

2.7.2 Future scenarios of the private hospital industry

The level of medical technology adoption and the health insurance coverage noted earlier formed two independent dimensions that appeared historically to impact significantly on the private hospital industry. Juxtaposing these two dimensions together generated four possible scenarios for this industry as shown in Figure 3.

Figure 3 Key elements for scenario construction
Scenario 1: High technology adoption – High health insurance coverage

In this scenario, technology is constantly advancing, providing medical practitioners with better diagnostic and therapeutic tools. More screening tools that are available on hand will lead to enhanced diagnostic tests and early detection and treatment of diseases. The increased requirement for hospitalisation, due to more detection of diseases combined with the high insurance coverage, will result in an increase in admission numbers to private hospitals. The large percentage of fixed costs in hospitals means that every increase in volume will boost the net profit leading to significant positive margins (Smith, et al., 1994). With a favourable net profit, private hospitals can reinvest in capital expenditure and facility development.

Similarly, public hospitals will be suffering from a financial deficit resulting from the burden of escalating technology costs. With the increase in government spending on medical technology, lower budgets will be allocated to the maintenance and refurbishment of hospitals’ building infrastructure which will deteriorate and become run down. As a result, public hospitals will be forced to close beds and operating theatre
rooms. Further ramifications of high investment in the healthcare system and less elsewhere can be manifested in poorer social and environmental conditions across the nation.

Scenario 2: Low technology adoption – High insurance coverage

A decline in the global economy can limit the development in medical technology at the international level. Nationally, the limited dependence of healthcare on technology will force medical practitioners to resort back to conventional surgery that requires lower capital equipment cost. The running cost of hospitals will be at its lowest levels leading to better financial performance. More money will be available to spend on staff and capital building maintenance and expenditure. Without the burden of new technology acquisitions and the associated escalating healthcare costs, private health insurers will decrease their insurance premium leading to more affordable private health insurance. Low private health insurance premiums will encourage the public to take up private health insurance. The health insurance coverage rate will increase amongst all age groups. With more people being privately insured, public hospitals will also be more financially relaxed and able to better meet clinicians’ and patients’ needs.

Scenario 3: High Technology adoption – Low insurance coverage

With low private health insurance coverage and escalating costs of technology, neither private hospitals nor private health insurers will be able to sustain the rise in capital investment costs. More mergers and acquisitions amongst private hospitals would occur with limited number of big players dominating the market. Tertiary private hospitals, with commitment to research and good infrastructure, will attract the majority of private
patients’ volume. With low private health insurance rates the sustainability of private hospitals becomes harder. High fixed costs and low activity will start to reduce private hospital efficiencies. More redundancies at management level will take place to reduce fixed costs. Less permanent positions will be offered in private hospitals relying on casual workforce during busy periods. Rather than upfront purchasing, leasing will become the method of choice for accessing capital, which is usually uncommon business practice in the healthcare sector. Private hospitals will not have the liquidity that is essential to attract funding for capital investment (Smith, et.al,1994).

Private health insurers will increase their premium fees to cover the rising costs of new technologies adopted by medical specialists in private hospitals. As a result, fewer patients can afford private health cover and the health insurance rate will drop further. The pressure on the public sector will increase with longer waiting lists and more pressure on bed access. The government will respond to this crisis by introducing a new initiative to boost private health insurance as it has happened in the past. New hospital funding models will be introduced by private health insurers to reduce funding and to shift the financial risks to private hospitals. Health insurance premium rates will increase to an extent that people will not be able to afford private health insurance. As a result, more pressure will be on public hospitals leading to longer waiting lists. Only a limited number of patients with high socio-economic status will be able to afford private health insurance.
Scenario 4: Low Technology adoption – Low insurance coverage

The low technology acquisition by the private hospital industry will maintain the cost of patients’ care at its minimum. As a result, private healthcare becomes very affordable and accessible by simply paying the hospitals directly fee for service. People do not feel the need to join private health insurance. A significant number of admissions to private hospitals is anticipated to be self-insured patients who can afford to pay hospital fees without being a member with the private health insurers. This number of self-funded patients helps to maintain private hospitals’ viability. In this scenario, the significant impact will be more on the health insurance firms who have to drop insurance premiums to attract more members. The government is more likely to intervene in this scenario with a new initiative to boost private health insurance coverage. Public hospitals will maintain their status quo with more government money injected in expansion and capital building rather than capital equipment.

In summary, scenario building was used as the method of choice to forecast the long term horizons of private hospitals in Australia. Using the two dimensions, medical technology acquisition and health insurance coverage, a two by two matrix was developed to form four scenarios which were chosen as a guide to some plausible features of this industry. However, the researcher has no intention to list and analyse the critical factors influencing executives’ strategic decision making in every scenario. This thesis represents a snapshot of the private hospital industry at present and the critical factors influencing the decision making phenomenon at executive level using an Interpretivist approach.
To gain an insight into the development of the research topic would be best described by examining the industry from the researcher’s perspective. Therefore, it is beneficial to shed light on the researcher’s professional journey in this discipline reflecting on personal experience and interest in this industry for the last two decades.

2.8 The Role of the Researcher’s Background as a Practitioner in the Topic

Selection

The researcher is a member of the middle management team in a private hospital, dealing with consequences of executive decisions was a daily practice. Decisions at that level tend to impact several stakeholders such as staff, patients, doctors and the organisation’s performance as a whole. In addition to tacit knowledge, acquired knowledge gained through tertiary education formed the platform that the researcher used to start a career in healthcare. Delivering nursing care at the patient bedside was the first step in that career path.

The researcher, in her pre-research role as a nursing practitioner, was appointed to several positions and was exposed to different facets of the private hospital industry. People were experiencing pain, suffering from symptoms of a disease, grieving the loss of a father or enjoying the birth of a child.

With every new role, the practitioner was taking a step away from bedside clinical nursing towards more senior positions. As the practitioner was moving to senior
positions within private hospitals, the gap in rationality between financial and clinical aspects of healthcare was widening.

The practitioner’s roles often involved communicating and implementing executive decisions which presented a challenge to the practitioner particularly with higher customer expectations and market competition increasing. The request from medical practitioners to purchase latest equipment often using leading technology became the catalyst for several disagreements between hospital executives and medical specialists. As the use of advanced medical technology improved the diagnosis and management of diseases, medical technology becomes a necessity in the provision of healthcare services in private hospitals.

In light of this dichotomy between the humanitarian and economic aspect of private health care, the practitioner became a researcher developing an interest to gain deeper understanding of how executives make decisions when managing private hospitals and what factors influence these decisions in this social context.

Whilst executive decisions have been examined generally as phenomena that occur in any organisation, the researcher had an interest to explore this concept specifically in private hospitals. The points of differentiation of this industry are often taken for granted by people working in these organisations. As noted by Parry (2003: 240):

We take for granted the social and cognitive processes that we employ to socially construct the organisations in which we work. Our beliefs, assumptions, stories and interactions with others help us to bring order to what is going on, to make sense of our own reality.
However, for a new executive starting a career in private hospitals, deeper understanding of this social context is required to manage these organisations in the short-term, while ensuring their viability long-term.

Consequently, the motivation behind this research was to illuminate strategic decision making at executive level in private hospitals by identifying the factors that interplay to create these decisions. The researcher’s experience (as a practitioner) in this social context and observation of the social phenomena occurring at micro and macro levels in Australia, suggest the need for thorough understanding of what really matters in the running of private hospitals.

The researcher aims to create a comprehensive platform based on the synthesis of theoretical views on decision making and the interpretation of practical insights into the private hospital industry. The researcher has no intention to generate a recipe for managing private hospitals, but to produce a reference for informed executives’ strategic decisions.

By examining explicitly the elements that matter from executives’ perceptions, better understanding is gained of decision-making phenomena within the private hospitals’ context. The following chapter will present the different views on the concept of management decision making as identified in the literature reviewed.
CHAPTER 3

LITERATURE REVIEW

3.1 Introduction

The thesis aims to better understand executives’ decision making in private hospitals by shedding light onto the factors that influence their decisions.

The concept of decision making has been for years an area of interest for economists, sociologists and psychologists. The literature reveals a significant body of knowledge analysing decision making at the individual (Saaty and Vargas, 1991; Kahneman and Tversky, 1979), organisational (Simon, 1997; Tarter and Hoy, 1998) and environmental levels (Richardson, 1994; Donaldson, 1996; Hough and White 2003). There is no shortage in the number of theories generated to address the human decision making process highlighting contending perspectives and their implications for practice. Major empirical and theoretical studies encountered in the literature were searching for the “good” or “best” decision (Simon, 1997) using different guiding principles (Tarter and Hoy, 1998).

The aim of this chapter is to identify the different theoretical approaches adopted in the literature to examine management decision making and the factors influencing this social act. The selected literature reviewed was conducted in the disciplines of business management, psychology and social and organisational behaviours. The first section will
provide an overview of decision making from different theoretical aspects followed by the decision making models designed in the literature to provide administrators with a practical guide for decision making. The factors influencing decision making as identified by the literature being individual, environmental and organisational were explored. The literature review focuses in the latter on the organisational goal or mission and strategy in an attempt to examine their roles (if any) in executive decision making.

The concluding remarks present the synthesis of the literature reviewed. The definition of decision making will be covered in the following paragraph as a starting point for investigating this social phenomenon.

### 3.2 Decision making: Definition

Decisions as defined by Gibson, et al (2000: 427) are “means to achieve some result or to solve some problem; outcome of a process influenced by many forces.” Decision making has often been considered in the literature as a key aspect in managerial and executive roles at daily operational (Woods and Bandura, 1989; Swayne, et.al, 2006) and at strategic level (Mintzberg, et.al, 1998; Simons and Thompson, 1998; Brousseau, et.al, 2006). Whether studied at individual or organisational level, decision making is generally considered as a cognitive and multidisciplinary process beginning with a stimuli or motive for action and ending with commitment for action (Mintzberg, et.al, 1976; Cutting and Kouzmin, 2002). The confusion and controversy remained in the middle phase of the process particularly when scholars questioned whether in reality there were any phases in the decision making process (Wood and Bandura, 1989).
Mintzberg, et.al (1976) challenged this research inquiry and was determined to find “the structure of unstructured decision processes” by comparing and contrasting 25 strategic decision making processes. The research results showed that within the structured model, seven different groups were formed, with only four involving similar outcomes (Mintzberg, et.al, 1976). The majority of the literature agrees that the decision making process is not linear, but it is spiral exposed to pressures and forces driving the decision forward or even backwards (Mintzberg, et.al, 1976).

Decision making has been studied from different angles based on the theoretical approach and the school of thought to which the researcher belonged. The following section will present a theoretical overview of the literature reviewed.

3.3 Decision Making: Theoretical overview

The literature reviewed about the concept of management decision making was grouped into three major theoretical approaches: The economic approach, the cognitive approach and the administrative behavioural approach.

3.3.1 Economic approach

Positivist researchers were challenged in applying the concept of numbers into human decision making. Experimental research on human decisions has been problematic with researchers often unable to provide “deeper understanding of the underlying phenomena” (Sahlin, 1991: 6).
Using economic theory as a starting point, the decision making process began with a means-ends analysis aiming to maximise benefits and to create wealth (Haddad, 1996; Tarter and Hoy, 1998). The economist, according to Perrow (1970: 23), “works with data several times removed from ongoing situations which involve the behaviour of the individual.” This objective approach to decision making did not reflect the human element in the process, which was addressed with the introduction of the Expected Utility Theory- the foundation of modern economic theory (Sahlin, 1991). Based on the latter, the outcomes of a decision derive from the utilities and the probabilities that are determined by human desire and belief respectively (Sahlin, 1991). This human element was again manifested in form of a number added to the equation. The Expected Utility Theory has proven over time to assist in generating significant empirical data, but was still unable to give insight into human cognition (Sahlin, 1991). Time is often spent “arguing about mathematical techniques rather than trying to understand human cognition” (Sahlin, 1991: 9).

Dealing with numbers alone which do not reflect the human cognitive aspect became apparent with new theories emerging with time, introducing alternative ways in order to factor in the human impact on the decision making process. For example, Kahneman and Tversky (1979) developed the Expected Utility Theory further and introduced Prospect Theory for decision making under risk. Kahneman and Tversky (1979) have added the decision’s weighting and value function to the equation. Value is assigned not to the
final outcome but to change in wealth or welfare which describes or predicts humans’
decision behaviour (Sahlin, 1991).

The major drawbacks in Prospect Theory, as identified by Sahlin (1991) and more than a
decade later by Nwogugu (2005a), were the limitations in the research methodology and
shortcomings in measuring risk and decision making. Kahneman and Tverskin (1979)
used a scientific experiment on a selected sample to predict human decision, a paradigm
that often produces questionable results when it comes to studying human psychology
and the cognitive system (Sahlin, 1991). Research into decision making using economic
theory did not take into consideration the decision maker’s cognition and skills
(Nwogugu, 2005b).

3.3.2 Cognitive approach

Scholars in the cognitive school, particularly in cognitive psychology, have been focusing
on understanding the human cognition and processing of information to make decisions
(Mintzberg, et. al, 1998). Decision makers build their cognitive “maps” depending on
their ontological and epistemological predisposition (Dixon and Dogan, 2003: 40) which
explains why the element of subjectivity was higher in the individual based decision
making model compared to the organisational based model (Tarter and Hoy, 1998).

It was challenging for cognitive theory alone to understand individual decision making
without taking into consideration the context and the factors leading to behavioural
outcomes. The emergence of social cognitive theory provided a conceptual framework to
clarify the psychological mechanisms that link organisational performance with social-structural factors (Wood and Bandura, 1989). After all, organisations as defined by Gibson, et.al (2000) are entities that enable society to pursue accomplishments that cannot be achieved by individuals acting alone. Mintzberg, et.al (1998) referred to organisations as a collective system of processing information which goes beyond the biases in human cognition.

In an attempt to gain a better understanding of the managerial decision making process in organisations, Cutting and Kouzmin (2002) went deeper in their analysis by dissecting decision making into three phases of a process encompassing:

Menetype #A: experience or data scanning
Menetype #B: perception or meaningful interpretation
Menetype #C: decision or cognitive commitment

The more the organisational or individual focus moves toward “Menetype C: decision or cognitive commitment”, the more “the influence is on what is the right thing to do given the reality of the situation” (Cutting and Kouzmin, 2002: 29). The decision making process develops into a very personal and political process with the aim to find the decision that fits the current circumstances (Cutting and Kouzmin, 2002). This is identified by Preston (2001: 21) as a problem that often executive managers fall into depriving organisations from future business development.

One big mistake that many healthcare executives make in evaluating service line performance is to review recent history or present performance rather than couch the analysis in terms of future potential. In doing this, executives may commit the egregious (but not uncommon) error of discarding or downsizing tomorrow’s brightest opportunity for today’s budgetary mandate.
This example emphasises the need for executives to make management decisions with “one eye on the present and the other on the future” (Calabrese and Zepeda, 1999: 11). Wood and Bandura (1989) argued that the future is too distant to influence present behaviour and recommended a combination of both short and distant goals. Short goals act as motivators to reach the distant goals.

The individual tendency to exhibit goal-oriented behaviour has been emphasised in social cognitive theory (Wood and Bandura, 1989). The importance of setting goals that tend to determine individual’s behaviour was also highlighted by Gibson, et.al, (2000). Similarly, at organisational level Perrow (1970: 134) emphasised the need to examine the organisational goal when seeking to analyse organisational behaviour. The problems identified by Perrow (1970: 134) in organisational goals were:

- Organizations do not have goals; only individuals do
- Goals are hard to observe and measure
- How do we distinguish between a goal and a means?

In reality, the question about what determines individual behaviour in organisations remains unclear especially when “organizational goals are often ambiguous or in conflict with each other” (Mcshane and Von Glinow, 2005: 241).

Another attempt in the literature to structure the decision making mental process at individual level was noted with the emergence of the Analytic Hierarchy Process (APH) theory (Saaty and Vargas, 1991: 11). The AHP theory had its premise based on the following assumptions:

- That the methods we use to pursue knowledge, to predict, and to control our world are relative, and that the goal that we seek, i.e., knowledge, is itself relative. It all depends on what purpose motivates us to seek that knowledge at that
specific time, or, as the case is the scientific method, what beliefs others have instilled in us about the world and how we should go about understanding it.

The ontological and epistemological assumptions of the AHP theory appear to be rooted in the Positivist paradigm. Despite this theory’s attempt to stress the ‘relative’ aspect of human cognition, the method and tools adopted to reach the desired decision showed to be purely mathematical. Saaty and Vargas (1991) aimed to convert subjective variables into objective ones by allocating numerical values to subjective judgement based on the relative importance of these elements. Assessment is then based on paired comparisons with the best course of action granted for the variable with the highest ranking. Prioritising was based on allocated weight of the different factors and implementing the activities based on their ranking (Saaty and Vargas, 1991). By using the concept of priority rather than probability Saaty and Vargas (1991) believed that they could synthesise the different elements by comparing two at a time and therefore converting the intangible criteria for decision making to tangible ones. This attempt to measure the intangible outcome was a common thread in the business literature (Kaplan and Norton, 2004; Banker, et.al, 2001; Saaty and Vargas, 1991) particularly with the introduction of balanced scorecards by Kaplan and Norton (2001).

If using empirical research when studying human decision making has often been accused of lacking the deep understanding of fundamental phenomena (Sahlin, 1991), researchers using cognitive theory were also faced with other challenges. The fact that human beings have cognitive limitations has led many scholars to believe that
behavioural decision theory provides more accurate description of the way individuals make decisions in organisations (Simon, 1997; Mcshane and Von Glinow, 2005).

3.3.3 Administrative Behaviour Approach

Administrative behavioural theory for decision making was led by Simon Herbert, an economist who won a 1978 Nobel Price for introducing the concept of bounded rationality and satisficing into decision making theory (Simon, 1997). Bounded rationality refers to limited information and the ‘bounded’ representation that a decision maker uses to make a decision. Only the most salient information that relates to the problem at hand is considered when making a decision. With satisficing, the decision maker arrives to the decision by choosing the first option that matches the set standards. A minimally satisfactory option is selected (Beach and Conolly, 2005).

Simon Herbert was often accused of using the positivism paradigm as a platform to build his Administrative Behaviour Theory (Simon, 1997; Brown, 2004). In his writings, Simon (1997) has frequently adopted analogy and comparison between scientific concepts and social phenomena in an attempt to build a bridge between these two schools of thought. The dichotomy between the Positivist and the Interpretivist paradigms was reflected in Simon’s work (1997) in his frequent use of contradicting terms such as “fact and value”, “logical and psychological”, “policy and administration” and “knowledge and choices.” In his attempt to compare both worlds, Simon (1997: 119) went a step further by comparing the good decision of an “economic man” compared to the “administrator”.
Satisficing, as originally defined by Simon (1997: 119), is a characteristic of the administrator who “looks for a course of action that is satisfactory or “good enough” compared to the economic man who maximises by selecting “the best alternative from among all those available to him.”

Drawing on Simon’s theory, Brousseau, et.al (2006) introduced a two-dimensional matrix involving information use (satisficing/ maximising) and number of options (single focus/ multifocus), to generate four style of executive decision making. The four styles identified by Brousseau, et.al (2006: 112) were referred to as: “decisive (little information, one course of action); flexible (little information, many options); hierarchic (lots of data, many options); and integrative (lots of data, many options).” In this research, the Positivist research methodology was adopted to plot different levels of management into the applicable decision making style. Whilst the validity of this study was (or appeared to be) relatively high in term of the large sample size used (120,000 individuals), the weakness lay in Brousseau’s (2006) attempt to link these four decision making styles with managers’ success using the salary index as a proxy for success, and therefore, possibly lacking construct validity.

The concept of satisficing and bounded rationality introduced by Simon (1997) explained the limitation in the administrative behaviour which can be considered the starting point of differentiation between the economic theory and the administrative theory. This cognitive limitation and its impact on human perceptions, according to Wood, et. al (2004), impairs the key steps in the decision making process. After all, the limitation of the human cognitive ability in acquiring all information, selecting all alternative
strategies and evaluating all possible outcomes drive the decision far from being rational (Simon, 1997). Simon’s administrative behavioural approach to decision making questioned the ability of the executive to access or have available all the information and scenarios possible in limited time to make a decision about the job at hand.

Bounded rationality has been redefined by Mcshane and Von Glinow (2005: 240) as “processing limited and imperfect information and satisficing rather than maximising when choosing among alternatives.” Bazerman and Chugh (2006) took this argument further by referring not only to seeking information, but whether this information is used and shared. The lack of using and sharing the information after acquiring it was considered by Bazerman and Chugh (2006) as a symptom of what is known as “bounded awareness.”

The difference in Bazerman’s and Chugh’s (2006) definition of bounded awareness and Simon’s (1997) bounded rationality lies in the ability of learning the former. Bazerman and Chugh (2006: 91) claimed that “people can learn to be more observant of changes in their environment, which will help to remove their decision-making blinders.” This claim was based on the training offered to United States of America secret service agents to scan and notice things that would not be usually common to everyone. Further case examples or research studies are recommended to increase the validity of this claim. and Tversky and Kahneman (1974: 1131) classified the decision making behaviour into two types of heuristics that decision makers tend to adopt during choice making, “availability” heuristic when decision is based on the information available, and
“representativeness” heuristic when the assessment of the likelihood of an occurrence is performed by trying to match it with a pre-existing category.

In his empirical study on the strategic decision making of 233 small Dutch firms, Brouthers, et.al. (1998: 136) used a series of empirical tests to find whether there is any correlation between the size of the firm and the rational decision making process. The findings (as illustrated in Table 2) revealed three factors that could not be accepted from the Positivist research perspective and were claimed to be nonrational activities. The managerial solutions recommended by Brouthers, et.al (1998: 136) were simply the conversions of these “nonrational” activities into a language that is valued within a Positivist research paradigm, such as gathering quantitative information, scanning the environment and using computerised analytical tools.

**Table 2 Improving strategic rationality**

<table>
<thead>
<tr>
<th>Nonrational activity</th>
<th>Managerial solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Use of nonquantitative analysis techniques</td>
<td>1. Increased use of computerized analytical tools</td>
</tr>
<tr>
<td>2. Not including information or analysis in decision making</td>
<td>2. Rely on gathered information and analysis- less on intuition</td>
</tr>
<tr>
<td>3. Influence of managers’ personal opinions- unsupported by facts</td>
<td>3. Improve environmental scanning</td>
</tr>
</tbody>
</table>


In addition to the cognitive limitation, the role that emotions play as a force directing choices and decisions towards particular goals was also noted in the literature (Simon, 1997). However, the questions that remained unanswered were: whose goal will that be: organisational goal or individual goal? And, meeting which goal is considered the rational decision and for whom? The problems faced by Simon (1997) half a century ago in applying the economic rational model to organisational behaviour is still faced in
contemporary organisations which is reflected in the recent work of McShane and Von Glinow (2005) on organisational behaviour. Figure 4 illustrates the comparison conducted by McShane and Von Glinow (2005: 241) between these two decision making models in term of “goals, information processing and maximization”. The characteristics of the environment also play a key role in the adoption of the most suitable theory. According to Wood et.al (2004: 550), the behavioural decision maker is seen as acting under uncertainty and with limited information compared to the classical decision theory that “views the manager as acting in a world of complete certainty” to achieve optimum outcomes.

Figure 4 Rational model assumptions versus organisational behaviour findings.

<table>
<thead>
<tr>
<th>Rational decision model assumptions</th>
<th>Observations from organizational behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decision makers use goals that are clear, compatible, and agreed upon.</td>
<td>Decision makers use goals that are ambiguous, are in conflict, and lack consensus</td>
</tr>
<tr>
<td>Decision makers can process information about all alternatives and their outcomes.</td>
<td>Decision makers have limited information-processing abilities.</td>
</tr>
<tr>
<td>Decision makers evaluate all alternatives simultaneously.</td>
<td>Decision makers evaluate alternatives sequentially</td>
</tr>
<tr>
<td>Decision makers evaluate alternatives against a set of absolute standards.</td>
<td>Decision makers evaluate alternatives against an implicit favourite alternative</td>
</tr>
<tr>
<td>Decision makers process factual information.</td>
<td>Decision makers process perceptually distorted information</td>
</tr>
<tr>
<td>Decision makers choose the alternative with the highest payoff (maximizing)</td>
<td>Decision makers choose the alternative that is good enough (satisficing)</td>
</tr>
</tbody>
</table>

Source: McShane and Von Glinow (2005:241)
The three different theoretical approaches to decision making (economic, cognitive and administrative behaviour) did not stop the emergence of a new radical paradigm questioning whether decision making is an analytical process or whether intuition is the key element after all.

3.4 Decision Making: Intuitive or Analytical

The controversy in the decision making literature could be considered to lie around the absence or the presence of critical thinking and planning (Gladwell, 2005; LeGaut, 2006). Can decision making be planned as a step-by-step process or is it an intuition known as ‘gut feeling’, which is the essence of speed? It was interesting to observe the birth of the concept of ‘intuition’ in the decision making literature with time. Originally the use of intuition was considered a limitation to rationality (Brouthers, et. al, 1998), until it was recognised as an important decision making element particularly in circumstances, such as non-planned decisions, limited timeframe, high risk or uncertain environment (Wood, et.al., 2004). Gladwell (2005: 11) referred to intuition as “another kind of decision-making apparatus that’s capable of making very quick judgments based on very little information.” This ‘instant’ decision making based on the ‘gut feeling’ is related to the individual’s characteristics, which Buchanan and O’ Connell (2006:40) described as “a personal, non-transferable attribute, which increases the value of a good one”
On the other hand, another school of thought considered the familiarity with tasks to make individuals rely on intuition rather than analysis (Spicer and Sadler-Smith, 2005). LeGaut (2006) used this argument as a starting point to critique the concept of intuition as described by Gladwell (2005) in his best seller “Blink”. According to LeGaut (2006), intuition is based on the social actor’s thinking, critical reasoning and interpretation of the world, drawing on a solid base of knowledge of concepts and models. Whilst LeGaut’s (2006) book “Think: Why Crucial Decisions Can’t Be Made in the Blink of an Eye” appeared originally to be a response to Gladwell, in fact, it analysed the decline in reasoning and logic that LeGaut (2006) perceived to affect many societies particularly American life.

These two authors appeared to conduct their quest at different levels: social and individual. Both theories can potentially be applied in social sciences under different circumstances and scenarios. In an attempt to define the concept of intuition, Behling and Eckel (1991) revealed in their research findings six different conceptualisations of the term intuition, but only one definition being “choices made without obvious formal analysis.” The six ways of conceptualising intuition included (Behling and Eckel, 1991: 47):

- Intuition as a Paranormal Power or Sixth Sense
- Intuition as a Personality Trait
- Intuition as an Unconscious Process
- Intuition as a Set of Actions
- Intuition as Distilled Experience
- Intuition as a Residual Category

Despite Brouthers’ et.al (1998) effort in using the Positivist approach to provide administrators with an analytical managerial solution, the role of intuition could not be
eradicated. One of Brouthers’ et. al. (1998: 136) recommendations to administrators ended up being to “rely less on intuition” in decision making rather than completely omitting it from the package. This claim was also supported by Lamond and Thompson (2000) who were calling practitioners for a shift in the cognitive continuum from relying on intuition towards using analytical thinking based on the situation. Researchers could not deny the role that intuition plays in decision making and the inevitable human cognition that uses intuition depending on the speed in the decision, the information required and the quality of choices (Behling and Eckel, 1991). Frishammar (2003) found that although decision makers rely originally on soft ideological information which they translate into hard numerical information, at the time of making the decision human intuition comes into play. The choice of the decision making approach is also related to emotional involvement which make individuals more likely to base their decisions on intuition (Spicer and Sadler-Smith, 2005). Even when Robins, et al (2004) worked on replacing intuition with a systematic process, the outcome ended up a method to strengthen intuitive decision making through gaining more awareness to accurately analyse and explain predictions. This controversy in the definition and the explanation of intuition has witnessed an increasing interest in the field of psychology with reference to this phenomenon as “the adaptive unconscious” (Gladwell, 2005: 11)

In his attempt to combine the analytical and emergent views, Swayne, et. al (2006: 17) stated that “strategic managers will have to think, analyse, use intuition, and reinvent as they go.” According to Wood, et.al (2004: 553), by using intuition, this element of spontaneity helps in achieving “creativity and innovation”. However, the concern in using intuition remains in the invisibility and inability to have insight into how the
individual reached the decision (Lamond and Thompson, 2000). After considering the different theoretical approaches to decision making, the next section will shed light onto the practical models that were identified in the literature.

3.5 From Theory to Practice

An attempt has been noted in the literature to synthesise the work of major theorists into concepts, models or recipes for managerial decision making that could be applied by practising managers (Tarter and Hoy, 1998; Cutting and Kouzmin, 2002; Nwogugu, 2005b). In his book on “Organizational Analysis”, Perrow (1970) identified “concepts” as the common language between practising managers, theory builders and academics. These conceptual tools aimed to assist in managerial decision making. Tarter and Hoy (1998) illustrated six contemporary models of decision making in a simplified way before introducing his Contingency theory that acted as a tentative guide to administrators in generating situation specific decisions. Tarter and Hoy’s (1998) decision models ranged from being anchored in a theoretical perspective to being based on chance and politics.

On the other hand, Kilman (1991: 35) was more interested in capturing the factors that matter most in organisational success to provide executive administrators with a managerial recipe which ingredients included the following: “adjustment in culture, skills, groups, strategies, structures, and reward system, all undertaken with an enlightened view of the world and its various stakeholders.” Kilman (1991: 5) introduced
six fundamental principles for managing beyond the quick fix in order to improve
organisations. The six principles encompass:

   Principle 1: World as a Complex Hologram Versus World as a Simple
      Machine
   Principle 2: Complex Versus Simple Problems
   Principle 3: Multiple Versus Single Approaches
   Principle 4: Participative Versus Top-Down Management
   Principle 5: What Managers Can Do With Consultants Versus Without
      Consultants
   Principle 6: Commitment to Organizational Success Versus More Quick Fixes

These principles had frequent references to rules, procedures, systems, objectives and
processes which reflected Kilman’s systematic Functionalist approach. Kilman (1991)
provided the reader with the “blue prints” for building his argument along with
quotations from other publications to further support this argument. In addition, Kilman
(1991) often referred to analogy from natural science to explain and clarify his argument,
which reflects the influence of the Positivist paradigm on the Functionalist literature.
This notion of referring to natural science was also eminent in Simon’s (1997) work on
administrative behaviour in organisations. The fundamental principles that Kilman
(1991: 5) suggested for healing the “living, breathing organization” were equivalent to
the healthcare plan for managing the biological health of human beings which
encompasses:

   1. Ability to see differently in order to recognize the symptoms (problems)
      while performing the assessment;
   2. Finding the reasons behind the diagnosis of the problem or the disease;
   3. Identification of the pathophysiology of the illness(why);
   4. Planning the treatment regime;
   5. Choosing the right healing team; and,
6. Specifying the conditions under which the treatment should be followed to achieve the desired outcomes.

Nwogugu (2005a) agreed with Kilman (1991) on the complexity of managing organisations and emphasised the need for less rigid models for decision making. The six common decision making models identified in the literature have been defined by Tarter and Hoy (1998: 221) as being: the “Classical, Administrative, Mixed Scanning, Incremental, Garbage Can and Political” models (Table 3). Tarter and Hoy (1998) analysed these models in their journey to introduce a contingency theory of decision making. The interplay of the three approaches mentioned earlier in decision making: economic, cognitive and administrative behaviour, were the common denominator of these decision making models. The paradigm shift from the classical model to the political model provides instant change from objective to subjective decision making.

**Table 3** Comparison of decision making models

<table>
<thead>
<tr>
<th>Setting goals</th>
<th>Classical</th>
<th>Administrative</th>
<th>Mixed scanning</th>
<th>Incremental</th>
<th>Garbage can</th>
<th>Political</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives are set prior to alternatives</td>
<td>Objectives usually are set prior to alternatives</td>
<td>Policy guidelines are set prior to alternatives</td>
<td>Objectives and alternatives are intertwined</td>
<td>Objectives emerge spontaneously</td>
<td>Objectives emerge spontaneously but are personal</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Means-end analysis</th>
<th>Classical</th>
<th>Administrative</th>
<th>Mixed scanning</th>
<th>Incremental</th>
<th>Garbage can</th>
<th>Political</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always begins with a means-ends</td>
<td>Frequently begins with a means-ends analysis, but occasionally ends change</td>
<td>Broad ends and tentative means focus the analysis</td>
<td>No means-ends analysis. Means and ends are not separable</td>
<td>Means and ends are independent; chance connects them</td>
<td>Personal ends determine organizational means</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Test of a good decision</th>
<th>Classical</th>
<th>Administrative</th>
<th>Mixed scanning</th>
<th>Incremental</th>
<th>Garbage can</th>
<th>Political</th>
</tr>
</thead>
<tbody>
<tr>
<td>The best means to an organizational end</td>
<td>A satisfactory organizational outcome</td>
<td>A satisfactory organizational outcome</td>
<td>Decision makers agree that the decisions are in the right direction</td>
<td>Participants agree that the solution and problem match</td>
<td>Personal objectives are accomplished</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Guiding principles</th>
<th>Classical</th>
<th>Administrative</th>
<th>Mixed scanning</th>
<th>Incremental</th>
<th>Garbage can</th>
<th>Political</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theory</td>
<td>Theory and experience</td>
<td>Theory, experience, and comparison</td>
<td>Experience and comparison</td>
<td>Chance</td>
<td>Power</td>
<td></td>
</tr>
</tbody>
</table>

Source: Tarter and Hoy (1998: 221)
The other stream of practical models encountered in the literature for guiding decision making in organisations stressed the importance of alignment of decision making at unit level with organisational mission or corporate strategy (Kaplan and Norton, 2001). Kaplan and Norton (2001) derived their concepts and models from practical and real life cases at macro and micro levels basing it on strategies adapted by successful organisations rather than theoretical scholarly work. With the introduction of the balanced scorecards, Kaplan and Norton (2001) achieved the first milestone in introducing a practical tool to convert non tangible outcomes into tangible one. They attempted to align the overall mission and strategy of the organisation all the way down to daily management at grass roots level. However, Kaplan’s and Norton’s (2001) revolutionary practical management tool fell short in the ability to measure and control the real motives at individual level. Collins and Porras (1998: 214) interpreted alignment to be more than achieving target numbers, for them alignment means “being guided first and foremost by one’s own internal compass, not the standards, practices, conventions, forces, trends, fashions, and buzz-words of the outer world.”

Strategic decisions are generally linked to the long-term objectives of the firm’s grand strategy in comparison with short-term objectives and operational strategy (Pearce, 1981; Richardson, 1994). Nevertheless, warnings remain in the literature advising executives to avoid adopting fad management tools that do not fit with the organisations’ overall objectives (Shapiro, 1995).
In conclusion, these practical management models tend to move the decision making concept from a helicopter view approach to a microscopic approach necessitating closer examination of the factors that help constructing the reality in which executives’ decisions occur. In the next section, factors influencing or contributing to executives’ decision making will be explored as identified in the literature reviewed.

3.6 Factors Influencing Decision Making

The majority of the factors identified in the reviewed literature can be grouped under three major headings: environmental, organisational and individual. Table 4 depicts the influential factors acquainted chronologically in the literature. The individual aspects of the decision maker were the most eminent factor over several decades. A summary of the key factors under each category will be presented.

**Table 4** Major factors influencing decision making

<table>
<thead>
<tr>
<th>AUTHOR</th>
<th>ENVIRONMENTAL</th>
<th>ORGANISATIONAL</th>
<th>INDIVIDUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wood &amp; Bandura (1989)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mintzberg (1990)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Donaldson (1996)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simon (1997)</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Harrison and Pelletier (1998)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dargie (2000)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Gibson, et. al (2000)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nowicki (2001)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Grant (2003)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Kirby (2005)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Nwogugu (2005)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Spicer and Sadler-Smith (2005)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Buchanan and O’Connell (2006)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Porter (2008)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
3.6.1 Individual Factors

It was clear upon examination of the tabulated summarised literature that the decision maker’s individual characteristics were the dominant factors influencing decision making particularly in the last five years. Gibson, et al (2000: 93) emphasised in his book on behaviour, structure and processes in organisations that “individuals are similar, but they are also unique.” Personal ambitions and values of decision makers were cited by Suutari (1999) as influencing the decision making at individual level. According to Gibson, et.al (2000: 92) the individual characteristics that shape of the individual’s behaviour and cognitive ability included: “ability and skills, family background, personality, perception, attitudes, attributions, learning capacity, age, race, sex and experience.” Executives’ cognitive diversity was also added to the mix by Miller et al. (1998) and Pearce (1981). A close examination of the “triangle of limits” that Simon (1997: 84) claimed to bound rationality also revealed that individual characteristics have significant weight in the decision outcomes. These individual characteristics or limitations comprised (Simon, 1997: 46):

- The decision maker’s unconscious “skills, habits and reflexes”
- The decision maker’s values and conception of purpose
- The decision maker’s knowledge of the job particularly with the escalation of specialisation in most industries.

Another key element to be considered at individual level is the decision maker’s leadership. With their interpersonal motivation skills and their leadership style, executives have been considered as the key players in effective decision making and the
strategic management process (Beaver, 2002; Suutari, 1999). Zaleznik (1992) added the significance of interpersonal communication skills in the role of a leader. Real case studies and decisions made by industry leaders have often been used in the literature as examples to support the effectiveness of a particular school of strategic management. Beaver (2002) claimed that high achieving companies have chief executive officers that lead organisations with their talent and commitment taking into consideration the demands of the stakeholders.

Dargie (2000) shadowed the role of eight chief executive officers from public, private and voluntary sectors, aiming at analysing the cross-sectional differences in this role. In addition to the organisational and environmental influences, the individual role played a significant part in the chief executives’ positions. Data collection was conducted by examining chief executive officers’ diaries, observation and direct interviews. Triangulating the data collected gave Dargie (2000) a better insight into executives’ behavioural roles exhibited across the three different sectors including private, public and voluntary sectors. These roles, which were adopted from Mintzberg’s (1973: 92) interpretation of the characteristics of managerial work, appeared in Dargie’s (2000: 41) study to be dictated by the structure of each sector and encompassed: the role of “negotiator”, “liaison” and “disturbance handler” in the public sector; “monitor”, “disseminator” and “spokesman” in the private sector; and, “leader”, “liaison”, “spokesman” and “disseminator” in the voluntary sector. However, due to the small sample size of the study (8 participants), Dargie’s (2000) findings could not be generalised beyond the sample of this study.
According to Beaver (2002) effective business leadership is achieved by not only getting the big decisions rights, but also incorporates the development and the communication of the organisational vision, shared values, empowerment and inspiration. Visionary leadership by chief executive officers was also claimed by Suutari (1999) to be the key for effective strategic decision making. In his critique of the two schools of strategic management, (Suutari, 1999: 12) added that the ability of the chief executive officers to balance the “planned” and the “organizational” based strategic models is fundamental to establish an effective strategy.

When Beaver (2002) was focusing on the chief executive officer as the “showman, statesman and strategist”, other researchers such as Miller, et al (1998), Eisenhardt (1999) and Hough and White (2003) also considered other executive members’ involvement in the decision making process as the corner stone for effective strategy. Based on the formal authority and status of the executive, Mintzberg (1990) dissected the managerial job into three role categories with every category being the input to the one after. The three categories encompassed: interpersonal, informational and decisional roles. The subcategories classified under the decisional roles (entrepreneur, disturbance handler, resource allocator and negotiator) had their premise in the school of leadership. In this article, Mintzberg (1990) did not hesitate to share with the reader the findings of his study, but was reluctant to provide a summary of the research methodology that he adopted. The reader would be hesitant to accept the validity and reliability of the research results without referring first to the original study.
In addition to the decision maker’s individual characteristics and leadership style\(^1\), the significance of past performances on executives’ decision making has attracted considerable attention in the literature. The debate that remained between scholars revolved around whether past failures or past successes drove choice making and future organisational behaviour (Ashmos, et.al., 1998; Eisenhardt, 1999; Suutari, 1999; Desai, 2000). The executives’ perceptions and interpretations of the issue in hand was also considered critical in the decision making (Eisenhardt, 1999; Ashmos, et.al, 1998). Executives’ perceptions of risk, for example, was emphasised by Pearce (1981) who stated that the strategic managers’ attitude towards risk is amongst the criteria for considering strategic choice alternatives. This is supported by Parnell (2003) who emphasised the need for executives to be skilled in identifying risk in an attempt to avoid it or to minimise it.

In studying organisational behaviour, individual characteristics will need to be studied within an organisation, a system (Gibson, et. al, 2000). Hence, Simons’ (1997: 46) definition of rationality is concerned “with the selection of preferred behaviour alternatives in terms of some system of values whereby the consequences of behaviour can be evaluated.” The organisational goal needs to be examined when seeking to analyse organisational behaviour. Rationality of the decision, for example, could be

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\(^1\) The study of different managerial leadership styles is beyond the scope of this research inquiry. The researcher’s interest is in revealing the factors that influenced executive decisions as perceived by experts in the industry. The research findings to be generated from this study will determine whether the leadership style was perceived by participants to be an influential factor in their business decisions in private hospitals.
judged when comparing personal goals versus organisational objectives (Tarter and Hoy, 1998; Gibson, 2000).

Scholars were challenged to study the cognitive process in isolation. In an attempt to control the environment, Wood and Bandura (1997) used simulation to study the cognitive process of the decision making which was based on two variables: prior performance and perceived self-efficacy. In fact, the outcome of this research inquiry ended up as an analysis of the causal relationship between cognitive and other personal factors, behaviour and the external environment under the auspices of social cognitive theory.

3.6.2 Environmental Factors

The influence of the environment on decision making has been consistent in the literature (Hough and White 2003; Richardson, 1994; Pearce, 1981). Authors often used the term ‘environment’ when referring to the external environment such as Simons and Thompson (1998) who focused on national culture, national economics and industry conditions as environmental factors. Donaldson’s work (1996) is another example which considered environmental situational factors such as technology and strategy to impact on the organisations from outside. As a result, these organisations tend to restructure from the inside to fit in the new external environment. In spite of Donaldson’s (1996) work being strongly anchored in the Functionalist organisational theory, he relied heavily on social facts to build his argument. There was no evidence of empirical data in his writing to support or reinforce his recommended theoretical framework. It was disappointing not to
come across any reference to human behaviour in Donaldson’s (1996) article especially when organisations are ‘made of people’.

Richardson (1994) has emphasised that the major influence of the environment is on the type of the decision making process followed and the leadership style adopted. Using simulators to mirror scientific research and to control the environment was commonly used in the literature (Wood and Bandura, 1989; Hough and White, 2003). Hough’s and White’s (2003) research inquiry was to examine strategic decision making rationality and environmental dynamism. The strength of Hough’s and White’s (2003) study was in the use of the behavioural simulator which offered the ability to control the environmental context, to access a large sample size, to examine the change in the process with the change in the decision and to shed light on the causal relationship between process and outcomes (Hough and White, 2003). The results revealed that the decision process varies according to the environmental context. In a stable environment, for example, executives were able to identify critical variables which are essential in decision making and strategic position compared to high velocity market where time is critical and decisions made have the potential of not being fully rational (Hough and White, 2003). This argument is debatable because decisions made in similar environmental context cannot be guaranteed to be the same due to the interplay of other factors such as the managers’ leadership styles and cognitions which could not be controlled in Hough’s and White’s study (2003). Eisenhardt (1999) argued the possibility of reaching rational decision in high velocity market by demonstrating in her research that organisations that maintain time pace, prototype and consensus to keep the momentum of the decision making in these circumstances are high performers. In addition to the high pace environment,
Miller, et al (1998) acknowledged the importance of firm size in influencing strategic decision making and made an effort in his paper to control both variables in the sample selection and the data collection phases of the research.

Competitiveness as an aspect of the external environment was also considered a key element in influencing decision making (Pearce, 1981; Eisenhardt, 1999). Porter (1985) studied the link between competitive advantage and technology by integrating the latter in the framework of the firm’s value chain. The outcome of Porter’s (1985) analysis showed the ability of technology to play a role in shaping the structure of the industry by achieving lower cost and/or differentiation of its value activities.

Based on the strategic planning model the reasoning to reach decisions is purely guided by economic logic and the need to seek competitive advantage by positioning the firm and setting up organisational goals (Suutari, 1999). However, the organisational model adopts a collective process based on negotiations with the organisation’s management team and influenced by its culture (Suutari, 1999). Pearce (1981: 41) considered competitiveness as part of the “task environment” which incorporates all the forces and circumstances that influence strategy compared to the “remote environment” where the forces and conditions are provided by the overall political, social, economic and technological framework in which organisations operate. In addition, Swayne, et al (2005) considered regulation as another environmental force. Pearce (1981: 41) defined the external environment as consisting of “the sum total of all conditions and forces which affect the strategic options of a business but which are typically beyond its ability to control.”
Stakeholders were also considered part of the environmental forces by Harrison and Pelletier (1998) who defined these groups as entities processing tangible claims on firms. Although the definition of stakeholder groups is broad, the common thread in the scholarly and business publications tend to concentrate around client’s demand. The risks of not meeting the client’s demand or mismatching the services with the market needs were highlighted by Simons and Thompson (1998). Gibson, et. al (2000: 8) viewed the external environmental forces as a must for organisations “to respond to the needs of its customers or clients, to legal and political constraints, and to economic and technological changes.”

Having explored the external forces of the environment the next step will be to shed light on the internal factors often referred to as organisational factors (Dargie, 2000).

3.6.3 Organisational Factors

The mix of organisational or internal factors influencing decision making varied in the literature based on the research inquiry. However, the frequently stated internal drivers were structure, power and politics, culture and goal setting. Suutari (1999) summarised the organisational model by claiming that it adopted a collective process based on negotiations with the organisation’s management and influenced by its culture.

The way the structure and hierarchy were set in the organisation could constrain employees leading to a less empowered culture (Henderson and McAdam, 2001).
Different units or departments within the organisation exert their politics and power to modify the outcome of the decision making process (Brouthers, et.al. 1998; Henderson and McAdam, 2001). These conflicting pressures within the organisation influenced the executive administrator’s role and activities even in decentralised organisations (Dargie, 2000). Managing in such an internal environment challenges management ability to stay focused on the organisational goal. According to Mcshane and Von Glinow (2005: 241), by goal setting the organisation would identify ‘what ought to be’ and, therefore provided a standard against which different alternatives could be evaluated.” Perrow (1970: 180) argued that organisational goals are “multiple, conflicting, pursued in sequence, open to group bargaining, and, in general, problematic, rather than obvious and given.”

The three key aspects of goal setting as highlighted in the literature were: (1) the timeframe of achieving the goal meaning short-term versus long-term (Wood and Bandura, 1989; Simon, 1997); (2) specific divisions’ goals versus general goals (Simon, 1997); and, (3) personal goals versus organisational objectives (Tarter and Hoy, 1998). The essence of organisational role lies in the nature of the goal and the strategies required for achieving it (Perrow, 1970). Hence, effective management is important (Harrison and Pelletier, 1998) in setting the goal and executing it. According to Simon (1997: 19)

Every executive makes decisions and takes actions with one eye on the matter at hand and one eye on the effect of this decision upon the future pattern – that is to say, upon its organizational consequences

The question whether this claim is applied in reality depends on the individual’s characteristics, leadership and effectiveness in decision making which takes the argument
back to the individual factors discussed earlier and the need to study the individual characteristics within an organisation, a system (Gibson, et. al, 2000).

According to Ashmos, et. al. (1998), when strategic decisions are involved the importance of executives adopting the rules of the organisation as tools for choice selection was debatable. The danger was in mixing day-to-day decision making with strategic choices, which has the tendency for executives to visualise strategic opportunities as threats (Ashmos, et.al, 1998). However, Ashmos, et.al’s (1998) results of the study cannot be generalised as it was limited to one industry (healthcare) and based on overall organisational response rather than executives’ individual response. Only organisations with common decision responses and common informants were included in Ashmos et. al’s (1998) study sample. On the other hand, Frishammar (2003) conducted his research on the use of information in strategic decision making by applying case studies in four different industries. However, Frishammar’s (2003) empirical finding was mainly interested in the internal environment as a primary source of information for the decision maker through customers and personnel.

Organisational goals have often been identified in a form of mission statement, in mission driven organisations which are often referred to in the literature as “leadership with purpose” (George, 1999). Although the “strategic value” of the mission statement had been widely discussed in the literature (Bart and Hupfer, 2004: 92), the studies that examined the role of the mission statement in the organisational decision-making process were rare. The aim of the next section is to assess the value of mission statement in
mission driven organisations and to explore decision making in light of organisational mission and strategy.

3.7 Mission

The three common aspects of mission statements that were explored in the literature have mainly been: the existence of the mission, the components of its content, its value and the relationship between mission statement and the organisation’s performance (Analoui and Karami, 2002). Whilst having a mission statement based on set core values was seen by Collins and Porras (1998) as becoming fashionable when running a business, they did not consider it as the “essence” of visionary companies. According to (Glasrud, 2001) and George (1999) the key aspect of mission driven organisations is not in the mission statement itself, but in the strategic and day-to-day objectives that are crafted around this mission statement.

3.7.1 What is a Mission Statement?

The mission has been defined by Rigsby and Greco (2003: 30) as a statement that reflects “who the organisation is, what they do, to whom they offer products and services and how they will be offering those products and services in terms of basic philosophy and technology.” Mission statement as a concept has been a subject to a large number of criticisms and analysis in the literature, ranging from dissecting its content and its different components (Bart and Hupfer, 2004) to exploring its relationship with the
organisation’s performance (Analoui and Karami, 2002). However, the common thread identified in the literature has been the importance of having a mission statement and urging organisations to develop one if they currently do not have one (Richman and Wright, 1994).

The mission statement has increasingly been referred to as the most common management tool used by senior executives (Analoui and Karami, 2002; Bart and Hupfer, 2004) and the most crucial factor in the strategic planning of an organisation (Analoui and Karami, 2002). According to Glasrud (2001), having a mission statement could be for not-for-profit organisations the most useful tool especially if it was well written and focused. It will be advantageous to shed light onto the stance encountered in the literature in regards to the content of the mission statement and its various components.

3.7.2 Mission Content

When writing about mission statement, both academics and practitioners tend to conclude their writings with a recommended recipe for the formulation of a meaningful mission statement (Wickham, 1997, Rigsby and Greco, 2003). These recommendations are often general without specific components relevant to a particular industrial context (Bart, 1999). Examples of common general mission components identified in the literature were summarised concisely by Sufi and Lyons (2003: 258) including:

Concern for the customer, purpose, identity/image, differentiation factors, corporate values, products, markets, and concern for the survival, growth, profitability, company philosophy and employee and social concern.
Bard and Hupfer (2004) have highlighted the gap in the literature as being a result of generalisation in the components and the achievement of the mission statement. Thus, Bard and Hupfer (2004: 99) contributed to knowledge by narrowing down the mission to the hospital context which “product/market focus should be specified in a unique manner that distinguishes it from competitors and builds a desirable public image.” The inability to use the mission statement in hospitals’ management was evident in the response expressed by senior hospital executives when asked about their needs in relation to mission statement formulation. Bard and Hupfer (2004: 95), quoting hospital executives, mentioned that “the wide range of statement content possibilities was too diverse to be of practical use.” What hospital executives really needed to know was what to incorporate in the mission statement and what will happen with every mission component included (Bard and Hupfer, 2004).

Exploring the values of the mission statement could give more insight into what makes the organisation’s mission an essential management tool and an important element of strategic planning.

3.7.3 The Value of Having a Mission

The need for organisations to have a mission statement has been heavily encouraged in the business world by academics as well as practitioners (George, 1999; Analoui and Karami, 2002; Rigsby and Greco, 2003). Collins and Porras (1998: 8) advocated the role of mission in providing context for building a visionary company that operated as follows:
Visionary companies pursue a cluster of objectives, of which making money is only one- and not necessarily the primary one. Yes, they seek profit, but they’re equally guided by a core ideology - core values and sense of purpose beyond just making money.

Using a large sample of 500 fortune companies, Collins and Porras (1998) identified the habits of 18 visionary companies which generated a conceptual framework for practical application based on three key aspects in managing organisations encompassing: clock-building, preserving the core and stimulating progress. The strength in Collins and Porras’s (1998) approach was in building their framework based on the analysis of a large sample of visionary companies. The list of companies selected to participate in their study derived from interviews with chief executive officers who had experience, insight and knowledge of what it takes to run businesses that ‘last’. Taken on face value, the research methodology adopted stands up to scholarly scrutiny.

Mullane (2002) has also confirmed the significance of employing the mission properly in the organisation’s strategy and daily management by illustrating it in two case examples encountered in his personal research experience. The two cases in this paper described two different paths that two organisations have followed when using their mission as a “strategic tool” (Mullane, 2002: 449). Drawing on the experiences of two firms, Mullane (2002: 453) illustrated the model employed in both scenarios to “make their missions and visions useful tools for enhancing performance.” According to Mullane (2002: 453), the key steps in the process were the commitment of top management, identification of key concepts and specific targets from the mission, and communication and involvement of different management levels in all functional areas.
The fundamental step in strategic planning is claimed to be the formulation of a mission statement (Wickham, 1997). Developing and planning business strategies have ranked first amongst the top four purposes for having a mission statement in Analoui’s and Karami’s (2002: 16) study findings. This result confirms the common claims in the literature considering the mission statement as being a cornerstone in an organisation’s strategic planning and management (Glasrud, 2001; Analoui and Karami, 2002).

The importance of the mission statement in strategy formulation did not seem to change with the size of the organisation. The findings in Analoui’s and Karami’s study (2002) in small and medium sized enterprises were comparable with a similar study conducted in 1996 including larger firms. Analoui and Karami (2002) have limited their sample to small and medium size electronic manufacturing enterprises and chose to compare their results with the available data generated from a previous study conducted on large organisations of an unknown industry. The value of this comparison is questionable in light of the numerous independent variables such as the industrial context, the time of the study, environment, and the tool used for data collection.

The other reasons identified in the literature showing the value of owning or developing a mission statement are listed chronologically in Table 5.
Table 5  Summary of mission values

<table>
<thead>
<tr>
<th>Mission Values</th>
<th>Author</th>
<th>Year &amp; Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Provides a unifying theme for internal stakeholders and acts as an aide-memoire</td>
<td>Wickham</td>
<td>1997, p. 381</td>
</tr>
<tr>
<td>Locates the business in the minds of external stakeholders”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encourages centralization of decision making</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Illuminates Guides Motivates”</td>
<td>Glasrud</td>
<td>2001, p. 35</td>
</tr>
<tr>
<td>Assists in developing and planning business strategies; Increases the firm’s</td>
<td>Analoui &amp;</td>
<td>2002</td>
</tr>
<tr>
<td>financial performance such as profit and growth rate; Promotes a sense of shared</td>
<td>Karami</td>
<td></td>
</tr>
<tr>
<td>expectations between the entrepreneur and all employees; and Provides clarity of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>direction for the employees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serves as a communication tool within and outside the organization</td>
<td>Sufi and Lyons</td>
<td>2003</td>
</tr>
</tbody>
</table>

The other stream of publications in the literature debated the strategic value of the mission and its impact on the organisation’s performance (Bart and Hupfer, 2004; Glasrud, 2001). Bart and Hupfer (2004) attributed the diversity of opinions in regard to the mission statement’s strategic value to the difference in its definition and its various components. Others such as Glasrud (2001) contradicted this claim by stating that the success of mission driven organisations was not in the mission statement’s content but in the way organisations articulated their mission into their strategic and daily operational management. Glasrud’s (2001) publication was a list of “do” and “don’t do” items representing a warning for executives in general, and the not-for-profit sector in particular against the ‘mission of the mission statement’. The use of case examples where companies misused their mission statement would have given Glasrud’s (2001) article more strength rather than basing it on Glasrud’s own perception.
With the evaluation of the value of the mission and its content varying between different scholars and practitioners, the convergent views about the possibility of misusing the organisational mission has been strongly reinforced in the literature, with often recipes prescribed to avoid this problem from occurring.

### 3.7.4 Avoiding Mission Misuse

With mission often being referred to as a “tool” in the literature (Mullane, 2002; Sufi and Lyons, 2003), its misuse, like any other tool, tends to cause detrimental effects. Two common warnings have been noted throughout the literature: the danger of confusing mission and strategy (Mintzberg, 1997; Collins and Porras, 1998) and the use of the mission statement in marketing material (Glasrud, 2001). Nevertheless, these warnings in the literature did not stop scholars from recommending the use of the mission statement as a baseline and a starting point which will lead the organisation toward the set of corporate goals (Mintzberg, 1997; Glasrud, 2001).

In relation to mission formulation, the lesson to be learned from the literature was overwhelming. The importance of getting the content and detailed components of the mission statement right was emphasised by practitioners and academics (Wickham, 1997; Glasrud, 2001; Analoui and Karami, 2002; Mullane, 2002; Sufi and Lyons, 2003). The main pitfall that should be avoided in the mission’s content was financial terminology such as the word “profit” (Rigsby and Greco, 2003: 30). The majority of Rigsby and Greco’s paper (2003) was structured around questions and answers scenarios that gave
practitioners practical guidelines for crafting a mission statement. When considering crafting a mission, the question to ask is who develops the mission statement and how is it perceived at different levels of the organisation?

### 3.7.5 Perception of the Mission Statement

When referring to the formulation of a mission statement, the literature tends to present it as a product designed by the organisations’ board members and senior executives (Richman and Wright, 1994; Bard and Hupfer, 2004). Looking at the mission from the lower echelon’s perspective, mission statements can be considered as a means for the high management level to control those staff by having the resource parameters for empowerment and achievement entrenched at the executive level (Richman and Wright, 1994). This claim was supported by Mullane (2002) who admitted that both organisations in his case studies used the top-down approach to identify the key concepts of their mission. This process tends to mirror the strategic model adopted by the Design school of thought, in order to ensure that key concepts seen by executives are given priority (Mullane, 2002).

In an attempt to find out the lower echelon’s staff perception of the mission, Richman and Wright (1994) researched nurses’ attitudes and knowledge of their hospitals’ missions. The findings of this study confirmed the dichotomy between upper and lower echelons’ staff perceptions of missions. Only fifteen per cent of line staff nurses in this study acknowledged the significance of the mission in their practice (Richman and Wright, 1994). Improvement in quality was considered as the main influence of mission
statements on lower echelon’s daily work practices (Richman and Wright, 1994). It is fundamental to explore other ways to measure the achievements of overall organisations’ missions particularly when different perceptions of the mission’s role exist at different levels of the organisation.

3.7.6 Mission and Performance Measures

Several attempts have been noted in the literature to measure the relationship of organisations’ mission statements and their components with the organisations’ performance. The methodology often consisted of developing constructs from the missions’ contents and examining their relationship (if any) with performance indicators such as “behavioural [measures], financial performance, and mission achievement variables” (Bard and Hupfer, 2004: 97). Researchers have largely adopted the Interpretivist approach by measuring organisations’ performance using executives’ perceptions and subjective interpretations of the organisations’ performance indicators without referring to objective numbers (Bart, 1999; Bard and Hupfer, 2004; Analoui and Karami, 2002). Studies adopting the Positivist approach such as Sufi and Lyons (2003) relied on indicators including annual turnover, net profit margin and return on equity to measure the organisation’s performance. Although Sufi and Lyons (2003: 255) study results indicated “a statistically significant correlation between the mission statements and the annual turnover, there was no significant correlation with the net profit margin or the return on equity.”
This section highlighted the significance of having a well-crafted mission statement that could act as a valuable strategic tool, starting from strategy formulation to measuring organisational performance. The following part will shed light on the concepts of strategy and strategic decision making as identified in the literature reviewed. The value of having an organisational goal or mission is fundamentally related to the type of strategic management adopted in the organisation. A synopsis of the controversial concept of strategy amongst scholars and practitioners will be depicted in the next part.

### 3.8 Strategic Decision Making

This section will cover management decision making in light of the concept of strategy and its position amongst upper echelons within the organisation.

#### 3.8.1 Decision Making and Strategy

In the management literature reviewed, decision making and strategy appeared to be areas of interest for many scholars and practitioners (Pearce, 1981; Richardson, 1994; Mintzberg, 1994; Harrison and Pelletier, 1998), with increasing claims stating that “effective decision makers create strategy” (Eisenhardt, 1999). In fact, the interrelationship between the concepts of “decision making” and “strategy” is so compelling that Eisenhardt (1999: 65) titled her paper “Strategy as Strategic Decision Making.” Other researchers such as Suutari (1999), Ashmos, et. al. (1998) and Pearce (1981) also described or examined the “how” and “what” questions of strategic decisions when writing about strategy. Simon (1993: 131) defined strategy as “decision making
that deals with the Big Questions.” Similarly, strategic management is referred to as the approach to determine and to direct the efforts of the organisation for the long term in comparison with short term objectives and operational strategy (Pearce, 1981; Richardson, 1994).

In the last two decades, management literature witnessed strong debates between two differing strategic schools of thoughts: the Planning school (also known as the ‘Design’ or ‘Wholistic’ school) on one hand and the ‘Organizational’ school (often referred to as the “Emerging” or “Tactile” school) on the other (Pearce, 1981; Richardson, 1994; Suutari, 1999). Different names were used in the literature when referring to these two dominant approaches of strategic management, but the concept underpinning each school remained the same: “those with strategies that are planned, and those that arise from within an organization’s experience, beliefs and culture” (Suutari, 1999: 12).

Similarly, the decisional process is multi-faceted depending on the schools of strategy (Richardson, 1994). “Processes of decisional activities” was the first element used by Richardson (1994) in his framework for examining strategic configuration. Based on the Planning model for example, decision making follows a linear sequential pattern with executives involved in seeking information, analysing, evaluating, and making choices before proceeding to implementation (Richardson, 1994). In contrast to this model where strategic decisions are pre-planned, the Organisational model would seek the participation of firms’ personnel using their previous experiences and past performances (Ashmos, et.al. 1998).
These contradicting views demonstrate the ongoing debates between academics and practitioners about which strategy and decisional processes are more effective. Desai (2000) examined the value of strategic planning by measuring, using the increase or decline in stock prices as indicators, the impact of dispensing the company’s strategic planning. Based on his findings, Desai (2000) advocated the effectiveness of the planning model that increases the firm’s value short-term and ensure its viability long term. Richardson (1994:31) referred to this approach as the rationale corporate planning model that emphasises:

A linear sequential sequence of decision making which involves top management in seeking out and utilizing all relevant information before generating, evaluating and choosing the way(s) forward for the organisation.

Desai (2000) added that the planning approach increased the market confidence in the firm’s competitive strength even if the firm’s strategic planning was symbolic and not comprehensive. On the other hand, this approach to strategy was perceived by Porter (1984) to have the tendency to create a gap between strategy formulation and implementation. Mintzberg (1994) has also echoed the potential formation of a divide when moving from the planning to the performance stages. Porter (1985:33) tried to address this gap by introducing the concept of competitive advantage through the firm’s value chain, which involved an analysis of the sources of competitive advantages by adopting a “systematic way of examining all the activities a firm performs and how they interact.” The criticism of this book would be in Porter (1985) recommending generic strategies to be adopted in most industries without the reference to specific factors that differentiate each industry. Strategic positioning was the common platform that Porter
(1996: 14) considered to be applicable to any company that is able to perform different activities or to adopt different ways.

After this synopsis of decision making and strategy, the next question would be to explore the viewpoints in the literature about the echelons responsible for strategic decision making in organisations.

3.8.2 Strategic Decision Making: Its Position Amongst Upper Echelons

While the majority of research studies examined decision making in organisations at executive level (Pearce, 1981, Richardson, 1994: Suuatri, 1999), participation of lower echelons within the organisation remained debatable amongst scholars and practitioners, and often related to the strategic school of thoughts that they adopted. The two strategic schools of thoughts had significant impact on the need for middle and low level managers’ and stakeholders’ participation in decision making. Based on their philosophical basis, two streams have emerged in the literature in relation to this subject.

The first group emphasised the need for early staff members’ and stakeholders’ involvement in strategy formulation which would facilitate the implementation process (Eisenhardt, 1999; Ashmos, et.al, 1998; Lorange, 1998; Martin, 1998; Koch, 2001). For example, Eisenhardt (1999) claimed that decision making needs to happen at different levels of the organisation: unit level, multi-business level and corporate level. This claim was supported by Martin (1998) who believed that the strategy of an organisation is generated from the interaction of the three management levels: the functional level, the
divisional level and the top level. In organisations with highly autonomous divisions, Drago (1998) stressed the need for formal vertical communication between these different divisions when gathering internal and external data that is crucial to the decision making process. This analysis indirectly reflected the philosophical basis adopted by these authors in their bottom-up approach to strategy.

The second group who followed the top-to-bottom decision making process limited middle and lower management's and stakeholders’ involvement to implementation only with no input into decision making. This school of thoughts claims that involving personnel other than executives would make strategy more focused into daily operational issues and would result in the loss of the grand strategic objectives (Pearce, 1981). Researchers who believed in the planning school of strategy would argue that strategy formulation was best carried out following the top to bottom approach, thus limiting the decision making process to the senior echelon executive (Pearce, 1981; Richardson, 1994; Suutari, 1999). In fact, an in-depth review of the literature would reveal that the majority of research examining the decision making process or strategic planning were conducted at executive level including top executives and Chief Executive Officers (CEOs) as the subjects of the study (Hough and White, 2003; Parnell, 2003; Eisenhardt, 1999; Miller, et.al, 1998). This argument is even stronger in the stream of research advocating the use of a mission statement as a valuable strategic tool (Bard and Hupfer, 2004), hence reflecting where the mission sits within the organisation.

The impact of executives’ and managerial decisions on corporate strategy at different levels of the organisation has been the focus of attention in a recent publication drawing
on real examples and case studies (Bower and Gilbert, 2007). Managers’ decisions about resource allocation created or destroyed the company’s corporate strategy. The recommendations of this study presented an emergent school of thought attempting to marry the bottom-up and top-to-bottom objectives of an organisation (Bower and Gilbert, 2007).

Whilst executives play a significant role in organisational decision making under the governance of boards of directors, the literature has witnessed an influx of publications in corporate businesses advocating the need for stakeholders’ involvement in the management of organisations beyond the conventional model of only maximizing shareholders’ value. This notion was referred to as stakeholder theory which will be covered briefly in the next section.

3.9 The Role of Stakeholder Theory in Decision Making

Stakeholder theory has added another element to managerial decision making, embodied in executives’ need to work for the interest of multiple stakeholders rather than only those of shareholders (Goonan, 2007; Mitchell, et.al, 1997; Sternberg, 1997; Preston and Sapienza, 1990). Stakeholders’ participation in decision making has frequently been noted in the literature to lead to favourable business outcomes (Koch, 2001; Bower and Gilbert, 2007) or to be treated as the corporation’s moral obligation to its stakeholders (Phillips, 2004). These two streams of stakeholder theory were often referred to respectively as “instrumental” and “normative” (Thomas, 1999). The first approach
tends to be pre-occupied with improving financial outcome, thus remaining within the concept of economic theory. However, the second approach reflects corporate social responsibility and the notion of triple bottom line comprising a collaborative approach to the environment, the society and the economy (Riggio and Smith Orr, 2004; Jeyaretnam, 2002).

Corporate social responsibility is defined by Petkoski and Twose (2003: 5) as follow:

> Corporate Social Responsibility is the commitment of business to contribute to sustainable economic development, working with employees, their families, the local community and society at large to improve quality of life, in ways that are both good for business and good for development.

This theory contradicted traditional management theories that aimed to achieve corporate excellence by maximising shareholders’ dividends – a practice that was rooted in economic theory (Johnson, et al., 1985). The stakeholder concept meant that shareholders were considered as part of the stakeholders’ group without the advantage of having additional benefits, as described by Donaldson and Preston (1995: 68):

> All persons or groups with legitimate interests participating in an enterprise do so to obtain benefits and that there is no prima facie priority of one set of interests and benefits over another.

In addition to the original two streams of instrumental and normative stakeholder theory, Donaldson and Preston (1995) considered the third fundamental type of stakeholder theory to be descriptive. The objective of using stakeholder theory was described by Donaldson and Preston (1995: 71) as follows:

> Descriptive/empirical: to find out and describe how an organisation is managed. Instrumental: to identify the connections or lack of connections between stakeholders’ management and the achievement of traditional corporate objectives. Normative: to interpret the function of the corporation.
Other forms of adopting stakeholder theory in the literature appeared to be a modification of these three types. For example, convergent stakeholder theory was a hybrid model proposed by Jones and Wicks (1999), who assumed that scholars who use the instrumental type are more likely to consider the normative group and vice versa.

The value that the stakeholder theory has brought to corporate management was a controversial topic amongst scholars and practitioners. The first group described the contribution of stakeholder theory to practical corporate management to be both explaining and guiding managers’ behaviour (Donaldson and Preston, 1995; Preston and Sapienza, 1990). Whilst conventional management theories treated the management process as the “black box” using an input and output model, stakeholder theory built two-way relationships between the corporation and its stakeholders (Donaldson and Preston, 1995). The second group emphasised the defects that stakeholder theory has created in perceptions of corporations which forced a number of scholars to look for alternatives by creating new versions or models for stakeholder theory and organisation/stakeholder relations (Friedman and Miles, 2002; Sternberg, 1997).

With the controversy amongst stakeholder theorists around the identity, the number and the classification of the stakeholders (Preston and Sapienza, 1990; Freeman and Evan, 1990; Bremmers, et al., 2004), Phillips (2004) perceived the emphasis in stakeholder theory to be more on equitability, rather than equality. Striking the right balance between the interests of different stakeholders during managerial decision making was the preoccupation of other scholars such as Preston and Sapienza (1990). Nevertheless, this
view of fairness associated with the application of stakeholder theory was disputed in Thomas’ (1999: 1) publication who claimed that “stakeholding can become a crude means of manipulation which provides a surface gloss to managerial decision making but leaves fundamental inequalities unchanged.”

Thomas (1999) studied stakeholder theory in light of strategic management and the interaction of the latter with managerial practice using secondary data. This research process provided a limitation in evaluating the true meaning of the theory under study using managers’ own interpretations of its practical applications. The notion of managers being considered as stakeholders, when they are ‘agents working in the organisation’, generated several debates in the literature (Preston and Sapienza, 1990). Donaldson and Preston (1995) mirrored the concern that this shift from the traditional shareholder model to a stakeholder focused approach may lead to an increase in power and emoluments amongst managers who exhibit self-serving behaviour in the name of shareholders’ interests.

The point of differentiation in the literature in term of stakeholder groups has been mainly in the competitor and media classification. With “stake” being defined as a potential benefit, Donaldson and Preston (1995) argued that these two groups, consisting of competitors and media, do not seek benefit from the organisation. However, Schacter (2004: 2) argued that stakeholders were “the groups that are likely to feel a significant impact- positive or negative; social, environmental, economic or financial- from corporate actions and therefore have a ‘stake’ in the corporation.”
On this note, Donaldson and Preston (1995) emphasised the need to distinguish between influencers and stakeholders: not every influencer is a stakeholder and vice versa. The acknowledgement of the validity and legitimacy of the stakeholder is considered to be a management function (Donaldson and Preston, 1995) and communication with this group to be a moral obligation (Phillips, 2004: 2):

Stakeholder communication is more than good for the organisation. It is a matter of moral obligation. Individual and groups who contribute to the organization should be permitted some say in how that organization is managed.

Despite these divergent views and the attempt to create a convergent version of stakeholder theory (Jones and Wicks, 1999), its overall intention remained “to explain and to guide the structure and operation of the established corporation” (Donaldson and Preston, 1995). The practical application of stakeholder theory was noted in Jones’ and Wicks’ (1999: 206) claim that “unlike other theories of organisation, it demonstrates how managers can create ways of doing business that are both moral and workable.” It was also perceived as an alternative way of adapting socioeconomic thinking (Donaldson and Preston, 1995).

Whilst corporate social responsibility cannot be considered a new idea, its emergence as a factor influencing decision making has only recently been prominent (Scharcter, 2004). “Stakeholders need information to make sound decisions, just as managers within companies need information on stakeholders’ wishes to be able to adjust their policies accordingly” (Bremmers et al, 2004).
In a large empirical study on stakeholders’ approach to explain Environmental Management System Development, Bremmers, et al (2004) indicated the need for a change in private companies’ attitudes towards communicating and cooperating with stakeholder groups. Despite the statistitical rigour in Bremmers et. al’s study, the research design was questionable. The population and sample selection were different groups drawn from two separate industries each performed in a different year. Organisations that considered profit as a measure rather than goal were more likely ‘to listen’ to stakeholders’ voices and to incorporate their needs in decision making and strategy formation (Lehtimäki and Kujala, 2005).

The definition and the involvement of stakeholders in organisational business decisions were debatable in the literature (Reidenbach and McClung, 1999; Lyons, 2001; Phillips, 2004). Jones and Wicks (1999) attempted to converge the views on stakeholder theory by studying its application in strategic management. Other scholars were more practical about the use of stakeholder theory. For example, Phillips (2004: 2) argued that not all stakeholders would like their voice in the decision making of the organisation, but those who do should be given the opportunity. Quality management is sometimes considered in the literature as a way to get stakeholders’ involvement in organisations’ decisions (Robbins et al., 2004).

The role of stakeholders in shaping strategic decisions has been highly advocated in the business literature, to the extent that a quantitative matrix has been created to give organisations a tool to measure and to manage stakeholder value known as Value-
Performance Chain (Reidenbach and McClung, 1999). This value calculation was seen by Reidenbach and McClung, (1999: 22) as the most accurate way to manage stakeholders’ satisfaction, which they defined as “an emotional response to a cognitive decision.” The use of empirical methods for the analysis of what was seen as “emotional” and “cognitive” lacks the ability to generate in-depth data to illuminate this social phenomenon. Nevertheless, the strength of this tool lay in the link created between satisfaction and performance. This dynamic approach was not found in other stakeholder publications adopting conventional quality assurance mechanisms which often appeared in the form of surveys or focus groups (Lyons, 2001).

The other end of the continuum tends to be seen mainly in not-for-profit organisations where service users are members involved in the governance of the organisation in the form of divisional committees (Lyons, 2001). In this sector, social responsibility develops further to become social accountability integrated within the mission framework of the organisation, such as the following definition of social accountability from the Sisters of Charity Health Service’s Stewardship Report Framework (2007: 10):

Social Accountability: Term used for the planned, documented and evaluated approach to service provision for our core services that is beyond the level of funding provided by key funding providers

Whilst stakeholders’ participation in business decisions was often encouraged in the literature, the focus on recruiting “service–oriented employees” was seen as the key success for creating a “customer-responsive culture” (Robbins, et.al, 2004). The trend in the literature appeared to link customers’ satisfaction with loyalty to the organisation and financial performance (Reidenbach and McClung, 1999; Robbins, et.al, 2004). Most
research studies addressing this topic tend to provide a snapshot of current practices or case studies research. A longitudinal research study would be advantageous in studying the interrelationship between these variables including customers’ satisfaction and loyalty to the organisation and financial performance.

3.10 Concluding Remarks

In conclusion, managerial decision making is considered a complex phenomenon with no consensus in the literature on its definition and its application (Simons and Thompson, 1998; Wood and Bandura, 1989). For several decades, mission and strategy remained the highlights of many business publications as separate constructs often not taking into account executives’ decisions and the range of factors that could influence decision making at this administrative level.

Drawing on the literature reviewed, three different magnifying lenses have been identified (the cognitive approach, administrative behaviour approach and economic approach) to examine the major factors influencing decision making (individual, organisational and environmental) respectively. A closer examination showed that these factors are interrelated and need to be addressed in the context of each other (Gibson, et.al, 2000). Figure 5 illustrates the matrix of approaches and factors and the interrelatedness of the latter.
The majority of scholarly published papers on decision making have been concentrating on the evaluation of an existing decision making model at operational or strategic level (Leonard and McAdam, 2002), or the generation of a novel decision making theory (Simon, 1997; Nwogugu, 2005b). The ongoing debates amongst academics and practitioners remained in identifying the most effective strategy for executives’ decision making. The numerous factors influencing the decision making process left Simon (1997) wondering how much discretion in reality is left to the decision maker. However, this assumes that individual factors (and a cognitive approach) are also beyond individual discretion.
CHAPTER 4

RESEARCH METHODOLOGY

4.1 Introduction

The previous chapter covered the different approaches that were used in the literature to study decision making and the factors influencing executives’ decision making at individual, organisational and environmental level. The literature reviewed suggested that most research studies looking at management decision making were mostly based on theoretical views, sometimes backed up by empirical evidence from research. Studies were often general and lacking rigour in depicting the specialised elements of private hospitals that reflect the complexity of the nature of these business enterprises. The topic of decision making was often addressed from one particular angle depending on the discipline in which the research inquiry took place or the research paradigm (if one was adopted). For example, the Functionalist theoretical approaches were used by theorists/researchers interested in the outcomes of decision making from an economic perspective; whereas, at the individual level, the cognitive process was more the focus in psychosocial research.

This deficiency in the literature in addressing the multifactorial aspect of executives’ decision making in private hospitals generated the following research question and
corresponding objectives being: **What** are the critical factors that influence executive decision making in private hospitals? ; And, **why** are these factors perceived by executives as significant when they are engaged in these social acts of making business decisions?

This chapter will discuss the rationale behind the selection of the research methodology encompassing the research purpose, strategy, design, data generation and analysis.

### 4.2 Research Purpose

Most studies on executives’ decision making were generic and rarely focusing on the healthcare industry particularly private hospitals. The small number of studies that existed in this field was usually conducted with the American or Canadian healthcare systems in perspective. Examining executives’ strategic decision making in the Australian private hospital context, is what makes this research different, presenting therefore an opportunity to fill the gap identified in the literature. Private hospitals are healthcare organisations providing specialised services with various stakeholders having different objectives and needs. A closer examination of ‘what really matters’ when managing these organisations was made possible by studying the factors that influence executives’ business decisions when they are engaged in the social act of managing private hospitals.

This research is exploratory in nature. According to Blaikie (2003: 73) “Exploratory research is necessary when very little is known about the topic being investigated, or about the context in which the research is to be conducted”
This research study aims to explore the factors that influence strategic decision making as perceived by executive members in private hospitals, and to understand these factors in light of their role in ensuring the longevity of these organisations. This research is about studying executive business decisions in private hospitals, a context that is not often examined by business research. Blaikie (2003: 72) differentiated between “to explore” and “to understand” by defining the two terms as follows:

To explore is to attempt to develop an initial, rough description or, possibly, an understanding of some social phenomenon

To understand is to establish reasons for particular social actions, the occurrence of an event or the course of a social episode, these reasons being derived from the ones given by social actors.

In basic research, exploring can be considered as the first step to reach understanding (Blaikie, 2003: 72). The research objective that this social inquiry attempted to achieve played an integral role in the research paradigm adopted.

4.3 Research Paradigm

Miller and Brewer (2003: 220) have defined paradigm as deriving from the Greek word “paradigma, meaning pattern” and reflecting a “theoretical structure or a thought that acts as a template or example to be followed.” Using a particular paradigm dictates the research methodology to be adopted throughout the study from setting the research objectives to reaching the research findings.
For decades, the two dominant research paradigms commonly used by scholars have been Positivism and Social Phenomenology (Blaikie, 1993; Gill and Johnson, 2002; Blaikie, 2003; Collis and Hussey, 2003; Miller and Brewer, 2003). Where Positivism is usually preoccupied with quantities, numbers, observable events and causal relationships, Phenomenology is, on the other hand, concerned with finding the true meaning of reality for the individuals being studied (Blaikie, 1993; Miller and Brewer, 2003).

Phenomenology was founded by the German Philosopher Edmund Husserl (1859-1938) who claimed that the true essence of the phenomena is gained by bracketing off ideas, beliefs and knowledge that are normally taken for granted, in order to achieve “pure consciousness” (Miller and Brewer, 2003: 227). Consequently, Social Phenomenology aims to understand human experience and explain a phenomenon using qualitative data in naturalistic ways (Karami, et.al: 44). The researcher who, in Positivism normally plays an independent role with an outside view to the research is now fully emerged in the actors’ social world. The study of the social phenomena necessitates, according to Blaikie (1993: 36) “an understanding of the social world which people have constructed and which they reproduce through their continuing activities.” This method of inquiry gave social research the emphasis on people’s interpretative and cognitive abilities (Miller and Brewer, 2003: 220).

This research study is concerned with generating social meanings through exploring the perceptions and interpretations of the social actors. Hence, the Phenomenological paradigm using Interpretivist research was well suited to answer in depth the ‘what’ and
‘why’ (exploratory) research questions of this study being: **What** are the critical factors that influence executive decision making in private hospitals? **Why** are these factors perceived by executives as significant when they are engaged in these social acts of making business decisions?

Burrell and Morgan (1979) identified the underlying assumptions of the Interpretivist paradigm to be in seeking to explain and to understand social reality through the realm of participants’ individual consciousness and subjectivity as opposed to the observer of the social act. This paradigm is preoccupied with understanding the essence of the everyday world. The emphasis on the constructed meaning of reality drives the Interpretivist to explain social phenomenon from the individual’s viewpoint. Given this view of social reality, decision making is best examined in this study using the interpretive lens to magnify the embedded meaning of this social phenomenon. The sociology of regulation in the analysis of social processes provides the underlying assumptions for this research inquiry, which was set to examine the factors that influence executives’ decision making and their interrelations at the level of subjective experience as opposed to the objective observer. The emphasis in the Interpretivist paradigm lies in understanding the way in which “the individual creates, modifies and interprets the world in which he or she finds himself” (Burrell and Morgan, 1979: 3).

In his description to the Interpretivist social science, Blaikie (2003: 15) added:

> It is the everyday beliefs and practices, mundane and taken for granted, which have to be grasped and articulated by the social researcher in order to provide an understanding of these actions.
The key differentiation between Interpretivist and Positivist is in studying the human experience in the former as interpreted by the social actor from within rather than relying on the physical sensory material apprehension from outside (Blaikie, 1993). Gill & Johnson (2002: 168) added that:

Unlike animals or physical objects, human beings are able to attach meaning to the events and phenomena that surround them, and from these interpretations and perceptions select courses of meaningful action which they are able to reflect upon and monitor.

In the Interpretivist paradigm, theorists focus on understanding the social world that is produced and reproduced by people through their continuing activities. Making sense of the basis and source of social reality embedded within these activities, meaning and language was the preoccupation of the Interpretivist paradigm (Blaikie, 2003). Burrell and Morgan (1979: 31) described this paradigm by stating that interpretive philosophers and sociologists “delve into the depths of human consciousness and subjectivity in their quest for the fundamental meanings which underlie social life.”

The ontological assumption of Interpretivism regards social reality as “the product of processes by which social actors together negotiate the meanings for action and situations; it is a complex of socially constructed meanings” (Blaikie, 1993: 96) Similarly, the epistemology of Interpretivism requires the researcher to enter “the everyday social world in order to grasp the socially constructed meanings, and then reconstructs these meanings in social scientific language” Blaikie (1995: 96).

Based on Social Phenomenology, Anthony Giddens (1984) introduced Structuration Theory to provide a theoretical framework to social sciences to address the debates
around the relationship between the individual and society, or what Giddens referred to as “agent” and “structure” (Held & Thompson, 1989: 2). Giddens’ (1984: 377) theoretical approach was a novel way of looking at structure as “rules and resources, recursively implicated in the reproduction of social systems” rather than a rigid framework. Giddens (1984: 374) referred to his concept as the “duality of structure” which he explains to be derived from his belief that:

The structural properties of social systems do not exist outside of action but are chronically implicated in its production and reproduction.

Giddens’ Structuration Theory was concerned with the “acting self” and the “social institutions” and the interrelationship between them within a given time and space (Blaikie, 1993: 99).

In his Structuration Theory, Giddens moves beyond pure interpretation of social actors’ meanings to emphasise on the knowlegeability of the agents. Giddens (1984: 375) defined knowledgeability as:

Everything which actors know (believe) about the circumstances of their action and that of others, drawn upon in the production and reproduction of that action, including tacit as well as discursively available knowledge.

In conclusion, with the Positivist and Phenomenological paradigms forming the two extremes of a continuum (Collis and Hussey, 2003), the research strategies adopted within each paradigm differed based on the ontological and epistemological assumptions of their philosophical foundations (Blaikie, 2003).
4.4 Research Strategy

The four common research strategies identified by Blaikie (2003) were the inductive, deductive, retroductive and abductive research strategies. The following table (Table 6) extracted from Blaikie (2003: 101) clearly examined and compared each of these strategies in light of its aim, process and the outcome to be achieved.

**Table 6** The logic of four research strategies

<table>
<thead>
<tr>
<th></th>
<th>Inductive</th>
<th>Deductive</th>
<th>Retroductive</th>
<th>Abductive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim</td>
<td>To establish universal generalization to be used as pattern explanations</td>
<td>To test theories to eliminate false ones and corroborate the survivor</td>
<td>To discover underlying mechanisms to explain observed regularities</td>
<td>To describe and understand social life in terms of social actors’ motives and accounts</td>
</tr>
<tr>
<td>From</td>
<td>Accumulate observations or data</td>
<td>Borrow or construct a theory and express it as an argument</td>
<td>Document and model a regularity</td>
<td>Discover everyday lay concepts, meanings and motives</td>
</tr>
<tr>
<td></td>
<td>Produce generalizations</td>
<td>Deduce hypotheses</td>
<td>Construct a hypothetical model of a mechanism</td>
<td>Produce a technical account from lay accounts</td>
</tr>
<tr>
<td>To</td>
<td>Use these ‘laws’ as patterns to explain further observations</td>
<td>Test the hypotheses by matching them with data</td>
<td>Find the real mechanism by observation and/ or experiment</td>
<td>Develop a theory and test it iteratively</td>
</tr>
</tbody>
</table>

Source: Blaikie (2003, p. 101)

Using the Interpretivist paradigm, the abductive research strategy was the most pertinent to this study. The key factor influencing the selection of this research paradigm was the researcher’s aim to generate social meaning from the accounts created from the participants’ interpretations of their motives and actions in their social world (Blaikie, 2003). Denzin and Lincoln (2005: 833) considered the abductive logic as the way
through which “analysts explore the social or natural world through practical engagements with it, derive working models and provisional understanding, and use such emergent ideas to guide further empirical explorations.”

By researching and interpreting the reality that private hospital executives were experiencing in their governance on a daily basis, social scientific meanings were developed. Gadamer (1989) referred to this process of understanding as the “hermeneutic tradition”, which considered the discovery of truth to be in the reading of a text, recognising its particular time and place, rather than in the text itself. The researcher uses technical concepts to describe and to understand social phenomena which have their origin in social actors’ daily language rather than the discipline (Blaikie: 2003). This is consistent with the ontological and epistemological assumptions of the abductive research strategy that takes social scientific knowledge to be acquired from everyday meanings relative to the participants’ reality not only by the outside observer (Blaikie, 2003).

These social accounts that are generated from social actors’ own reflections and interpretations of these routine activities unveil meanings and theories (Blaikie, 2007: 90). Blaikie (2003: 140) emphasised further the strong relationship between hermeneutics and the use of abductive research strategy by claiming the following:

It is the hermeneutic tradition that is most appropriate for genuine abductive research. This is because the generation of technical concepts from lay concepts is a hermeneutic process.
Even though researchers in natural sciences criticised the use of abductive research for generating data, this research strategy remains a widely accepted approach for generating knowledge in social sciences, (Collis and Hussey, 2003:).

The logic of enquiry adopted in this research (generating social meaning by interpreting social actors’ perceptions of the social phenomenon under study) and the choice of the research strategy (abductive research strategy) guiding the research design will be covered in the next section.

4.5 Research Design

Given the researcher’s desire to generate accounts from participants’ interpretations of their own social world using the Interpretivist paradigm, qualitative data was generated to answer the research question. The difference between qualitative and quantitative data was best described in Blaikie’s (2003: 232) following statement:

Quantitative methods are generally concerned with counting and measuring aspects of social life, while qualitative methods are more concerned with producing discursive descriptions and exploring social actors’ meanings and interpretations.

The objective of the study was to gain better understanding of the factors that influence executives’ strategic decisions in private hospitals. The social actors’ interpretations of their social world were the essence in capturing what really matters in private hospitals. Counting numbers by using quantitative method would have produced a broad brush painting lacking the details that characterise this specialised social setting. Qualitative
research is about studying the social reality inhabited by the participants rather than reconstructed reality using demographics (Blaikie, 2003).

4.5.1 Research Sample

The research sample was purposive encompassing sixteen senior hospital executive members who worked in private hospitals in Australia. In this thesis, ‘executives’ were defined as individuals who belonged to the upper echelons in private hospitals comprising chief executive officers and their senior management staff who together form the executive team.

Executive level decision making was the focus of the study due to the influential role that executive members play in managing private hospitals.

The sample was strategically selected choosing experts in the private healthcare industry who are familiar with the management of hospitals in both for-profit and not-for-profit private sectors.

The sixteen selected research subjects had senior executive positions encompassing eight Executive Directors, six Chief Executive Officers and two Group Chief Executive Officers.

Subjects were equally drawn from two different sectors of the private hospital industry.

Eight executive members were approached from each sector:

- Not-for-profit sector which incorporated three religious entities in Australia running private hospitals nationally; and,
For-profit sector encompassing three independent private chains/groups of corporate organisations running private hospitals both nationally and internationally.

The criteria for selection of the sixteen research subjects encompassed the followings:

- Currently employed as a senior executive in private hospitals
- Possess more than ten years’ experience in managing private hospitals
- Australian citizen currently residing in Australia

Having more than ten years’ experience in private healthcare was an essential criterion to increase the validity of the data generated. According to O’Murchu (1995) the human grasp of reality deepens with each experience. Therefore, the longer the experience duration, the closer the data generated could be to reality. To be able to shed light onto the critical factors influencing executive decision making in private hospitals, it was essential to target a population the members of which have worked in such an environment.

### 4.5.2 Data Generation

Focused and semi-structured interviews were the methods of choice for generating the data required to meet the objectives that were set to be achieved in this study. Kvale (1996: 5) defined semi-structured interviews as “an interview whose purpose is to obtain descriptions of the life world of the interviewee with respect to interpreting the meaning of the described phenomena.” Blaikie (2003: 234) acknowledged the value of in-depth
interviews as they allow the researcher to “get close to the social actors’ meanings and interpretations, to their accounts of the social interaction in which they have been involved.” The benefit of using research interviews is not limited to Interpretivist research. Kvale (1996: 1) believed that qualitative research interviews play a role prior to scientific explanations by attempting:

To understand the world from the subjects’ points of view, to unfold the meaning of people’s experiences, to uncover their lived world prior to scientific explanations.

The researcher approached senior private hospital executives who had high profiles in the private hospital industry and invited them to participate in this study. Prior to the interviews, interviewees were asked to read an explanatory note stating the purpose of the research (Appendix A) and to sign a consent form (Appendix B) to confirm their voluntary participation and understanding of their rights as participants.

Interviews were conducted over a six-month period at mutually convenient times and places.

The researcher personally conducted these face-to-face interviews with sixteen hospital executives in their work environment or in a conference precinct. The researcher’s knowledge of the industry strengthened the rapport with the participants enabling deeper conversation and richer data to be generated. Generating knowledge through human interaction was the main theme that underpinned Kvale’s (1996: 14) book titled Interview in which he defined the latter as “literally an inter view, an inter-change of views between two persons conversing about a theme of mutual interest.” Hence the
researcher’s industry knowledge and interest in the topic under study was an essential element in collecting rich field data to answer this research inquiry.

The key interview questions (Appendix C) comprised ‘what questions’, to unveil the critical factors that underpin the executives’ decision making in private hospitals and ‘how questions’, to deeply examine the actors’ perceptions and meanings of this social act. No ‘why questions’ were asked, as responses were embedded in the ‘how’ questions. The interview durations ranged from one hour to an hour and a half.

The interviews conducted by the researcher were semi-structured in nature using open and close-ended questions. To increase the validity of the data collected, the interviews were conducted one-to-one following the same list of questions which were posed in similar ways to each respondent. Probes were used at times to encourage the participant to elaborate further, and to gain clarity of the answers given by the interviewee. The researcher generated information about the experience of private hospital executives and the meanings derived from being in these positions within their organisations. During the interview, field notes were taken by the researcher to document participants’ responses including verbal and non verbal messages. Collis and Hussey (2003: 192) highlighted the importance of making notes during the interview by stating that “the main advantage of note-taking for recording qualitative data is that you can record your observations and responses to questions immediately.” The researcher’s notes were reviewed straight after each interview to increase the clarity of the data generated. Additional comments were
also added by the researcher to reflect the interviewees’ non-verbal communications and any other observations.

To increase the validity of the data generated, other sources of data were accessed. Data comprised written documentation such as hospitals’ annual reports, internal newsletters, media releases and publications. This was facilitated by the researcher’s insider position in the industry, her profile and knowledge in the field of study. The latter is an essential element in “producing knowledge through conversation” (Kvale, 1996: 13).

The other measure adopted to increase the validity of the data generated was by comparing and contrasting responses of participants working in different private hospitals within the same corporate group or network. Similarities and contradictions in participants’ viewpoints were documented.

The data generated were qualitative aiming at describing participants’ perceptions of the concepts under study. Interviews for data collection purposes were ceased when no new themes were emerging, which led to a sample size of sixteen. According to Parry (2003: 256), in qualitative research “the sample size should help understand the phenomenon, not represent statistically the population.”
4.6 Data Analysis

Data analysis is strongly related to the topic under study, the research tool used and the research paradigm adopted. By analysis, “objective facts and essential meanings” are extracted from the data generated and shaped into their definitive form (Kvale, 1996: 4).

This research enquiry adopted the Interpretivist paradigm which reflects the researcher’s interest in illustrating the reality as perceived by participants. With this objective in mind, the researcher used in this research inquiry a “low stance” approach which according to Blaikie (2003: 241) enable the development of “technical concepts and theoretical propositions from accounts provided in lay language.” This is in contrast to the high stance where the researcher usually forms and imposes concept on the data (Blaikie, 2003), typically in such an instance, as derived from the literature review.

This approach was relevant to this research study for the following reasons:

- The focus of this research inquiry was to illuminate the factors influencing decision making (social phenomenon) as identified by executives (social actors) working in private hospitals (social setting) based on their perceptions and interpretations.

- The researcher’s objective was not to test a hypothesis, but aimed to explore the meanings of the phenomena under study.

- The researcher did not attempt to impose an existing theory on the research findings but was interested in themes and concepts generated from the research data. Adopting a theory from the start of the research creates limitations to the researcher and the ability to reach the participants’ points of view (Blaikie, 2003).
Using the “low stance” approach, content analysis needs to be conducted with vigilance to retain the original meaning instigated in participants’ responses. Concepts are therefore generated following a bottom-up manner which is the preferred research strategy by abductivists (Blaikie, 2003: 241). Schütz (1963: 231) referred to the everyday taken for granted typification that constitutes social life as first order construct, and the sociological typification or ideal types constructed by the social researcher as second order constructs.

Throughout the data generation, reduction and analysis, the researcher attempted to remain as close as possible to the lay concepts and social meanings generated by the participants. The data generated was mainly nominal based on participants’ responses. The process for data reduction and analysis encompassed five phases. Figure 6 illustrates a summary of these phases in a sand-timer shape starting from broad raw data generated from the participants’ social worlds to specific categories describing specific motives and actions in specific situations to become ingredients for typical motives and typical actions in typical situations (Blaikie, 2003).
The five phases of the data analysis process included the following:

**Phase 1:** Raw data in form of field notes containing participants’ responses and researcher’s observations and comments were referenced accordingly to distinguish between interviewees’ responses and the researcher’s comments and reflections. Accounts were generated for all participants.

**Phase 2:** The raw data were analysed and categorised following an open coding process. Responses were broken down and dissected following ideas, key words and phrases that were relevant to the question and the research topic at hand. Responses reflecting similar meaning were highlighted using colour coding and grouped together to form different concepts. By examining and comparing these concepts, the frequency and the order in which they appeared, categories and themes were extracted from the data. Subcategories
were formed when more than one group were identified under the same concept. By the end of phase two, lay concepts deriving from participants’ daily life and tacit knowledge formed the first order construct to which Schütz (1963) referred. In coding the data, Miller and Brewer (2003: 45) claimed that “the contents of the text or accounts are classified in terms of its structure as embodied in the words used and the ideas, categories and concepts employed.” This analytical procedure provided a method by which the considerable volume of material that is generated by qualitative data collection methods, can be managed and controlled (Collis and Hussey, 2003: 263).

**Phase 3:** This stage involved further analysis of the data following axial coding. The researcher looked for relationships between the identified categories and subcategories and identified patterns and themes. By examining irregularity, uniformity, and variation amongst these categories and subcategories meaningful relationships were created. This process allowed the restructuring of the data in a new format following a bottom-up approach without imposing new concepts and meanings. Collis and Hussey (2003: 273) described axial coding as “the restructuring and rebuilding of the data into various patterns with the intention of revealing links and relationships.” With this process lay accounts derived from everyday typifications evolved to become ideal types and categories that Schütz (1963) referred to as second order constructs.

**Phase 4:** Recording of findings was conducted throughout the data analysis phases to capture the different concepts and themes distilled from the data. The researcher logged notes relevant to meaningful findings. At every stage of the grouping and the regrouping
process, the researcher’s comments and thoughts were documented and analysed systematically.

**Phase 5:** Interpretation of the findings was performed by comparing and contrasting the research findings with the theoretical model developed (Figure 6) in the literature review. The model was used to guide the reduction and the analysis of the data and was beneficial considering the exploratory nature of this research.

### 4.7 Limitations

This research study is exploratory, attempting to shed light, at the time of the research, on the key factors influencing executives’ decisions in private hospitals. The adoption of an abductive research strategy in this study was essential to conduct an in-depth research into decision making in a specialised sector of the Australian healthcare industry being private hospitals. Semi-structured interviews were conducted to generate data, a qualitative research technique that Miller and Brewer (2003: 240) considered to be the reason to sacrifice the “breadth of scope and scale for richness and depth.”

In light of the time, context and sample size limitations, limited and tentative attempts will be made to achieve generalisations from the findings of this study. When Collis and Hussey (2003) emphasised the problems of rigour and subjectivity associated with a qualitative approach, Blaikie (1993: 36) argued from the same principles their claim, by stating that “the social world is already interpreted before the social scientist arrives.” When subjectivity is inevitable in Interpretivists’ approach, efforts were made to reduce the researcher’s bias by taking several measures such as:
- Asking non-leading questions posed consistently in the same way during the interview;
- Taking notes of participants’ responses, special incidents, observations or ideas that arose during or after the interviews; and,
- Using participants’ own words during data generation and analysis.

The validity of the data was maximised by comparing and contrasting the data generated from the interviews with organisational documents, industry reports and publications.

### 4.8 Summary

This chapter has described the method applied to data to answer the research enquiry, being:

**What** are the critical factors that influence executive decision making in private hospitals? ; And, **why** are these factors perceived by executives as significant when they are engaged in these social acts of making business decisions?

The selection of the research strategy, design, the methods used for data collection and analysis were illustrated in this chapter. The following chapter examines the research findings of this study.
CHAPTER 5

RESEARCH FINDINGS

5.1 Introduction

The objective of this chapter is to convey the findings of this study comprehensively and systematically to answer this research inquiry into executives’ decision making and the factors underpinning these decisions in private hospitals. The research findings chapter describes the journey of the transformation of the data generated into technical accounts. The research aimed to use participants’ lay concepts and motives to produce more technical accounts, a low stance approach involving the abductive research strategy in its purest form (Blaikie, 2003).

To understand the social phenomenon under study, any generated data was reduced into dominant patterns via the process of open and axial coding. Blaikie (2003: 239) described open coding as the first stage of the “process of breaking down, examining, comparing conceptualizing and categorizing data.” As a result, patterns and themes are extracted and grouped under categories and subcategories, which were labelled based on their meanings and the ideas they represented. Subsequently, the researcher examined these categories and subcategories looking for any interrelationships and links. This
formed stage two of the data reduction known as axial coding, where the data was rebuilt in a new form. According to Blaikie (2003: 239), this step involves:

Thinking about possible causal conditions, contexts, intervening conditions, action/interaction strategies used to respond to phenomenon in its context, and the possible consequences of action/interaction not occurring.

This chapter will communicate the research findings as the researcher constructed them from the data generated from the participants’ responses to the questions during the interview. Second-order constructs were derived from the interviewees’ words representing their meanings (first-order constructs). ‘Factors influencing executives’ decision making in private hospitals’ acted as a centre of gravity and focal point around which the coding of the data and analysis were conducted. Before proceeding further with the findings of the study it is essential to give more details of the private hospital industry and the specialised characteristics of its different sectors as perceived by the research subjects.

5.2 Characteristics of the Social Context: Private Hospitals.

The researcher aimed to gain insights into the factors influencing executives’ decision making in the private hospital industry. Prior to analysing the specific drivers that face executives in the management of these organisations, it is beneficial to illuminate the social context of the research and its characteristics as perceived and constructed by the research subjects. It is worth noting here that although research subjects were invited to participate in this study as individuals not as organisations, a number of elements of
organisational or even cultural ‘structure’ (as defined and exemplified earlier in Giddens’ Structuration Theory) can be glimpsed/ viewed in the individuals’ described meanings.

The 16 selected research subjects had senior executive positions in Australian private hospitals including executive directors (8), CEOs (6), and group CEOs (2). Subjects were equally drawn from two different sectors of the private hospital industry. Eight executive members were approached from each sector:

- Not-for-profit sector which incorporated three religious entities in Australia running private hospitals nationally; and,
- For-profit sector encompassing three independent private chains/groups of corporate organisations running private hospitals both nationally and internationally.

When asked about their perception of the two sectors, participants alluded to characteristics that best described each sector: for-profit and not-for-profit. By comparing and contrasting participants’ responses, the researcher grouped together the concepts generated from participants’ own words to describe each sector separately. Two common concepts referred to by participants as ‘patient care’ and ‘profit generation’ appeared to be a common denominator across both sectors as illustrated in Figure 7.
With these characteristics in mind, the next section will explore the decision making factors that were perceived as important by research subjects. Six categories of factors influencing executives’ strategic decision making in private hospitals have been extracted from the primary analysis and open coding of the data as depicted in the next section. These categories and subcategories, which the researcher referred to as factors influencing decision making, were identified from the raw data using respondents’ own words as generated from lay accounts. The researcher classified the thread in the various responses alluding to the same meaning under the same category name. Certain categories were further divided into subcategories when words, phrases or ideas within a particular category diverged to form multiple facets of the same concept.
Six categories of factors were collated based on their value and significance when making business decisions as perceived by respondents explicitly. When significant variation is noted amongst the responses between participants working in for-profit compared to not-for-profit private hospitals, reference to the sector type was made with intentions to gain more depth in the meaning of this category.

### 5.3 Factors Influencing Decision Making

A number of factors influencing executives’ strategic business decisions in private hospitals as experienced and interpreted by research respondents were recognised and collated to form the following list in order of significance:

- **5.3.1 Interpersonal Factors**
- **5.3.2 Cultural Factors**
- **5.3.3 Strategic Factors**
- **5.3.4 Economic Factors**
- **5.3.5 Community Benefit Factors**
- **5.3.6 Political and Clinical Governance Factors**

The next section will provide a detailed description of each of these factors as perceived by research subjects.
5.3.1 Interpersonal Factors

The comment that “healthcare is a ‘people’ industry” was explicitly stated in several interviews whether in responding directly to a question or mentioned as a concluding remark towards the end of the interview. Participants used the term “people” to refer implicitly to all frontline personnel involved in the delivery of services to the ultimate customer, the patient. All personnel participating in patients’ care were referred to as clinical staff and were employed by the hospital with the exception of the medical specialists. From the data generated, it appeared that medical specialists played an integral role in the private hospitals’ businesses which warrant their classification under a separate category. Therefore, two subcategories were formed within this category: clinical staff and medical specialists. Both groups were considered by participants as stakeholders of private hospitals. Other stakeholders listed not in order of priority were: “patients, health insurers, business owners or operators and the community as a whole.”

5.3.1.1 Clinical Staff

The ‘quality’ of individual staff members was strongly emphasised by executives, particularly in the for-profit sector, as being an important criterion in running successful hospitals and playing an integral role in shaping business decisions. The emphasis on valuing “competent staff” was highlighted consistently by participants who belonged to the two national for-profit private hospital groups in Australia. It was apparent from the responses the preoccupation of this group with staff retention compared to participants in
not-for-profit sector, who were more focused on recruitment strategies rather than retention. The quality aspect of individual staff members appeared to be of less significance in the not-for-profit sector as long as the overall team was performing.

\begin{quote}
We cannot afford to lose our staff in the for-profit sector. Our aim is to have motivated staff members who love the job they do (For-profit executive 10).
\end{quote}

\begin{quote}
The quality of the people who I work with is very important. In my decisions I have to have confidence in the quality of our people and their experiences (For-profit executive 9).
\end{quote}

On the other hand, the critical role that medical specialists played in driving executives’ business decisions was equally valued in both for-profit and not-for-profit sectors.

\subsection*{5.3.1.2 Medical Specialists}

Different terms were used by research subjects to describe the relationship of medical specialists with private hospitals such as “partners”, “clients”, “distributors” and “stakeholders” to name a few.

\begin{quote}
A consultation process should be followed when dealing with doctors and when making decisions. They are small independent businesses that we really rely on for our business. Most strategies are emanated from listening to them. I believe they are key stakeholders (Not-for-profit executive 5).
\end{quote}

\begin{quote}
There is a contract binding private hospitals with doctors but both are dependent on each other. We as administrators need to understand their needs to meet their demands. The essence is mutual trust and development of common good. The best way to describe this relationship I would say is that doctors are strong informal partners (Not-for-profit executive 11).
\end{quote}

\begin{quote}
As Executives I think we should manage ourselves but involve them early in decisions. We cannot run the business without their support but we cannot let them dominate. Doctors are partners and we exist to service the patient (For-profit executive 12).
\end{quote}
Doctors titled in doctors’ favour. They have strong influence in decision making. I feel intelligent management engage doctors in hospital outcomes as they do have an intellectual stake in the business (For-profit executive 16).

Doctors have a great influence in selecting hospitals since 95 percent of admissions are doctor driven. At the end of the day they are our clients (For-profit executive 13).

The failure in the management of private hospitals by Mayne Health in Australia was a dominant example referred to by the majority of respondents to stress the detrimental effect of not involving medical specialists in executive decision making in private hospitals.

Whilst the view of valuing medical specialists was dominant amongst participants, the obvious point of differentiation between the responses was their degree of involvement to which they should be entitled in executives’ decisions. These diverse interpretations were more obvious in the for-profit sector with inconsistent responses amongst participants in this sector when prompted about medical specialists’ role in executives’ decision making. The researcher’s observations during the interviews described the discrepancies in opinions regarding private hospital executives’ relationship with medical specialists to be based on executives’ personal experiences. For example, during the interview seven participants were pointing to their chests when describing isolated decision making scenarios demonstrating the consequences of consulting versus not consulting with medical specialists.
5.3.2 Cultural Factors

Executives who referred to the culture factor had already bypassed the decision making stage and started thinking of the execution and the consequences of their decisions. The culture factor appears to have more significance for participants working in for-profit hospitals compared to their colleagues in the for-profit hospitals. There was a concern amongst this group about the flow-on-effect of a business decision that does not align or fit with the culture of the organisation and the readiness of its staff. This is consistent with the preoccupation of this account with the human resource element that was mentioned earlier in this chapter.

You should consider the culture depending on the decision, for example, does the culture of the new business fit the culture of the organisation. Alignment of the culture is important no matter what the culture impacts on business (For-profit executive 6).

Organisational readiness and sequencing should be considered in any decision you make. The culture of the place can guide and direct you; and there is no point in initiating something at a time when you feel the organisation and staff are not ready for it. Often, in scenarios like this you will be asking for disasters (Not-for-profit executive 8).

A decision to change in the way we do business should consider the readiness of change in the area where change is impacting on. You have to understand the readiness for change as it will impact on success (Not-for-profit executive 15).

The theme of organisational culture was also implied in the weight given by research subjects to the communication process. Ensuring people are informed and have input into executives’ decisions were noted in several accounts. However, ‘when’ to communicate was the point of differentiation between respondents and accordingly the
researcher formed two subcategories: the first group advocated the communication of the decision ‘during’ the planning phase to engage stakeholders; whilst the second group communicated the decision to stakeholders ‘after’ the decision was made.

- Communication prior to decision being made

| You should think about the implementation and ensure proper communication while the theory is in process and before the decision is made (Not-for-profit executive 5). |
| At a CEO level, it is important to be visible to staff, doctors and patients. This is of course harder when one CEO is over many hospitals, which limits access and contact. Doctors should have input into management decisions particularly doctors who bring customers to us (For-profit executive 3). |

- Communication after the decision is made

| I expect a decision to be executed if an executive decision is made (For-profit executive 9). |
| The size of the decision is important and who is asking for this decision. Do not disclose everything (Not-for-profit executive 7). |

5.3.3 Strategic Factors

The top three organisational goals listed by executives in their response to the first question of the interview, being their perceptions of the three top organisational goals, were used as the outcomes they strive to achieve, against which the responses for their subsequent questions were compared and contrasted. This approach assisted the researcher in assessing whether participants referred to these goals at the time of decision making.

Research subjects referred explicitly and sometimes less directly to the strategic factors as influencing their business decisions. Responses ranged from stating the word
“strategy” to using metaphors such as the expression “lose a particular battle, but win the war.” A thorough examination of the responses indicated the connotation of time with the use of the concept of strategy as a factor influencing decisions. Strategy was often referred to by participants as a future long term organisational goal to be gained as stated by one of the participants: “Do not make decisions for right now…Short-term gain sometimes is not good for long-term gain.” Operational goals were often used by participants when referring to present short-term goals. It was evident from the data generated that executives participating in the study perceived their decisions to be strategically goal orientated. The majority of these organisational strategic goals concentrated on ensuring clinical excellence which was mainly reflected in patient care and maximising financial performance and profit generation.

Whilst all executives stated these two goals amongst their top three organisational goals, executives in the for-profit sector were more vocal about the need to maximise profit. There was no explicit mention of the word “strategy” by research subjects working in for-profit private hospitals. The commercial and financial imperatives, which are explored under section 5.3.4, were embedded in their responses as representing their organisational goals. For this account, meeting the financial objective was a priority in terms of factors influencing decision making. This factor was strongly highlighted and taken into consideration in the business operations as implied by one of the respondents in this statement: “In the for-profit sector you are managing and looking forward to delivering the objective.” Although no specific time frame was noted by interviewees in the for-profit sector, several expressions indicated their motives in creating profit margins short term more than long term.
In the for-profit immediate performance is necessary as it has immediate consequences on share price (For-profit executive 14)

Generally for-profit hospitals have a greater sense of urgency and awareness of the importance of decisions. The dividend is distributed back to investors (For-profit executive 6).

For-profit hospitals are more commercial about decisions. They are more short-term in thinking compared to the greater longevity in ownership and decision making which aims for long term outcomes in the not-for-profit sector (Not-for-profit executive 2).

Only one executive amongst the research subjects in the for-profit sector emphasised the importance of the “balance in business objectives between medium to long term goal if the hospital is serious about its business.”

On the other hand, for the not-for-profit sector, both clinical and financial goals were equally as important. Participants in not-for-profit hospitals referred to strategy as the accomplishment of their mission to the extent that these two words were interchanged by interviewees necessitating the researcher to prompt further clarifications. The need to have a Mission as a goal driving strategic decisions was the widely held views amongst executives in this group.

With these goals in mind whether being clinically, financially or mission driven, the majority of respondents perceived their organisational strategy to be crafted to achieve these goals. Making business decisions in alignment with the hospital mission was strongly advocated amongst the majority of executives working in the not-for-profit sector. In the absence of a mission statement, participants in the for-profit exhibited explicitly a “just do it” attitude with more emphasis on practical ways in managing
people who deliver services. Their strategy concentrated heavily on investing in human and capital resources.

The three top goals that I aim for are in the following order: Achieving clinical excellence first to make people want to use us, by providing doctors with best equipment and facilities; Second, supply patients’ needs and third will be the financial return which cannot happen without the first two (For-profit executive 11).

5.3.4 Economic Factors

The two main themes extracted from the data encompassing: financials and marketing aspects were constructed as the economic factor. Research participants referring to these factors acknowledged the importance of having ‘strong financial understanding’ as an important executive’s attribute in their role as decision maker.

The increasing competition of the private healthcare sector was identified by the majority of research participants particularly in the for-profit sector. The economic factor appeared to be more significant in the for-profit sector. Nevertheless, there was recognition by subjects in the not-for-profit sector of the need to monitor the bottom line similarly to the private for-profit sector. This finding demonstrated a paradigm change in the management of not-for-profit hospitals.

Participants frequently used terminology such as “balanced scorecard” and “key performance indicators” when discussing the evaluation of the outcomes of a decision.
Other references to the financial aspect of the business in participants’ responses encompassed the following:

- Financial sustainability
- Financial performance
- Cash flow positive
- High performing hospital
- Financial return
- Surplus to invest
- Reasonable good return
- Generating Profit

Generally, participants working in the for-profit sector indicated more assertively the need to ensure the highest financial performance when making business decisions by using expressions such as ‘maximising profit’ and ‘increasing profitability’.

Market competition was another constant concept identified in the responses particularly amongst research subjects in the for-profit sector. A common theme was identified amongst responses alluding to the ever increasing challenges faced when negotiating contracts and agreements with private health insurers. One research participant summarised the asymmetry amongst the two parties (private hospitals and health insurers) by stating that: “health insurers have better use of data about performance of each hospital, which is the strategic weakness of private hospitals.”

There is an increase in competition with the market growing, the ownership of private hospitals becoming more concentrated and negotiations with private health funds being harder (Not-for-profit executive 1).

Having a competitive edge was perceived as important by research subjects and appears to play a significant role in executives’ decisions. To ensure this market positioning,
participants were adopting three defence mechanisms which involved investment in technology, facility development and specialisation.

The use of technology assisted the executives to compete in attracting medical specialists who were considered to play an integral role in business development. Investing in technology involved the purchase of advanced medical equipment, instruments and other information technology infrastructure. Capital investment as a result of advancement in technology appeared to be a huge burden on hospitals’ budgets. Furthermore, research subjects referred to the constant need to upgrade the hospital facilities to meet legislative standards, consumer expectation (the patient) and medical specialists’ needs. Facility development and expansion was another motive stated implicitly and explicitly by research subjects to be driving a significant number of decisions. The reference to the concept of “rationalisation” by creating large hospital groups through mergers and acquisitions was noted in several interviews. In addition to achieving an economy of scale through managing larger organisations, research subjects frequently stated the importance of size when negotiating with private health insurers.

The last theme that was identified under this category was participants’ intentions to increase the specialisation of their hospitals as a point of differentiation in their marketing plans. Specialisation implied offering more comprehensive services for a smaller range of products.

*Private hospitals are feeling the technology pressure like the recent use of robotic surgery and the cost involved in that not only the equipment itself but the consumable items as well. Add to this the fact that hospitals nowadays are price takers not price setters as before due to changes in funding schemes (Not-for-profit executive 15).*
The change in the healthcare industry perspective has come about with the increase in the aging population. New players have seen this as an opportunity with recent interest from property funds. The focus now for private hospitals remains in the specialisation of their services (For-profit executive 6).

Currently we are witnessing a natural consolidation of the industry not different for both sectors where you get the efficiencies you need by being in a group (Not-for-profit executive 4).

Eventually, private hospitals will be seen as hotels but that happen to deliver healthcare (Not-for-profit executive 8).

### 5.3.5 Community Benefit Factors

In reference to the research subjects’ responses, the meaning of the community benefit factor appeared to have dual meaning. Participants alluded to the concept of community benefit at the micro level when the community member was still in hospital as a patient, and at macro level by extending the services to incorporate the community as a whole.

The clinical outcome at the patient care level was identified by respondents to be similar in both sectors of the private hospital industry.

The quality of care is the same in both sectors. I think nurses dealing with patients at the coal face do not feel the difference in executive decisions between for-profit and not-for-profit (For-profit executive 10).

We, in the for-profit sector, are under more pressure and keener to make the final results. The essence of that is not-for-profit are not as strong, they are more flexible in their cost but there is no difference in the approach to reach the clinical outcomes (For-profit executive 14).

The majority of respondents in the for-profit sector considered community benefit to be achieved as a flow on effect from benefiting individual members through their hospitalisation experience. However, the meaning of community benefit appeared to
have a different facet in the not-for-profit sector. Community benefit was associated with the humanitarian and missionary aspect of the not-for-profit sector which seemed to be taken for granted amongst research subjects as the ‘raison d’être’ for the not-for-profit private hospitals.

Decisions are considered based on their financial impact and how it affects mission, community and patients’ needs. Our stakeholders are not only the owners, the Sisters but also the community in general are essential. This is what distinguishes us, it is in the way we relate to the family in caring for the patient. For example, we have a preoperative clinic prior to hospital admissions and an outreach service to be used by patients and their families post discharge (Not-for-profit executive 1).

In the not-for-profit sector, we may invest in work that does not generate profit but will benefit the community such as cancer treatment and aged care (Not-for-profit executive 8).

One of our goals is to provide service to as many people as we can even if we cannot get paid. For example, we sometimes treat a public patient even if there is no reimbursement. We don’t always look at financial implication but take humanistic and other considerations first like palliative care and other oncology treatment (Not-for-profit executive 4).

5.3.6 Government Legislations and Industry Standards

Government legislations and industry standards set out funding schemes and accreditation requirements for the operation of private hospitals to protect consumer rights, privacy and quality of care. This concern in meeting quality standards and government legislative requirements was preoccupying executives and strongly driving their decisions equally in both for-profit and not-for-profit private hospitals. A fear of the consequences of failing to meet government and industry policies were clearly exhibited in respondents’ verbal and non-verbal communication including gestures of the arms and
facial expressions. The words “compliance” and “consistency” were often featured in participants’ responses.

Decisions need be reviewed and emphasis should be on decisions to be consistent with policies and customer practice (Not-for-profit executive 2).

In every decision you have to be wary of the consequences and the feedback you’ll get from the Australian Competition and Consumer Commission for any breach of conduct. Compliance with the trading act is always emphasised in our dealings with suppliers and doctors or even our competitors (Not-for-profit executive 11).

You have to reach clinical excellence in order to make people want to use you by having the best equipment, doctors and facilities (Not-for-profit executive 7).

The key is to deliver reliable, robust and quality healthcare to achieve consistent outcomes of high standards. Once you reach this stage you can retain and grow reputation which helps in business development because it gives patients the confidence and attracts doctors (For-profit executive 5).

The government and industry legislative factors were considered by research subjects to be significantly influential in the way they dictated the operation and the business development of private hospitals. Political and clinical influences were generating feelings of disappointments when noted explicitly by respondents. The researcher observed signs of dissatisfaction on interviewees’ faces when the following statements were made:

Try to ensure that every decision is focused on the patient. This should be the overarching goal because at the end of the day what you have done is for the best of the patient. Of course you have to consider the medical politics and the government politics. The skill is in looking at the opportunities that coincide with the aim of improving the patient outcome by aligning politics with patients’ outcomes (Not-for-profit executive 15).
Unfortunately, decisions are sometimes based on political wins rather than health planning criteria (For-profit executive 6).

You do not have the ability to control the future so protect what you have got now. There is no logic to the allocation of funding according to need but it is more in accordance with political preferences than clinical need (For-profit executive 12).

The researcher acknowledges the possibility existing of other executives who shared similar thoughts but refrained from making this statement. No common and distinctive trends were noted in one particular sector compared to the other.

Using open coding, this section identified the different categories and subcategories that could be extracted from the data as factors influencing executive business decisions in private hospitals. The researcher had no intention of examining the rationality of decision making, but to explore and to gain more understanding of what executives valued in the management of private hospitals, and accordingly, base their strategic business decisions. Strategy, people, culture, community benefit, economic, political and clinical governance factors were considered by research subjects to influence their business decisions in private hospitals. These categories acted as pillars forming the foundations of the social world as constructed by research participants. The next section of this chapter will cover the second stage of the data analysis which involved mapping the factors that were extracted from the data to form a framework for illuminating the object of inquiry. Deeper analysis was conducted by examining the links, interrelations, or connections between the different categories and subcategories of decision making factors in order to address the research question. This process provided patterned similarities and differences in the responses which were grouped in different frames.
5.4 Decision Making Frames

Using axial coding, the categories and subcategories generated from lay accounts were mapped and examined aiming to find links and relationships. The raw data included researchers’ notes and observations which were reviewed and compared with the different factors generated during the first phase of the data analysis. Common themes were noted keeping the research’s objective, which is to illuminate executives’ strategic decisions in private hospitals, to act as a focal point for the data analysis. Categories and subcategories were framed in terms of their location inside or outside the organisation and the ability of the executive to control or to change these factors.

By studying the interconnections and associations between categories and subcategories two types of frames were constructed from the responses: external and internal. A description of the formation of each frame will be depicted next.

5.4.1 External Frame

The external frame encompassed a number of categories and subcategories of factors that were identified by respondents as shaping executives’ strategic decisions and exhibiting the following criteria:

- Factors that are located outside the organisation,
- Factors that influenced private hospitals’ performances; and,
- Factors that could not be directly controlled by hospitals’ executives.
The decision making factors that were considered by research subjects as significant and were classified under this frame included: government legislations and industry standards, technology, health insurance and market. Although full control of these factors did not rest with private hospital executives, they still played a significant role in influencing their decision making. Most business relations in this frame are set or dictated externally in terms of standards, market size, cost and funding.

Research subjects acknowledged in their responses the increasing challenges in meeting “legislative regulatory standards”, the cost of medical equipment and consumables with advancement in technology, the growth in the healthcare market with limited number of medical specialists and the harder negotiations with private health insurers. The current circumstances in terms of funding was clearly described by one of the research subject as following “previously hospitals determined funding rate changes when necessary, now the principal change is that hospitals are now price takers rather than price setters” (Executive in the not-for-profit sector). The point of criticism here is that respondents were referring to these factors in a passive tone, implying their inability to change the course of development of these external forces. The researcher’s observation of participants’ body language during the interview noted the change in participants’ posture by adjusting their position and resting their back when discussing the subject of health insurers. As an executive, wearing the increasing cost of advancement in technology without being able to attract the right funding for it from private health insurers, was a dominant concern amongst responses.
A reference to the increase in the private healthcare market was noted by research subjects with the periodic introduction of incentives from the government encouraging the uptake of private health insurance cover. Again, these initiatives highlight the significance of the government as an external force that played a major role in shaping the size of the ‘pie’ of privately insured patients - in other words the market.

Participants alluded to another change in the consumer market reflecting the ageing population. This change in the population mix was seen by participants to increase the number of aged patients undergoing more technology driven procedures which presented more challenges to hospital executives.

Similarly, a strong interconnection was noted between meeting government and clinical policies and the economic factor. Failure to meet the legislative requirement and standards was perceived by respondents as essential in keeping the business functioning as a private hospital, and impacting therefore on hospitals’ financial performance.

It is apparent that all these factors are external forces driven by external professional health bodies beyond the control of private hospitals’ executives.

The next section will shed light onto the categories and subcategories that were framed as internal factors to the organisation.
5.4.2 Internal Frame

The external frame was constructed from factors located outside private hospitals’ radius of control. On the other hand, the internal frame included recognition of factors which belonged to the organisation and were managed by the hospital executives. Decisions made as part of managing these internal factors were able to change many aspects of the business, such as resource allocations, business flow and processes. Factors considered internal to the organisation were grouped into categories and subcategories.

The two dominant categories which were consistently identified by respondents were: the interpersonal and the cultural factors. These two factors were considered by the researcher as the core of the internal frame particularly when both the interpersonal and the cultural factors cannot be isolated.

Strategy, community benefit and financial performance were also grouped under this frame and in effect, could be seen as forming the three pillars of the organisation. Community benefit and profit generation constituting the platform that underpins the strategy formation for a “high performing organisation” which was described by several respondents as being one of their main organisational goals.

A thorough examination of the last three categories (community benefit, financial performance and strategy) revealed that these factors had their origin strongly embedded
in the internal frame but with significant ramifications externally. Categories
demonstrating these distinguished characteristics were grouped separately to form a third
type of frame which the researcher called the hybrid frame. This frame was named after
its functionality in fusing and linking both the internal and external frames. The hybrid
frame exhibited strong association with the external frame whilst being located internally
to the organisation. Decisions made by respondents and executed internally appeared to
produce internal outcomes with ramifications in the external frame. An innovation in the
 provision of care which is classified under community benefit in the internal frame, for
example, can nevertheless alter the government funding allocation for research projects
for the diagnosis or treatment of a particular disease. Similarly, attracting a new service
which is under the financial category of the hospital can alter the private hospital’s
market position in relation to its competitors by increasing its share of the market which
is located in the external frame.
These ‘decision making frames’ are examples of Schütz’s (1963) second-order constructs
that was referred to in the methodology chapter. By adopting abductive reasoning, these
second-order constructs were extracted from individuals’ meaning of the decision making
(first-order constructs).

After examining the three decision making frames that were identified from examining
the relationships and links between the categories and subcategories of influences, further
decision making themes have been extracted from the data based on respondents’
approaches at individual level to decision making.
5.5 Approaches to Decision Making

Earlier in this chapter, three groups of factors influencing executives’ decision making were extracted and constructed from the data: internal, external and hybrid. The researcher examined the relationships between the different categories and subcategories within these frames to better understand the variation in executives’ responses at the individual level. By interpreting the respondents’ constructed realities guided by the literature reviewed, the researcher identified three different individual approaches to decision making. Executives appeared to perceive their approaches to decision making as outcomes focused, as processes or as intuition. The question here would be whether these three approaches were mutually exclusive or might be variously used within one organisation or by one executive? First, each of these approaches will be depicted separately.

5.5.1 Decision Making as Outcome

When examining participants’ responses and the categories and subcategories that were identified in the open coding phase, a common thread was noted in the majority of responses reflecting the tendency of research subjects to approach the decision as an outcome-based more than being a process. This observation explains the difference in the timing of communication amongst participants’ responses. Participants who believed decision making is a process involved stakeholders early during the “making” of the
decision. On the other hand, the second group focusing on outcomes did not identify the need to communicate the decision prior to the decision being made. There was no evident trend differentiating the two sectors in their approach to decisions as outcomes. The majority of accounts were preoccupied with evaluation measures comparing set target figures with actual performance numbers to assess the outcome of the decision. Methods such as ‘investment return rate, key performance indicators and shareholders’ dividend’ were the three common measures of decision outcomes with the latter being mainly in the for-profit sector.

<table>
<thead>
<tr>
<th>Generally, the for-profit sector has greater sense of urgency and awareness of importance of decisions. The dividend is back to shareholders (For-profit executive 6).</th>
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<tbody>
<tr>
<td>The private for-profit is based upon commercial reality. If you can show good return and business case, you are managing and looking forward to delivering the objective (For-profit executive 3).</td>
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Participants in the for-profit sector appeared to be clearer and more consistent with their responses with the outcome of their decision being aligned with the organisational goal which was profit generation. However, with the exception of one respondent, the majority of executives in the not-for-profit sector who stated that fulfilling their mission is their number one organisational goal, did not appear to take into consideration their original mission in the evaluation of the outcomes of their decision. Their original strategy which was strongly linked with accomplishing their mission appeared to take a different angle at the time of decisions based on the participants’ own values, judgment and line of responsibilities. When prompted about this observation during the interviews, most participants alluded to the need for the hospital to perform financially to achieve the mission.
The influence of the original orders is not as strong as in the past. For the not-for-profit to continue to survive and to deliver their mission they need profit. There is no more discounting or subsidized rates in not-for-profit like before (For-profit executive 2).

You should be mindful that after all it is a business whose goal is to do these things: to be a high performing hospital with a high performing team delivering high performance of mission. However there are rules that we need to follow with governance and strategic issues overriding the decision. You always have to ask yourself whether your decision is strategic. Is this the business you want to be in? Is it your core competency in term of specialty? If it is not your core business, do some investigations to see whether it is profitable or not. Profitable does not necessary needs to be financial. It could be the reputation you gain from or ....speak for your organization. At the end of the day, not all business is a good business (Not-for-profit executive 7).

Furthermore, achieving a “close enough, good enough” outcome emerged from the not-for-profit accounts as being an acceptable management practice which was not identified amongst participants’ responses in the for-profit sector.

There are still expectations of outcomes in the not-for-profit sector but more acceptance of variation. There is tendency in compassion in the not-for-profit to go into passiveness and consider near enough as good enough (Not-for-profit executive 8).

Achieving the best outcomes could be hard. A good enough approach can work if you are satisfied and comfortable that you are meeting the criteria (Not-for-profit executive 15).

No one can get it all right, as long as you have higher proportion of good decisions than bad ones you will be right (Not-for-profit executive 4).

5.5.2 Decision Making as a Process

Whilst the majority of respondents approached decision making as outcome-based, the second group of participants appeared to follow a process when asked about decision making. Participants stated explicitly and implicitly a number of steps to follow during the decision making act. This approach to decision making as a process was supported by the researcher’s observations during the interview. Research subjects were
explaining the process by counting on their fingers the number of steps adopted during the process.

<table>
<thead>
<tr>
<th>What you would do is: 1) You create the right environment for good people; 2) Set the strategy; then, 3) Put the right people to the right decision (For-profit executive 12).</th>
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<tr>
<td>First we have to make sure the doctors are happy since they have greater influence in selecting the private hospital. Second, the health funds need to be considered followed by the business operators or board who support decision; Fourth, the staff should be involved in the decision and really you have the patient last (For-profit executive 13).</td>
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The process in the for-profit sector was revolving around the “individual” by creating the right environment for the right “people” to make the decision at any level of the organisation. On the other hand, the process was often referred to by respondents as “bureaucratic” in the not-for-profit sector with “less flexibility” and “less efficiency”.

<table>
<thead>
<tr>
<th>Private Not-for-profit is traditionally more like public management. Decision making is less flexible, more bureaucratic and more top heavy (Not-for-profit executive 7).</th>
</tr>
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<tbody>
<tr>
<td>In for-profit sector, the individual has more autonomy and feel more empowered. Good ideas take off quickly looking at immediate consequences. Decisions are based on sound business cases and information analysed to death (For-profit executive 16).</td>
</tr>
<tr>
<td>For-profit hospitals operate more efficiently and are narrow in the service profile more along production line. They are more focused at ward level not administrative (Nor-for-profit executive 9).</td>
</tr>
<tr>
<td>You manage more effectively in private for-profit (For-profit executive 16).</td>
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5.5.3 Decision Making as Intuition

When the majority of research subjects were considering decision making as an outcome or a process a minority had no explanation to their executive decision other than being their “gut feeling” as individuals. For this account, the emphasis was on the element of “trust” in the information and its source. Once the element of trust was established, the
rest was left for the gut feeling to decide, as stated by one of the executives during the interview: “A good decision is often the decision that makes me feel warm and fuzzy, as simple as that.”

In the closing question, the researcher was keen to further explore executives’ attributes as decision makers in private hospitals, in an attempt to unveil the individual’s role as a factor influencing decision making. The majority of the responses considered possessing excellent interpersonal communication skills to be a prerequisite for working and making decisions in a people business. This attribute was strongly advocated amongst research participants who considered the people factor when making decisions.

*Healthcare is a relationship business and requires an executive with excellent intercommunication skills. Yes, it is essential to bring the right decision but you have to gain the heart. You have always to be seen, be out there and involved in it (Not-for-profit executive 8).*

*You have to like people and be comfortable in dealing with them. It is important in this role to have good communication skills including listening skills. I always remember when I am at work or even in my own private life the importance of treating others the way I like to be treated. Just be open and honest and you’ll always be remembered as someone who has been fair and did the job honestly (For-profit executive 14).*

*The ability to get people on site is important. You need to talk to people and respect them. In reality as a CEO, I think your approach is better being consultative, softer, engendering pride in the organisation and visibility in how the organisation is going (Not-for-profit executive 15).*

On the other hand, research participants considered, to a much lesser extent, *having a strong financial understanding* to be essential in executives’ role as decision maker. In fact, one of executives who had the longest tenure in one private hospital stated:
By running a good caring hospital concentrating on the mission, the costs will take care of themselves and the business will be successful. This is an advice that I was given when I started in my job as a CEO and in turn I would pass it on to others in similar positions. You have to have a degree of compassion. It is hard to make business decisions. You have to always consider the consequences (Not-for-profit executive 4).

The researcher aimed to gain more understanding of the phenomenon of executives’ strategic decision making in private hospitals by exploring and shedding light on the factors that influenced executives’ decision making in this social context as interpreted by the social actors. Thus, the choice of the Interpretivist paradigm was considered as most suitable to answer this research inquiry. Since the individual factor cannot be separated from participants’ daily transactions, more insight was gained into the social actors at the individual level and their social world through their perceptions, which acted as a predisposition to their personal behaviour within the organisation. The synthesis of the key findings of this study produced a conceptual framework with practical implications for executives’ decision making and management of private hospitals.

5.7 Summary

This chapter conveyed the transformational phases adopted using abductive research strategy to generate a technical framework from lay accounts. The data generated was coded and analysed following open and axial coding techniques to form categories and subcategories. The researcher interpreted participants’ constructed realities. Subsequently, meaningful relationships between these categories and subcategories were created, and everyday lay accounts (first-order constructs) were converted into second-
order technical ones. Six factors were identified to be key influences in executives’ strategic decision making. Common themes were noted amongst these categories and subcategories of factors which were classified within the external, internal or hybrid frame. The data analysis was taken another step deeper by studying and comparing the interconnections and links between the different categories and subcategories. Three different approaches to decision making were formed based on outcome, process or intuition. The next chapter will cover the discussion and interpretation of the research findings.
CHAPTER 6

INTERPRETATION AND DISCUSSION

6.1 Introduction

This research study aimed to explore the critical factors that influenced executives’ decision making in the context of private hospitals. The Interpretivist paradigm was adopted in an attempt to find the meaning of this phenomenon as interpreted by the social actors and perceived by the researcher. In-depth semi-structured interviews were conducted by the researcher to collect the data required to answer the research question being \textit{what are the critical factors that influence executives’ decision making in private hospitals? And, why these factors are perceived by executives as significant when they are engaged in these social act of making business decisions.} The data generated from the research field was analysed using open and axial coding within an abductive research strategy.

The preoccupation of this study was to examine executives’ business decision making (agency) in specialised organisations (structure) referred to as private hospitals. Individuals’ approaches to this social phenomenon will be analysed in light of Structuration Theory and the common school of strategic management identified in the
literature. Individuals’ perceptions reflected institutional/structural phenomena as well as their own individual meanings. Studying individuals’ approaches to decision making and the organisational strategic school of thoughts simultaneously was an attempt to identify the factors that motivated executives in their choice making, in order to secure the present and the future sustainability of their hospitals.

The analysis of the literature firstly and the findings of this study secondly have allowed a framework to be developed to deepen the understanding of the critical aspects of the private hospital industry. The outcome of the data analysis was the construction of a conceptual framework with implications in daily management practices at individual and organisational level.

6.2 Executive Decision Making Framework in Private Hospitals

By adopting abductive reasoning, the researcher was able to construct ‘second-order constructs’ from “first-order constructs” which was extracted from the meanings of individuals of their decision making experiences as hospital executives. Using open coding, categories and subcategories of decision making influencers were identified as perceived by respondents in their social world. Further data analysis was conducted by exploring and studying relationships, interconnectedness and links between these categories and subcategories using axial coding. Common themes and threads were identified and grouped under internal, external and hybrid frames of decision making as discussed earlier in this chapter. People and cultural factors formed the core of
the internal frame. Strategy, community benefit and financial factors were in the hybrid system with origins in the internal frame and ramifications in the external frame. Political and clinical governance, technology, health insurers and market formed the external frame. The social reality as constructed by research subjects when engaged with the social phenomenon of decision making gave an insider view of executives’ unarticulated social practices (agency) and private hospitals’ industry structure. A conceptual framework (Figure 8) was developed from these lay accounts guided by the literature review.

**Figure 8.** Executives’ management decision making framework in private hospitals.
This decision making model aims to enlighten and to assist executives in decision making within these complex and specialised organisations. Giddens’ (1984) ‘duality of structure’ is used as the premise for the decision making model proposed in this thesis, to be relevant at both individual and organisational level, limited to the context (space) and time of the study.

This thesis does not seek to explore the rationality of the decision making but to depict the factors that influenced executive decision making and the way they interacted within the private hospital context. The meaning of these factors was examined in terms of their location within the structure and their perceived strategic values.

The research findings of this study have highlighted the diversity in the social actors’ approaches to the social phenomenon at individual level. Nevertheless, at organisational level there was a united view amongst the responses of the importance of strategic decision making based on the organisation wide strategic goal that was often referred to as mission in the not-for-profit sector.

This chapter enables the researcher to interpret and discuss the thesis findings that were obtained in previous chapters. Furthermore, the opportunity to compare and contrast the research findings with the literature reviewed around the research topic will be undertaken as the last step in the process of converting lay accounts into technical ones. The different sections of this chapter will be presented in the following sequence:

6.2 The meaning of the Research Findings
6.3 Implications for Practical Management

6.4 Implications for Existing and Future Research

6.5 Limitation of the Research Study.

6.2 The Meaning of the Research Findings

The key findings of this study can be summarised in the following points:

- Three main approaches to decision making at individual level, in Australian private hospitals, have been identified amongst executives participating in this study, comprising: decision making as a process, as outcome and as intuition.

- The critical factors that appeared to influence research participants’ decision making in private hospitals have been grouped in order of significance to form a framework encompassing: 1) *interpersonal* and *cultural* as the core of the internal frame; 2) *Strategic goal, financial performance and community benefit* as the three pillars of the organisation which originate in the internal frame, with ramifications in the external frame: and, 3) the external frame comprised of *technology, market, private health insurances, government legislations and industry standards*.

- The proposed decision making model generated from individuals’ perceptions tends to be relevant also at organisational / structural level, and applicable to both for-profit and not-for-profit private hospitals.
• The longevity of mission based not-for-profit hospitals appeared to be in the strength of the mission set by the founders more than the financial performance of these hospitals.

• The presence of the hybrid frame reflected the strategic nature of executive decision making. A two-dimensional approach tends to be adopted in the management of private hospitals: The present-future and the internal-external dimensions.

• Whilst satisficing was an acceptable decision making practice in private not-for-profit hospitals, for-profit hospitals appeared to seek optimisation which is a strongly supported concept by economic theory.

• Executives identified medical specialists as playing a key role in business development, but remained hesitant about medical specialists’ degree of involvement in business decisions.

6.2.1 Analysis of the Framework

The researcher developed a decision making model based on executives’ individual perceptions of their mundane social practices. This model was illustrated in the form of a framework which identified three frames of factors influencing this social phenomenon amongst executives in private hospitals: the internal frame, the hybrid and the external frame.

The internal frame consisted of the core elements of the organisation being the people (interpersonal factors) and the culture (cultural factors). The hybrid frame comprised the
three pillars of the organisation manifested in the organisational strategic goal, financial performance and community benefit. The external frame encompassed forces in the structure that were perceived by executives to be beyond their control and outside the boundaries of the organisation. These external forces included: market, government and industry legislations, private health insurances and technology. Based on Giddens’ (1984) description of the structure as “rules and resources recursively implicated in social reproduction”, this thesis suggests that, although the external factors are often perceived by executives as out of their control and forming a rigid structure, transformation and reform of this structure could occur when agents produce and reproduce their day-to-day actions, by managing and mediating the relations between the internal and external factors via the hybrid frame across time and space. However, in this concept of duality of structure, Giddens (1984) stressed the importance of the knowledgeability of executives who were involved in producing and reproducing their social world.

This treatise has translated the critical factors underpinning management decision making, as perceived at individual level, into a conceptual framework which can assist other executives in crafting their decisions to produce outcomes that shape the structural phenomena at organisational level. This inference is guided by Structuration Theory which primary concern is to identify “the ontological features of both ‘agency’ and ‘structure’, and their mutual dependence (Blaikie, 1993: 90).

The multifactorial aspect of this social phenomenon in private hospitals reflected the complexity of this industry particularly with the presence of third party providers.
encompassing medical specialists who are responsible for admitting patients and delivering medical care and private health insurances who reimburse the cost of the service.

Interpreting and gaining understanding of the meaning of this framework is best defined in term of its dimensions in space. A close examination of the factors and the way they were framed give reference to two points: internal and external, with the hybrid frame in the middle, acting like a permeable membrane diffusing the factors between both mediums. The presence of strategic goal on the pinnacle of this hybrid frame introduced the dimension of time to this framework. The concept of strategy was found in this study and echoed in the literature to have strong reference to the future. Based on these interpretations, the framework appeared to be two-dimensional with the present-future constituting the first dimension and the internal-external forming the second one. The following section of this chapter depicts the elements of these two dimensions based on the research findings of this study and also referring back to the reviewed literature.

6.2.1.1 The Present-Future Dimension

The research findings reflected the dichotomy between managing the present and the future through reference to operational versus strategic decisions respectively. The present and the future formed the time dimension that research participants often referred to implicitly when engaged in the social act of decision making. The negative consequences of making business decisions in the present without consideration of their future ramifications was reflected in participants’ frequent references to changes in
ownership of a large number of private hospitals in Australia with the Mayne Health Corporation experience being the prominent real life example. Mayne Health Corporation was trying to achieve the economy of scale in the provision of private healthcare, focusing on short-term measurable performance without considering the detrimental long-term outcomes. Mayne Health’s case example could be considered a reflection of the strong impact of economic theory on businesses and private hospitals were not exempt.

The commonly adopted key performance indicators and balanced scorecard as tools to measure business performance indicators amongst research participants was another sign of the strong economic drive in executive decision making. In fact, the interest in the literature for providing managers with tools to measure organisational performance was overwhelming (Proctor, 2006; Kaplan and Norton, 2004; Banker, et. al, 2001). Shapiro (1995) critiqued contemporary management theories and warned managers not to take on any fad management tool without choosing the approach which best fits the organisation.

The reference to quantifiable measures such as profit and shareholders’ dividend was dominant amongst the majority of participants’ responses when evaluating the outcomes of their business decisions particularly in the for-profit sector. Executives in the for-profit sector appeared to be more short-term focused, seeking quick returns on investments and surplus generation. With one clear goal in mind, executives in for-profit hospitals based their decisions operationally and strategically on ways to achieve this ultimate goal: profit generation. Their businesses operated more efficiently in a non-
bureaucratic system. Decision making was often favouring investment of resources at the coal face in an attempt to improve service provision and increase revenue generation.

Private for-profit hospitals did not have mission statements. The majority developed the organisation’s “way” of carrying individual duties which was adopted at all levels of the organisation. This practical way of running the business was applied at different levels of the organisational structure, from administrators to clinical staff delivering healthcare at the patient bedside.

The individual performance was highly valued in for-profit private hospitals and effort was made to retain quality ‘people’; saving as a result, the cost and effort of attracting new ones. Resource allocation in not-for-profit sector appeared to be a priority at administrative level rather than at clinical (patients’ bed side) level which was reflected in the “bureaucratic”, “hierarchical” and “top heavy” structure that research participants often referred to in the data collected. On the other hand, research participants in not-for-profit private hospitals focused more on the performance of the team, rather than the individual. More efforts and costs appeared to be spent in recruiting new staff rather than the retention of existing ones. This finding is in line with Reidenbach’s and McClung’s (1999: 22) work who claimed that:

Those organizations that can retain profitable customers are profitable. The reason for this is simple. Customer acquisition costs run five to ten times higher than retention costs. Those health care organizations that retain members will be more profitable than their counterparts that are chasing them out the door while feverishly looking for new numbers to replace the defectors at a higher cost.
Whilst executives in both for-profit and not-for-profit hospitals had patient care and profit as their current and future organisational goals, the not-for-profit appeared to manage their hospitals while being mindful of a third objective located at a different point in time: fulfilling the mission set by the founders. Creating a mission statement to frame what the business was all about and the organisational goal to be achieved, has become fashionable business practices amongst the majority of industries (Collins and Porras, 1998). However, the practical application of the mission in the business operation and decision making remained questionable. The research findings of this study confirmed executives’ understanding of organisational mission as a strategic goal located in the future. The lack of reconciliation of decision making at executive level with the organisational mission confirmed the claim in the literature of the inability of diversified mission statement to be of practical use (Bart and Hufer, 2004).

The research findings highlighted the longevity of the not-for-profit sector in the ownership of private hospitals which appeared to be more related to the founders’ commitment to the mission. The mission statements of these hospitals were faith based, with strong emphasis on social accountability. In this study, executives strongly believed that community benefit in the form of social accountability was the way to proclaim the mission in not-for-profit hospitals and what differentiated them from their colleagues in the for-profit sector. This belief confirmed the existing literature that acknowledged the vital contribution of the not-for-profit sector to the social capital (Lyons, 2001) to the extent that both the for-profit and the not-for-profit sectors were often referred to as “business” and “nonprofit” sectors respectively (Riggio and Smith Orr, 2004: 151).
Studying this finding in light of the work published in the Book Built to Last by Collins and Porras (1998: XVIII) would show that participants in not-for-profit private hospitals managed passively the “clock building” aspect of their organisations, as they stated:

The concept of “clock building” an organization with a strong cut-like culture that transcends dependence on the original visionary founders has aided a number of social-cause organizations.

These organisations were classified by Collins and Porras (1998) as visionary companies regardless of their financial performance. In this study, research participants in private hospitals appeared to acknowledge the importance of being financially viable but remained hesitant to maximise profit, since profit generation was not considered as part of their mission. The literature has warned business leaders from using words such as profit as part of their mission statement (Rigsby and Greco, 2003) which could explain executives’ reluctance of giving this factor the same weight as their colleagues in the for-profit sector. The majority of executives working in this sector appeared to be aware of the need to achieve the mission set by the religious orders. The word “mission” was often interchanged with “strategic goal”.

Another interpretation for participants’ behaviour in not-for-profit hospitals could be related to mission statements being more faith based than business focused. Several publications in the business literature advocated the use of organisational missions as strategic tools (George, 1999; Glasrud, 2001; Mullane, 2002); thus, creating a dilemma amongst executives between profit creation and fulfilment of the mission set by the founders. The research findings confirmed the differentiation of the not-for-profit sector
in the private hospital industry to be in their core ideology represented in their mission statement and values. However, Collins and Porras (1998: 201) did not consider the possession of mission statement as the essence of visionary companies.

The longevity of not-for-profit private hospitals appeared to be the legacy of the past as described in the following statement of one of the research participants.

*The dynamics of not-for-profit organisations are very different driven by things that are considered important which others have done. The structure is laid down years ago and is hard to change, held by the inner sanctum (Not-for-profit executive 1).*

When the presence of a mission and social accountability came at no surprise in the not-for-profit sector, the novelty in this result was in early signs of community awareness that appeared to emerge in the for-profit sector. For-profit executives in this study interpreted their contribution to the community and society, through offering healthcare services to community members during their hospitalisation. The use of terminology such as community members is a step away from the traditional vocabulary often adopted in the corporate world such as the terms consumers, clients and customers.

Whilst executives in private not-for-profit hospitals appeared to consider their mission as their organisational strategic goal, it was surprising to find no reference to ways of measuring the achievement of their mission when evaluating the outcome of their business decisions. Participants considered “fulfilling the founders’ mission” as their ultimate goal and ‘raison d’être’. However, all participants (with the exception of one) did not appear to reconcile their business decisions with the organisational mission. This finding contradicted calls in the literature to use the mission statement as a baseline and a
starting point which will lead the organisation toward the set goals (Mintzberg, 1997; Glasrud, 2001). Operationally, mission appeared to be playing its part in the organisation vertically as an addition to the core business rather than being integrated horizontally. Not-for-profit hospitals often employed a dedicated staff member who is responsible for proclaiming the mission, rather than including this task within the work portfolio of each employee at different levels of the organisation.

Executives’ understanding of the role of the mission was framed within the boundaries of their organisations and reflected only in the organisational internal culture. This approach echoed Robbins’ et. al (2004) analysis of the organisational culture to be derived from the founder’s philosophy. Starting with the selection criteria at the original recruitment phase, Robbins et. al (2004) claimed that people within the organisation undergo a socialisation process to implant the organisational values that lead to formation of the culture. Signs of enacting the organisational mission and living the values through daily interaction and transactions between employees, customers and other stakeholders were made explicit by research subjects. However, the ability to extend the role of the mission beyond the boundaries of the organisation remained missing in the business transactions of several accounts.

In an increasingly commercial environment, the mission of not-for-profit hospitals could create a competitive advantage for these organisations. It has the ability to differentiate these organisations by increasing its marketability to stakeholders particularly medical specialists who tend to be the main stream for revenue generation.
A deeper analysis of executives’ understanding of the role of mission revealed the need to further integrate the meaning of the mission in the not-for-profit sector with the way the business is operating at executive level. Proclaiming the mission through integration with daily operations has the potential to retain the community benefit and the financial performance that constituted the two other factors of the hybrid frame of the decision making framework generated by this study. Strategy driven decisions have flow on effect internally and externally to the organisation which confirms the position of the strategic goal factor also in the hybrid frame.

Being an executive in a mission-based, not-for-profit private hospital does not warrant a different decision making framework particularly when ‘profit’ was found to be by this research study, to be one of executives’ aim in this sector. The contradiction in participants’ responses between the strategic goal and the business operation in the not-for-profit sector could be putting the sustainability of the hospital and its mission at risk. Whilst historically the founders were clear about the rationale for setting up private not-for-profit hospitals, the new executive is left with the legacy of the past, the challenges of the present and the uncertainty of the future. When a decision making framework in the form of a checklist was found by the researcher amongst not-for-profit private hospitals’ organisational documents, its scope and application appeared to guide major decisions at Board of Directors level rather than at executive level.

The analysis of the research findings showed two common goals between the two sectors: patients’ care and profit generation. The existence of the mission as a third major goal
for the not-for-profit sector appeared to create a different mind-set amongst executives when managing these hospitals. Profit turns into a secondary goal and “close enough, good enough” decisions appeared to be the norms. Daily executive business decisions in not-for-profit private hospitals appeared to be made based on today’s operational needs more than the long-term strategic goal or organisational mission. Executives in these hospitals tend to seek short-term changes to retain the status quo, what Donaldson (1997) referred to as a “quick fix” approach. The focus on short term financial outcomes and executive members’ self interest were identified by Sayles and Smith (2006) as key motivational forces. Bower and Gilbert (2007: 75) referred to this behaviour as “roles determine perspective” illustrated in the tendency of individuals to make decisions based on what’s pertinent to the success of their operating roles.

Following this management approach, the sustainability of these hospitals and the fulfilment of their mission become questionable. One of the research subjects clearly stated that “variations from targets are acceptable in the not-for-profit sector.” Research participants’ reference to “surplus invested back into the organisation rather than dividend to shareholders” cannot continue to be used as a key differentiator between private for-profit and private not-for-profit sectors in order to justify certain business decisions in the latter. The profit margin earned from these hospitals is required to be injected into social accountability and other community projects. To deliver its mission and to contribute to social capital, the not-for-profit sector is largely in need of margins earned from their business operations. For these organisations to be treated as private business enterprises, sound decision making that leads to favourable financial outcomes
to strengthen their financial balance sheet will be the first step in the process of achieving their mission.

The outcome of a decision that meets today’s objective does not guarantee attainment of the long term goal if the latter is not factored in the equation when processing the information during the social phenomenon of choice making. Therefore, similarly to their colleagues in for-profit hospitals, executives in the not-for-profit sector need to think of maximising profit generation while executive business decisions are made. The additional surplus generated by these hospitals would provide the necessary funds through the usual budgetary process in order to contribute to social accountability projects.

Ensuring a viable business was the common response identified amongst executives in not-for-profit sector to cope with the escalating costs and increasing market competition. Despite these pressures, only few research participants in the not-for-profit sector appeared to maximise their financial performance and profit generation. Executives’ responses were a reflection of the concern noted in the literature about the not-for-profit sector making surplus whilst they were tax exempt because of their not-for-profit status (Lyons, 2001). To be able to continue the social capital value, it is essential for the not-for-profit private sector to gradually shift towards generating economic value particularly with the increasing competition in the commercial private market environment. Should executives not apply general business principles to private not-for-profit hospitals, the questions that arise here would be what differentiate these private hospitals from public
not-for-profit hospitals? And, should the private not-for-profit sector remain managed with a public mentality, why would the two sectors not merge into one? Future healthcare reforms by the federal government could speed this merger, creating therefore a clear delineation between private hospitals and not-for-profit hospitals.

The concept of operationalising organisational mission is by no means a novel contribution to knowledge, but the uniqueness of this study lies in the link between the approach to decision making in mission-based private hospitals with the executives’ perceived meaning of mission. Bard and Hupfer (2004) attempted to provide practical examples and blue prints for developing an organisational mission incorporating the different factors that were significant to the mission statement and had a positive impact on performance. Bard and Hupfer (2004) used questionnaires to collect executives’ perception of behavioural, financial and mission performance indicators. This Positivist’s approach allowed the collection of lists of mission constructs without gaining a deeper understanding of their true meaning at individual level. Seven constructs were drawn using 23 mission statement comprising (Bard and Hupfer, 2004: 99):

- Business definition
- Benefactors (general corporate goals)
- Competitive orientation
- Grand inspiration (purpose, value and vision)
- Location and technology
- Concern for supplier
- Concern for survival.

The research findings demonstrated implicitly and explicitly the need for a profit to be generated operationally for private hospitals to remain viable, let alone to deliver on their mission. Whilst research participants in private for-profit hospitals were clear about
their organisational strategic goal, and the economic imperative behind their decisions, executives in not-for-profit hospitals remained struggling in striking the right balance between financial performance and social accountability. The research findings showed that executives’ decisions made in this sector are often based on a “close enough, good enough” approach that confirmed Simon’s (1997: 119) satisficing concept in administrative behaviour.

Studying the research finding in light of Simon’s bounded rationality indicates the tendency of Simon’s theory to be applied in the not-for-profit sector but far from being accepted in for-profit private hospitals. Frequent changes in ownership of for-profit private hospitals in less than a decade has occurred with corporate groups such as Health Care of Australia, Mayne Health, Affinity, Ramsey, Healthscope and Healthe Care Australia to name a few. These series of acquisitions reflect the inability of this sector to accept executive decisions, that lead to “close enough” rather than “good enough” results. These real industry examples from the industry strengthen further the findings of this study which indicated the focus of private for-profit hospitals to be on achieving positive financial outcomes short term.

The question that needs to pertain when making executive business decisions is: what’s best for the company? (Bower and Gilbert, 2007). This study confirmed calls in the literature (Lyons, 2001; Robbins, et.al, 2004) advocating the importance of goal setting in business management. At organisational level, having a strategic goal meant ensuring the viability of the business today and tomorrow. This outcome would imply satisfying the
shareholders in the for-profit sector and proclaiming the mission in the not-for-profit sector. However, at individual level, the mind-set that an executive possesses, remains the determinant of executives’ stand point when making business decisions and its position within the decision making framework that emerged from the research findings.

Competition was identified by the research findings to be equally driving both for-profit and not-for-profit private hospitals into measures to protect and to increase their market shares. However, shareholders’ dividend appeared to remain a strong motive driving for-profit executives to seek maximisation of profit and optimisation of services. This finding confirmed claims in the literature that competition and shareholders’ scrutiny were the two incentives keeping executives in the for-profit sector striving for optimal performance (Lyons, 2001). In light of this finding, one will question the impact of the revolutionary stakeholder theory on the business operations of private hospitals. From the lengthy list of stakeholders identified by participants including medical specialists, patients, staff, community, suppliers, and health funds to name a few, shareholders’ satisfaction remained implicitly and explicitly executives’ priority. Surprisingly, satisfying business owners by maximising organisational financial performance did not appear to have the same weight in the not-for-profit sector. This approach could be related to executives’ beliefs that the ultimate reason for the existence of these organisations is their ‘mission’ not their ‘margin’.

However, this standpoint should not prevent executives in the not-for-profit sector to apply business management principles similar to their colleagues in the for-profit sector.
The generated surplus would satisfy all stakeholders enabling, for example, investment in the latest medical equipment which is an added value to the medical specialists in the provision of care to their patients and the community overall. Furthermore, allocating a percentage of the financial margin generated to society and other community based projects would assist not-for-profit hospitals in proclaiming their mission. A shift in the paradigm set by the founders of these not-for-profit private hospitals is becoming a necessity for their business and their mission to exist. The increasing competition in the private hospital industry is gradually driving the need for executives in not-for-profit to manage with more focus on the commercial reality of their business. Failure to consider maximisation of profit when making executive business decisions due to the ‘not-for-profit’ status of private not-for-profit hospitals, could leave the future sustainability of these hospitals in question.

The research findings indicating early signs of corporate social responsibility in the for-profit sector and a paradigm shift towards economic awareness in mission based hospitals show the potential of these two sectors to adopt strategies that could improve the longevity of the for-profit sector and the financial performance of not-for-profit private hospitals.

This implication for the for-profit sector confirms the call in the literature by Schacter (2004: 8) for a new model of corporate management based on stakeholder theory with an increased interest of corporations in non financial performance:

This model depicts a world where the “corporate interest” that is supposed to be served by executives, and protected by the board of directors, is defined not only
by the expectations of shareholders, but also by the expectations of a wider range of stakeholders.

Furthermore, Riggio and Smith Orr (2004: 152) hypothesised that a collaborative approach could be the recipe for organisational long term achievement. Organisations with a social imperative that link their survival to the well-being of society may be better positioned in the long run to maintain their human and economic viability.

6.2.1.2 The Internal / External Dimension

Comparison between executives’ responses from both sectors revealed a common denominator. Both for-profit and not-for-profit hospitals strive to achieve the same two goals consisting of: profit generation and patient care. Whilst the former was discussed in the first section of this chapter as part of the present-future dimension, the latter will be explored further in this section. The controversy in relation to profit generation appeared to be in the decision makers’ approach to this economic imperative based on the hospital tax status. This study demonstrated that the private sector in which research participants were working, whether for-profit or not-for-profit, had the tendency to determine the intensity of this goal. Nevertheless, patient care remained constant regardless of the sector in which the decision maker was working at the time of the interview. The research findings were consistently demonstrating no difference in the commitment of both for-profit and not-for-profit to achieve “excellence” in the delivery of patient care. This commitment to the provision of quality healthcare appeared from the data generated to have two key motives: meeting government and industry legislative requirement and maintaining a strong reputation and market positioning. Firstly, complying with
government legislation and industry standards are essential criteria in Australia for the business to be registered and to remain operating as a private hospital. Secondly, by retaining a good reputation and being renowned for excellence in the provision of healthcare services, most respondents believed that their organisations would be considered “magnet” hospitals that attract specialists, staff and patients alike. As a result, a better market position is attained, and therefore more business will be generated.

*Both medical specialists and patients would be keen to use the hospital if you build a good reputation (For-profit executive 13).*

Referring back to the position of these factors within the framework, patient care appears to be located in the internal frame and market, government and industry regulatory bodies positioned in the external frame, thus creating a second dimension referred to as the internal-external frame. Although the provision of patient healthcare is considered a service delivered internally, the quality of that service appeared to determine the external strength of the hospital in the industry. The external environment of private hospitals was revealed by this study to be reciprocally influenced by decisions made internally to the organisation. For example, executives’ decisions to specialise and rationalise services internally were considered by research participants to improve efficiency and increase bargaining power. The profit generated could be put towards capital investment in technology acquisition.

Other examples noted by research participants that reflected the internal-external dimension were the claims that decisions for mergers and acquisitions are based on their beliefs that large private hospital groups can drive better health fund negotiations and
achieve economies of scale. This finding echoed calls in the literature by Donaldson (1996) who considered environmental situational factors, such as technology and strategy, to impact from outside on the organisations that tend to restructure from the inside to fit in the new external environment. The alignment between the internal and the external environment was demonstrated in this study with the emergence of factors that formed the hybrid frame in the decision making framework.

The hybrid frame acted as a window opening the internal organisational environment to the external one and ensuring their alignment. For example, executive business decisions influencing the provision of patients’ care inside the hospital is translated into community benefit when considering this patient as a community member. As a result the community benefit that originated internally demonstrated its advantages externally. Nevertheless, Collins and Porras (1998: 215) stated that “attaining alignment is not just a process of adding new things; it is also a never-ending process of identifying and doggedly correcting misalignments that push a company away from its core ideology or impede progress.”

Rather than being passive, reacting to changes to external factors, the availability of a hybrid frame provided executives with the ability to make decisions internally that could impact upon the positioning of their organisation externally. This framework confirms the concept of “competitive strategy” that was introduced by Porter (1985: 2) who explained its role as to “not only responds to the environment but also attempts to shape that environment in a firm’s favour.”
Orchestrating the internal factors, while being mindful of their ramifications on the external factors, has the tendency to put private hospitals in the lead strategically. In other words, alignment of the executive decision making internally to the organisation with its environment presents opportunities for impacting the external factors which usually are not under the direct control of executives in private hospitals. Therefore, while managing their internal environment, executives’ awareness of the external environment is integral to shaping the hospitals’ future and the healthcare industry as a whole. For example, by acquiring advancement in technology which allows the introduction a new treatment options for community members, hospital executives could lobby the government and heath funds for new funding schemes or refinement of existing ones. This approach could assist in reducing the burden of ever increasing costs associated with advancement in technology. Nonetheless, blind adoption of technology is an organisational risk reflected in the warning in the literature to avoid the use of the latest technology if it does not fit with the strategy and the operation of the facility to its greatest potential (Porter, 1985; Swayne, et.al, 2006).

This awareness of the critical internal and external factors is of specific value particularly when making executive business decisions. Bazerman and Chugh (2006: 90) warned executives from falling into the traps of their “bounded awareness” which occurs “when cognitive blinders prevent a person from seeing, seeking, using, or sharing highly relevant, easily accessible, and readily perceivable information during the decision-making process.” Executives often ran the risk of not recognising opportunities or
changes in their environment when focusing heavily on the issue at hand (Bazerman and Chugh, 2006). Knowledge of the external factors empowers executives in private hospitals to make informed decisions that contribute to the strategic development of their organisations. Government legislations and industry standards, market, technology and health funds formed the external frame of private hospitals.

Whilst economic theory advocated the need to collect all information required for making a decision, Bazerman and Chugh (2006) stressed the need not only to see and to seek information but to use and to share this information. This approach confirmed the research findings of this study which demonstrated that the knowledge required for executives to make business decisions in private hospitals was far from being limited to their internal environment. The challenge of this multifactorial aspect of choice making was in the efforts made by private hospitals’ executives in seeking information beyond the “walls” of their organisations. The finding that executives were relying primarily on internal sources to make strategic decisions had left Frishammar (2003) wondering whether in reality this was related to the low sensitivity that executives have towards information other than what they are actively seeking. Robbin, et.al (2004: 147) referred to this situation as “availability heuristic” which is defined as “the tendency for people to base their judgement on information that is readily available to them.”

Whilst cultivating an awareness of available information was seen by Bazerman and Chugh (2006) as possible, Simon (1997) acknowledged the limitation of the administrator in being able to collect and analyse all available information. Simon (1997) referred to his theory as “bounded rationality” which at the time was a diversion from the economic
theory. The dichotomy between the economist and the administrator was clearly illustrated in the literature review chapter (Figure 4).

The research findings identified the core element of private hospitals being the people who formed the culture of the organisation. Involving these key stakeholders appeared from the research findings to depend on the executive’s individual approach to decision making and the school of strategy adopted, with the exception of medical specialists’ involvement. This approach appeared to be based on executives’ previous personal experience and beliefs. The data generated did not show any differences in participants’ perceptions of medical specialists’ involvement in business decisions between both private hospital sectors. Participants in for-profit and not-for-profit private hospitals remained hesitant to engage medical specialists in business decisions, yet they admitted explicitly their big “stake” in the business. Medical Specialists’ involvement in business decisions were not shown to be different across executives’ approaches to decision making.

6.2.2 Different Approaches to Decision Making

Drawing on the findings of the study and supported by the literature, three key approaches to decision making have been identified comprising of: decision making as a process, as outcome and as intuition, with the two former approaches being the dominant ones. Using the strategic lens at an organisational level, a deeper analysis of the two dominant approaches emerging from the research findings provided nothing, but a
reflection of the emergent and design schools of strategy: “Those with strategies that are planned, and those that arise from within an organization’s experience, beliefs and culture” (Suutari, 1999: 12).

Studying executives’ approaches to decision making in light of the organisational strategy will illuminate the factors that come into play during this social act.

6.2.2.1 Decision Making as a Process and the Emergent School of Strategy

Executives who considered decision making as a process engaged staff at all levels of the organisation similar to the emerging school of strategy that was strongly advocated by scholars such as Mintzberg (1990). Strategy was not necessarily generated at executive level but was initiated at any level of the organisation often following a bottom to top approach. This style of decision making was consistent amongst research participants who listed the “people factor” as one of the main factors influencing their decisions. The emphasis was on the individual’s performance rather than the team. Visionary staff members were encouraged at all levels to be involved in decision making and to put ideas forward that will attain positive financial outcomes. “Good ideas take off” stated one research subject from the for-profit sector. This finding confirmed claims in the literature that the organisational emergent school of strategy would seek the participation of firms’ personnel using their previous experiences and past performances (Ashmos, et.al. 1998). Using case studies, staff engagement at individual level has proven, in the literature, to be “the basis for achieving the organisation’s mission and vision” (Goonan, 2007: 44). This view of involving employees and other stakeholders is in line with stakeholder theory
that advocates communication with stakeholders as an obligation of companies’
executives (Phillips, 2004).

Whilst executives advocating this style of decision making encouraged staff participation,
the degree of engaging Medical Specialists remained debatable amongst the responses. A
sense of caution appeared in the findings about the extent to which the Medical Specialist
should be involved in the decision prior to being finalised. The responses were spread on
a continuum with “definitely involve the medical specialist” to “medical specialists
should not be involved” located at either ends of the continuum. The data showed that
the majority of executives remained hesitant to consult with medical specialists prior to
making a business decision. Omitting this step of the process was surprising, particularly
when a number of executives falling into this category of decision making admitted the
influential role that medical specialists played in attracting business to private hospitals.

The integral role that medical specialists played in the private hospital industry has been
considered by the Productivity Commission (1999: XIV) as the first key differentiator of
the private hospital market from many non-hospital markets:

In consultation with their patients, doctors make most of the treatment decisions
and therefore have a major impact on the demand for a private hospital’s services.

This claim provides executives in private hospitals with the essential ingredient for
running successful business ventures. Embracing medical specialists in a hospital’s
vision could assist the attainment of both organisational goals and medical specialists’
objectives. However, integrating private hospital’s goals with medical specialists’
objectives is an applied art requiring a skilled executive with the knowledge of what really matters in private hospitals. Forming this business partnership with medical specialists could strengthen their commitment to the hospital which could consequently increase a private hospital’s strength to:

- Negotiate with health funds;
- Influence government and industry policies;
- Achieve better market positioning.

Another added value in early stakeholders’ involvement was to facilitate the implementation process of strategic decisions (Eisenhardt, 1999; Ashmos, et.al, 1998). With people and culture forming the core of the framework of influencers, the delineation in the medical specialists’ role within the people factor can be detrimental to the culture and the organisation as a whole. After all, medical specialists were considered by the majority of research participants as customers and key stakeholders to private hospitals. The lack of the consultative approach runs the risk of diminishing the sense of ownership and loyalty. Bower and Gilbert (2007: 77) stressed the integral role the customers could play in the development of strategic decisions:

Customer decisions can play a huge role in real strategy formation, particularly in businesses with a few very powerful customers. Companies that stay close to their best customers give them a virtual veto on product development and distribution.

The value gained from customers’ participation was echoed by Koch (2001: 139) to be an important ingredient for the route to success as per his statement below:

Decisions tend to be made well away from the customer front line, in the chief executive’s suite or the board room. They are meant to benefit the customer, but given the distance and the differences in perspective, it is a safe bet that the
decisions won’t achieve the desired effect. There are two remedies. One is to move the decisions closer to the customer, ideally to have the decisions made by the people who deal with customers daily, or even by the customers themselves. These don’t include decisions on issues such as pricing, where the customer’s interests conflict with the supplier’s. I mean decisions on new products, on how production and service are organized, and on everything to do with customer value except pricing and margin decisions. The other remedy to insure that the decision makers, especially the chief executive, are in daily contact with customers. In my experience the first remedy, although radical, is more realistic than the second.

Studying the findings of this research in light of stakeholder theory revealed the ongoing debate witnessed in the literature about its contribution to favourable business outcomes (Koch, 2001; Bower and Gilbert, 2007). The instrumental and normative approaches of stakeholder theory identified in the literature (Thomas, 1999; Donaldson and Lee, 1995) could both be applied to management practices in for-profit and not-for-profit private hospital sectors respectively. Social accountability in running the business of private hospitals particularly in not-for-profit sector mirror the calls of stakeholder theory to reach beyond the financial bottom line. On the other hand, in this ever increasing competitive market, building on the loyalty of stakeholders could ensure the alignment of their objectives with organisational strategic goals thus impacting financial outcomes.

The research data demonstrated the big “stake” that medical specialists possess in the private hospital business. Without communication and consultative approach to executive business decisions, medical specialists would find it difficult to develop a sense of ownership and loyalty and would therefore remain floating seamlessly between different private hospitals using their power to influence business decisions through the market factor located in the external frame. Executives following this approach ran the
risk of leaving the lever in the control of medical specialists who become in command of the market positioning of the hospital.

Whilst the research findings debate the level of medical specialists in business decision making, the literature strongly advocated the customers’ involvement (Reidenbach and McClung, 1999; Robbins, et.al 2004). However, this involvement in the literature was seen to take extreme approaches based on, the skill of the executive (Lyons, 2001).

Private hospitals require an alternative way of encouraging stakeholders’ participation such as adopting the Value-Performance Chain (Reidenbach and McClung, 1999) which tends to be located in the middle of the continuum of stakeholders’ involvement. Using such tools ensure that medical specialists are not considered outside customers with their satisfaction only measured through surveys, or seen to be taking over the hospital management to full fill their own agendas.

6.2.2.2 Decision Making as Outcome and the Design School

Executives who adopted the approach to decision making as outcome expected their decisions to be executed by their staff at different levels of the organisation. This follows the top-to-bottom approach adopted in the long range planning strategy (Pearce, 1981).

It came as no surprise the absence or limited involvement of stakeholders in private hospitals where executives followed this approach to decision making. Based on the planning model, decision making follows a linear sequential pattern with executives involved in seeking information, analysing, evaluating, and making choices before proceeding to implementation (Richardson, 1994). This school of thought claims that
involving personnel other than executives would make strategy more focused into daily operational issues and would result in the loss of the grand strategic objectives (Pearce, 1981).

It was apparent from the research findings that participants in these organisations focused on quantifiable measures often referred to in the literature (Kaplan and Norton, 2004) as key performance indicators at organisational macro or micro level. Certain publications have emerged warning about adopting management tools that do not fit a particular organisation (Shapiro, 1995). Whilst key performance indicators and other methods of decision making and management have been widely published and applied in the management of many organisations, the question remains in the long term strategic outcome of these decision making tools. Despite the efforts made in the literature to convert intangible outcomes into measurable ones, the concern remains in the ability of these tools to factor short term losses for long term gains.

The research findings confirmed the preoccupation of the majority of research participants particularly in the for-profit hospital with increasing their profit to maximise dividend to shareholders today. The risk in private hospitals remains in making business decisions based purely on economic imperatives without prior consultation and communication with medical specialists.

The Mayne Health way of managing of private hospitals could be interpreted as an example of decision made based on outcomes only, whilst forgetting the process in the
middle to get to the target. Involving key stakeholders impacted by the decision facilitate the execution of the decision. Mayne Health’s management tried to introduce general business concepts to private health care such as achieving economy of scale and centralisation that could have worked should a consultative approach was adopted by involving medical specialists in the early phases of the decision making. The operational success of today’s financial performance, for example, ended up costing Mayne Health a strategic failure (Lyons, 2001).

The research findings demonstrated that executives in not-for-profit hospitals were slowly following the ‘footsteps’ of their colleagues in the for-profit hospitals, with the majority of respondents in this sector identifying the need for having strong financial balance sheets and good market position. Despite the weight given by executives in the not-for-profit sector to the organisational mission as a strategic goal, its role was not mentioned by participants amongst the factors influencing decision making (with the exception of one). There was a strong call in the literature advocating the use of mission as a strategic tool (Glasrud, 2001) rather than statements on walls. The minority of executives who considered the organisational mission in their decision appeared to reconcile or align the decision with the mission after the social phenomenon of choice making has occurred. This practice does not guarantee full integration of mission with executive decision. However integrating the mission whilst the decision is forming has the tendency to increase the longevity of the organisation, by incorporating what is best for the organisation long-term rather than meeting short-term agendas. Whilst the findings of this study showed an effort from a minority of executives to realign their
strategic goals with their mission, the calls in the literature have been to use the mission as a baseline and platform to generate future organisational objectives (Glasrud, 2001). This finding reflects the gap in the literature that scholars have tried for decades to fill, by producing publications warning from misusing their mission or reinforcing that their “mission statement has a mission” (Glasrud, 2001: 35).

6.2.2.3 Decision Making at the Individual Level

The data generated from the research field illustrated two different approaches to executive decision making amongst research participants working in different private hospitals. However, no specific trends of approaches to decision making were noted to be linked to a particular private sector, which suggests the executives’ influence at individual level when immersed in this social act.

The research findings demonstrated the presence of a third approach to decision making adopted by a minority of research participants. This approach is known as intuition. The concept of intuition is strongly supported by the literature as an alternative decision making method (Robbins, et. al, 2004; Gladwell, 2005; Goodman and Collier, 2007). Intuitive decision making relies simply on the “gut feel” to make decisions. By following this approach, social actors use their own intuition overriding the influences identified in the decision making framework developed by this study. Individuals with this characteristic are often natural and cannot be guided by a framework as identified in the literature by Buchanan and O’Connell (2006). Recently, the growing controversy in the
literature has been attempts to create a process for intuition by making it akin to a skill that could be gained with experience (LeGaut, 2006).

The interesting finding in this approach is participants’ emphasis on the element of “trust” in the information available to them at the time of making decisions. For research participants, the short time it takes to make an intuitive decision necessitated the availability of information from a trustworthy source. The element of trust in decision making was also found by Mintzberg (1990: 9) to be an executives’ solution for approving projects:

One common solution to approving projects is to pick the person instead of the proposal. That is, the manager authorizes those projects presented by people whose judgement he or she trusts. But the manager cannot always use this simple dodge.

This precaution measure implied the reluctance of the majority of executives in private hospitals to base their business decisions on intuition alone. It was apparent in the research findings the absence of time pressure as a factor impacting on business decisions in private hospitals. Working in these circumstances, executives could afford more time to think and analyse the information on hand prior to making a decision. This finding confirms claims in the literature advocating a mix of skills in strategic management requiring the use of thinking, analysis and intuition (Swayne, et. al, 2006).

An attempt was made in this thesis to explore, at individual level, research participants’ perception of other personal attributes required for fulfilling their decisional role as executives. Possessing people skills was high on executives’ list of attributes required reflecting the significance of the interpersonal factor that emerged from previous
questions. The people factor represented the core of the decision making model around which the remaining factors influencing executives’ decisions were positioned. This finding stressed the importance that communication played in the decision making process or execution.

Whilst this study found interpersonal communication skill to be embedded within the decision making system, Mintzberg (1990: 7) considered the first category of managerial role that is the basis for information sharing which in turn was considered to be the “basic input to decision making.” In fact, communication skills were often considered in the literature to be the corner stone for a better performing business with clear strategic direction (Mintzberg, 1990). Communication has the power to distract people from the problem of “what decision to make” to the bigger problem of “how to make decisions” (Zaleznik, 1992: 20). The ability to communicate the decision, whether early in the planning process or after the decision is being made, tends to indicate the first step in the beginning phase of the execution. The argument that this finding generates is the potential variance in the degree of stakeholders’ ownership between early and late communication during the decision making process. The latter could be interpreted as a “one-way” information delivery rather than actual communication, which could be of concern particularly to medical specialists who have control over the management of patients’ episodes of care in Australian private hospitals (ABS, 2006).

This finding could explain the real life example witnessed in the industry involving the sell out of Mayne Health hospitals nationally and internationally. Despite the
controversy in the literature about the benefits of stakeholder theory and the definition of stakeholders (Friedman and Miles, 2002; Mitchell, et. al. 1997; Stenberg, 1996), making major management decisions without key stakeholders’ involvement (in this case medical specialists) has proven to be detrimental to the private hospital’s business.

The second attribute which participants considered to a lesser extent as an essential skill for executives’ decision making was strong financial understanding. However, this financial knowledge at individual level did not appear to be of high significance considering the weight that research participants gave to profit generation as an organisational goal. This finding confirmed further the nature of private health care which was described by the majority of respondents as people’s business.

The knowledge and capability of executives as agents producing and reproducing activities within their structure across time and space was considered by Giddens (1984) to be fundamental in his Structuration Theory. Similarly, manoeuvring the factors in the decision making model that was developed by this study would require a knowledgeable and capable executives, who can manage the factors in the internal and external frame. These repeated mundane actions could produce and reproduce outcomes and change in the external frame for the strategic benefit of the hospital. The next section will further cover the implications of these research findings for practical management.
6.3 Implications for Practical Management

The research findings provided a snapshot of the private hospital industry in Australia at the time of the research through the interpretation of social actors’ own worlds. The existing body of knowledge covered in the literature review (Chapter 2) on executives’ decision making was broad, often lacking the rigour of one specific industry, particularly private hospitals in Australia. The originality in this thesis lies in the ability to depict factors influencing management decision making in the specialised industry of private hospitals in Australia using an Interpretivist approach and Abductive research strategy.

The research findings are of practical value to existing and new executives joining this industry. The conceptual framework that emerged from this study represents the “rules and resources” (Giddens, 1984: 377) of the private hospital industry which executives can seek and adapt to make an informed executive decision that will be of benefit to the organisation short-term and long-term. This study aimed to illuminate the different elements that distinguished the private hospital market from other non-hospital markets. Awareness of the critical factors that underpinned business decisions in this specialised field would assist executives in making strategic operational decisions which lead to incremental progress with every decision towards the organisation’s overall strategic goal.

Whilst a number of identifiable factors influencing executive decision making in private hospitals had similarities with factors already existing in the literature, the difference
remained in the attempt to find a relationship between these factors and the executives’
approach to decision making. The three approaches identified in this study including
decision making as a process, outcome or intuition, were covered in some decision
making literature but hardly in light of the different schools of strategy.

The limitations of the literature reviewed tend to be in the delineation of each theoretical
approach to decision making based on the discipline from which it derived. Cognitive,
economic and administrative behavioural approaches were the three main theoretical
views covered in the decision making literature reviewed and reflected at individual,
environmental and organisational level respectively. An attempt was made in this
research to explore the three approaches by adopting an Interpretivist approach, using in-
depth interviews which generated rich data that was transformed into a practical
framework to guide new executives to the private healthcare industry in their business
decisions. The findings of this study offered a new paradigm for managing executives’
decision making in private hospitals. This framework could be used as a guide to assist
executives to manage strategically the internal factors of the organisation and to gain
more control over the external factors to the organisation.

Whilst the need to manage the business at micro level was made apparent in the research
findings, this inquiry demonstrated the ability to do so without losing the macro goal.
This type of management is best described as being strategic operational with outcomes
that could benefit private hospitals today and tomorrow. Basing decisions on operational
needs internally at the present point in time make the “Built to Last” concept introduced
by Collins & Porras (1997) harder to be achieved if not impossible. The need to integrate
the present and the future, the internal and the external factors necessitate a two-
dimensional approach to decision making as depicted in the analysis of the framework
that emerged from this research.

In studying the social phenomenon of decision making, the comparative analysis adopted
in this research between executives’ responses in for-profit versus not-for-profit private
sector demonstrated similarities and differences in management practices, thus reflecting
the market dynamics of this industry. The comparison between the for-profit and not-for-
profit sectors enriched the research findings with different aspects of these business
enterprises and concluded with a unified practical model benefiting executives in this
industry. Whilst the thesis draws attention to a number of different executives’ practices
in for-profit and not-for-profit private hospitals, its aim was not to demonstrate that one
sector was superior to the other. Executives in both for-profit and not-for-profit private
hospitals could learn from each other ways to maximise their performance by knowing
how to engage the right factors at the right time. Rather than leaving the hospital sector
to dictate the administrative behaviour, executive members at individual level should be
able to make their business decisions based on what is best for their organisations at both
strategic and operational levels. In particular, strategic operational decisions could be
achieved by adopting this framework that synthesise the internal and external dynamics
of private hospitals as units and as groups forming an industry.
Based on the research study undertaken, the identifiable factors that formed the framework appeared to be relatively similar for executives in both sectors of the private hospital industry. However, three key findings form practical recommendations that could benefit executives in each sector and consequently, their organisations. Firstly, the weight that shareholders’ value exercised on executives’ performance in term of profit maximisation appeared to result in more efficiently run private hospitals. Whilst the research findings shed light on early paradigm shifts with executives in not-for-profit sector about being more conscious of the importance of running a viable business, more effort could be done in this sector when making business decisions to generate additional profit without compromising clinical care. This change in practice has the tendency to produce more surplus that could be formally allocated to social accountability activities as a form of proclaiming the mission of the original founders.

Secondly, it was apparent from the research findings that the longevity of not-for-profit private hospitals was not mainly related to their strong financial performance. The secret lays in the ‘seed’ planted by the original founders whose strategic goal and mission when setting up such organisations, was in the satisfaction gained through helping their community.

This study revealed early signs of slight paradigm shift in the for-profit sector in which executives referred to their patients and customers as community members. It was apparent from the participants’ responses that the lesson learnt from the Mayne Health experience in Australia could have triggered this change. Based on this finding and confirmed by the literature, profit making did not appear to be the only ingredient to
secure a long lasting business. Adding value to the community and other stakeholders could provide private for-profit hospitals with the secret ingredient that was adopted by their colleagues in the not-for-profit sector and has proven over the years to extend the life of their business. It is anticipated that social accountability in the corporate world will be on the rise particularly with social and environmental awareness increasing amongst the Australian nation and globally.

Thirdly, the research findings suggested that the majority of executives in both sectors were reluctant, whether consciously or subconsciously, to engage medical specialists during the “making” stage of the decision. The slight nuance in the timing of the decision can have a detrimental effect on the culture. In spite of the controversy around stakeholder theory, the literature demonstrated on several occasions that having stakeholders’ ownership in the decisions is highly recommended in running a business and strongly advocated by stakeholder theory (Friedman and Miles, 2002; Mitchell, et.al, 1997). Executing decisions without consulting with a major stakeholder has proven in the private hospital industry, as with the Mayne story, to result in the loss of the business. Nevertheless, executives in private hospitals participating in this study remained hesitant to engage or to communicate business decisions with medical specialists early in the process. With the apparent controversy about the timing of the communication with hospital staff particularly medical specialists, the recommendations from this study would be to involve the medical specialist in business decisions that will impact on their practices. This early participation would create a sense of ownership of the decision to be
made which could facilitate execution and further empower the private hospital executive.

6.4 Implications for Existing and Future Research

This research study aimed to understand executives’ decision making in the context of private hospitals by exploring the critical factors influencing their decisions. The literature reviewed reflected scholarly work on decision making drawn upon examples from different disciplines which tended to advocate their relevant school of thought such as economic, cognitive or behavioural administrative approach. For example, the literature reviewed demonstrated the preoccupation of cognitive theorists with the understanding the human cognition and processing of information to make decisions (Mintzberg, et. al, 1998).

However, the researcher in this treatise approached the topic with no predisposition, aiming to study the phenomenon of decision making as perceived and interpreted by the social actor. Gill & Johnson (2002: 168) argued that:

Unlike animals or physical objects, human beings are able to attach meaning to the events and phenomena that surround them, and from these interpretations and perceptions select courses of meaningful action which they are able to reflect upon and monitor.

The researcher’s personnel experience and observations in the private hospital industry have generated the desire to depict the factors influencing executive decision making in private hospitals, hence the topic of this research was formulated. The literature reviewed showed a vast relay of research and publications studying decision making as a
generic social phenomenon applicable to any industry but lacking the depth required to generate meaning for the specific industry of private hospitals.

This treatise attempted to fill this knowledge gap by exploring executive business decisions in the private hospitals as experienced by experts in their field. The adoption of the abductive research strategy in this study was critical to shed light on the factors that influenced both implicitly and explicitly executive decision making in private hospitals. According to Blaikie (2003: 101), the aim of the abductive research strategy was “to describe and understand social life in terms of social actors’ motives and accounts.” The decision making model was generated encompassing the internal, external and hybrid frames. The framework introduced a new dimension of managing private hospitals through making internal decisions that has ramifications in the external frame. The research findings of this thesis form a platform for additional investigations in this area. Firstly, further research could be conducted to assess the application of this framework in different industries by exploring the critical factors in other social context.

Secondly, this framework could be expanded to include more personal factors that were beyond the scope of this study, such as executives’ cognitive abilities, personality traits and leadership styles. Thirdly, developing this study from being exploratory to explanatory could provide more in depth analysis and understanding of each factor identified in this study.
Lastly, both for-profit and not-for-profit could benefit from a longitudinal study looking at behavioural changes amongst executives before and after the adoption of this framework and its relationship with organisations financial performance.

With the ambiguity in their strategic and operational decision making, executives in private not-for-profit hospitals ran the risk of adopting extreme business decisions either commercially driven or focused on social capital. Governance of the Board of Directors and executive management plays an integral role in striking the right balance between both worlds: margin and mission. Economic theory has already questioned the role of the not-for-profit sector and its management principles (Lyons, 2001). The research findings have shown attempts, in not-for-profit sector, to adopt economic imperatives when making business decisions. Unless not-for-profit hospitals produce a set criteria against which the organisation’s performance is measured, this sector runs the risk of losing their tax exempt status. Nevertheless, private not-for-profit hospitals remained unable to reach the efficiencies and maximisation of profit that economic theory has advocated for decades. Further research into different management models is required in the private not-for-profit sector to ensure the long term viability of this Third sector (Lyons, 2001). Otherwise, two plausible futures can be forecasted. The first involves the amalgamation of this sector with the public not-for-profit. The second would be for corporate businesses to take over this sector introducing more efficiencies and commercially based decisions. However, such amalgamations should be dealt with caution to avoid the American healthcare experience after the introduction of third party administration services, known as managed care, to control healthcare costs by applying conservative
financial management to hospitals (Marcus, 2000). Managed care left clinicians wondering whether medicine was a “business before it was a science” (Bruhn, 2005: 311).

For-profit hospitals could also benefit from adopting strategies to create and embed values within their business practices beyond the economic imperatives alone. Researching the feasibility of introducing mission statements that incorporate the value and long term vision of these organisations could be of value to executives to strengthen the future of these hospitals and lengthen the life of these corporate groups in the management of private hospitals.

6.5 Limitation of the Research Study

The research question of this social inquiry was addressed based on the reality constructed by the social actors in their semi-natural environment. No attempts were made to generalise the findings of this study beyond the research participants for two main reasons: Firstly, this study belongs to social research and its results tend to be “limited in time and space” (Blaikie, 2003: 11); Secondly, the sample of sixteen participants was too small to generate conclusions beyond the research participants. However, the careful selection of experts in the private hospital industry to form the research sample has allowed the generation of rich primary data. The researcher used the data generated to build first-order constructs from which second-order constructs were derived converting therefore lay accounts into technical ones.
The researcher’s insider view of the social actors’ world was advantageous in using and understanding the technical language of the discipline, thus gaining more meaning of the social actors’ constructed reality. To minimise the problem of introducing “something of the researcher’s point of view” associated with qualitative research (Blaikie, 2003: 252), participants’ original words and expressions used in their responses were adopted throughout the data collection, coding and analysis.

Executives were approached individually to participate in the study rather than the organisation as a whole. Whilst this approach gave a good sample spread and ensured the breadth of the data generated from executives across both private hospital sectors (For-profit and not-for-profit), the risk remained in the ability to identify the presence of personal motives driving the executive business decisions. During the data collection phase, the researcher relied on several occasions on non-verbal communication signs, in order to reach the implied meaning of the responses rather than capturing purely participants’ explicit responses.

The research findings did not show the element of time in terms of the speed in which an executive’s decision had to occur to be a factor influencing decision making in private hospitals. The pace of the external environment, whether slow or turbulent, and its role in the decision making phenomenon and organisational strategy, did not appear in the research findings to play an important role in the private hospital industry, yet it had a significant weight in the literature reviewed (Grant, 2003).
Urgent decisions usually need to be made within a short timeframe, thus limiting the time available for the executive to gather all information and explore all possible options prior to choice making. In contrast, in a stable environment more time is available for the executive to gather more information and to make a more informed decision encompassing the key elements of the private hospital industry as it appeared in the decision making framework.

The size of private hospitals where executives were employed during the data collection was not factored into the equation of decision making. Participants were invited to participate in this study as individual experts in their field not as organisations. Decision making at executive level appeared from the research findings to be more based on the individual’s approach as opposed to the organisation. Furthermore, the commonalities in the generated themes that formed the different factors influencing decision making confirmed the irrelevance of the hospital size when executives were engaged in the social act of decision making.

Beside the dominance of economic theory in the decision making literature, a large number of scholarly work studied the cognitive processing in a human’s mind and the rationale of decision making. However, the researcher’s interest in organisational behaviour at executive level led the research to draw more on the economic and administrative approach rather than the cognitive processing of information in the human brain. Behavioural decision making states that “people act only in terms of what they perceive about a given situation” (Wood, et.al, 2004: 55). Therefore, adopting qualitative
Interpretivist approach equipped this study with the necessary tools to unveil the reality as perceived and interpreted by the social actors generating rich data that can be used to anticipate behaviour in relation to the social phenomenon under study.

Studying executives’ leadership styles were beyond the scope of this thesis. The large body of literature and specialisation of this topic warrant a dedicated thesis to study the relationship between different leadership styles and decision making.

6.6 Conclusion

This chapter provided interpretation and discussion of the research findings in light of the literature reviewed. The critical factors underpinning executives’ decision making in private hospitals were depicted in form of a framework generated from the data. Based on the research findings and reflecting on the literature reviewed, the framework of factors influencing decision making was analysed through both the individual’s approach to decision making and the organisational strategic lens. Three different approaches to decision making were identified comprising of process, outcome and intuition.

The research findings were of practical benefit for executives in both for-profit and not-for-profit sectors. The longevity of mission based not-for-profit hospitals appeared to be in the strength of the mission set by the founders, which could be used as a strategic and operational tool to guide executives’ decision making. The financial performance of the not-for-profit sector was proven to be as important as in the for-profit sector. However,
the mission based and tax exempt status is creating a laid-back approach amongst executives managing these organisations based on today’s operational need and not tomorrow’s strategic goal. Amongst the factors that were unrelated to sector, strategy or decision making approach appeared to be executives’ perception of the medical specialists’ participation in business decisions. The research findings showed practical implications to executives and their hospitals; and future areas of research were suggested such as studying decision making in light of executives’ leadership style.
CHAPTER 7

CONCLUSION

The aim of this concluding chapter is to consolidate the different steps of the research process, ending it with recommendations to fill the knowledge gap identified in the literature, based on the synthesis of the research findings and its theoretically informed analysis.

7.1 Research Purpose and Background

This thesis aimed to explore executives’ decision making in private hospitals by shedding light on the factors that influenced their decisions. The key elements of the structure of this specialised industry, which is not commonly examined by the business literature, have been captured by interpreting the perceptions’ of executives knowledgeable in this field. The insider view of the researcher facilitated deeper understanding of the dynamics of this industry as illustrated and perceived by executives participating in this study.

Similar to other industries, executives in private hospitals assumed the responsibility of making business decisions in their operational and strategic administrative roles. However, the point of differentiation in this industry is in the existence of third parties
that possessed more leverage in dictating patients’ volume and the revenue that these hospitals received. Medical specialists selected, on behalf of their patients, the private hospital of choice in which treatment was to be received and private health insurances set the funding rates. In the midst of all this, the escalating healthcare expenditure due to the advancement in technology and increasing cost of labour, resulted in scarce resources and cost shifting between healthcare providers, government and private health insurers. Whilst the private system assisted in taking the burden of the government funded public hospitals, the competitive nature of private businesses increased the complexity of this industry. A series of recent mergers and acquisitions amongst private hospitals in Australia triggered the researcher’s interest in gaining better understanding of executives’ decision making in private hospitals by exploring the critical motives and factors that influenced these decisions particularly when two sectors, being for-profit and not-for-profit, existed within the private hospital industry.

7.2  Relationship with Existing Literature.

The literature reviewed revealed a myriad of decision making publications, often taking the generalist view and lacking the rigour of one specific industry. Researchers were basing their writings on their own personnel stance, paradigm and discipline in search for a master recipe for the “rational” decision. As Cooper (2003, p.3) stated: “There always will be ‘art’ in the conduct of science. Scientists bring their personal insights to decisions about what and how to study.” The common thread identified in the literature was to create a process for decision making which tends to comfort social scientists when
dissecting this social phenomenon. The vastly adopted assumption that decision making is a process made the explanation of its physiology more manageable to the extent that finding universal answers became very appealing to researchers. Generic recommendations for executives’ decisions often involved a diagnosis of the current situation, analysis of the findings in comparison with previous experiences and generally followed by research outcomes being a prescription to attain rational decisions. The solution to decision making often involved meeting budgetary requirements, measuring actual performance outcomes against expectation or set targets such as the balanced scorecard concept by Kaplan & Norton (2001). The preoccupation of the researcher in this study was to explore the factors driving executives’ decisions as experienced by executives individually within their structure. As suggested by Burrell and Morgan (1979: 3) that the emphasis is on understanding what is “unique and particular to the individual rather than of what is general and universal.”

In a comprehensive and systematic review of the literature on high performance, Kirby (2005) identified clearly four levels of interests encompassing: individual, team, business units and corporate levels. Examining Kirby’s (2005) findings in light of Structuration Theory, these levels could be grouped into two groups: the individual level (agent) classified in one group and the remaining three levels (team, business units and corporate levels) forming the second group (structure). Based on the theorem of duality of structure emphasising the role of the human agent, the structure and their mutual dependence (Giddens, 1984) the knowlegibility of the agent in producing and reproducing day-to-day activities can shift structure to the benefit of the organisation. Therefore, this inference
might suggest that high performance at individual level could generate higher performance at organisational level.

Recently, with more emphasis in the literature on decision making at the individual level, an emergent trend in scholarly work demonstrated the role of intuition in making decisions and the innate personal traits associated with this growing concept. The controversy whether decision making is intuition or process has created heated debates in the literature, particularly with the recent publications of the books Blink by (Gladwell, 2005) and Think by (LeGaut, 2006) which represented these two school of thoughts.

Whilst the journey of decision making started with economic theory, the individual element and subjectivity could not be eliminated, thus creating a role for cognitive theory to play its part in the study of this social phenomenon. The convergence of these two theories appeared in the administrative behaviour theory which admitted individual’s limitations and accepted close enough, good enough results based on the information and the time available when decision making occurred. In light of the ongoing debates in the literature about this social phenomenon, the researcher believed that executive decision making in private hospitals was best studied by exploring the factors influencing executives’ decision and their interrelatedness as perceived by the social actors in their own social world.
7.3 Research Strategy and Outcomes

The researcher embarked on this exploratory journey of research inquiry using a low stance approach, generating from the fieldwork the response to the research questions: What are the critical factors that influence executive decision making in private hospitals?; And, why are these factors perceived by executives as significant when they are engaged in these social acts of making business decisions?

The use of qualitative research in this study, enabled deeper understanding of the social phenomena of decision making at executives’ level in private hospitals. This study adopted the Interpretivist paradigm using abductive research strategy to explore the social actors’ meanings of these social phenomena. Using Structuration Theory, the researcher moved beyond individuals’ interpretations of their perceptions of the structure, generating therefore findings that are relevant at organisational level.

The researcher constructed first-order constructs from lay accounts generated during the interviews with executives. Second-order constructs were derived from first order constructs to form technical accounts.

Executives’ decision making was compared and contrasted across both sectors of the private hospital industry (For-profit and not-for-profit) to gain more depth into the factors influencing executive decisions in each sector. A two-dimensional framework emerged from the social actors reconstructed reality unveiling the factors influencing decision
making at executive level. Moving between the present and the future, the internal and the external dimensions, three frames factors were developed from the research findings: internal, external and hybrid. The latter had its roots originating in the internal frame with ramifications in the external one. Reflecting on these research findings in light of the literature reviewed from the discipline of business, psychology and organisational behaviour demonstrated three approaches to decision making consisting of decision making as a process, outcome and intuition. The first two approaches appeared to be sharing common denominators with the two strategic schools of thoughts respectively being the design and the emergent schools of strategy.

Whilst strategy reflected future long term goals, for-profit private hospitals appeared to be clearer in the decision making management with both operational and strategic outcomes aiming for profit generation to satisfy shareholders. On the other hand, not-for-profit private hospitals demonstrated a dichotomy in their decision making which was apparent in the contradiction in the majority of responses. When executives claimed mission accomplishment to be their strategic goal, financial sustainability remained their short and long term focus yet they did not exhibit efforts to maximise their profit nor to integrate their mission in their decisions. This state of mind when making decisions appeared to create a dilemma for the executive who is trying to balance the margin and the mission, thus leading to a “close enough, good enough” approach to be adopted when making business decisions in not-for-profit hospitals. It was apparent from the research findings that to date the longevity of not-for-profit hospitals in Australia have been related to the strength of the constituters and their social capital ‘reason d’être’. The
decline in the numbers of religious founders or executive members who personally lived during this era and the ‘laid back’ approach in managing these businesses economically run the risk of weakening not-for-profit hospitals’ role and jeopardising therefore their future longevity. The threat of change throughout history of the dynamics and the role of both for-profit and not-for-profit sectors were best described in a metaphor by Phillips (2004) who reflected the grandiosity and power of these organisations to be embedded in their architectural buildings. Philips (2004: 1) referred to the change witnessed in Europe from Churches possessing originally the “oldest, largest, most elaborate buildings” to corporate headquarters nowadays having facilities in the “newest, grandest” building. These above examples from the literature reinforce the need for executives equally in both private hospital sectors to follow responsible, informed decision making that draws on the critical factors that interplay in their industry to achieve their organisational goals. With constant changes in the external environment of private hospitals including: the consumer market, the government and industry scrutiny, advancement in technology and tighter health insurance funding models, alternative models of executive decision making are required to retain the balance in the management of private hospitals. Neither attaining favourable financial outcomes alone nor relying purely on the mission of the founders would guarantee a secure future for private hospitals.

Whilst the literature gave a significant weight to the value of engaging stakeholders in the decision making particularly with the emergence of stakeholder theory, executives participating in this study remained debating the level of engagement to which medical specialists were entitled. The level of involvement of stakeholders in the executive
decision making did not appear to be linked to a particular decision making approach or to a specific sector in particular.

The next section of this chapter will present a number of recommendations that could be of benefit to executives who are currently working in this sector or novice in the management of private healthcare industry. The list of recommendations could be applicable at the individual level or extended to the organisational level in form of a decision making policy.

7.4 Recommendations

The following list of recommendations aims to contribute to practical knowledge for the management of executive decision making in private hospitals. Both financial and social dividends should be treated as of significance when making business decisions at the executive level in private hospitals regardless of the sector to which they belong. To achieve this objective the following steps are required to be adopted:

- Ensure all executive decisions in private hospitals are strategic decisions by integrating the factors adopted in the two-dimensional framework of choice making: present-future and internal-external. This approach will eliminate any ‘quick fix’ management that often meet today’s need and lead to the organisations’ detrimental future.
Establish mission statements in for-profit hospitals that show the contribution of the corporate sector to social capital and stakeholders’ value beyond the satisfaction of only shareholders.

Integrate not-for-profit private hospitals’ mission in executives business decisions, thus making proclaiming the mission an executives’ responsibility similar to the Board.

Do not be reluctant to consider financial gain when making executive decisions in not-for-profit private hospitals. Generating a surplus is indicative of a healthy business that is not only sustainable, but also able to inject funding back into society and attain the social capital gain as stated in these hospitals’ missions.

Gain ownership of medical specialists without the fear of them driving their own agendas, since the outcome of the latter is mostly benefiting patients’ care. Involving medical specialists in executive decision making is not a threat. It is a sign of a strong administrative management acting in the best interest of the patient.

Build communication and ‘people’ skills more than financial skills, which both were found to be by this study as key attributes for executives in their decision making role in private hospitals.
Based on the recommendations of this study, the incremental changes in management practice could lead to the genesis of a new era in the provision and management of private healthcare services.

7.5 Contribution of this Research to Knowledge and Future Research

The research findings shed light on the social phenomenon of decision making as experienced by experts in their semi-natural environment. Social meaning was constructed based on the researcher’s interpretation of social actors’ meanings of reality. Structuration Theory was adopted to move beyond the individual level to the organisational / structural level and their interrelationship. This approach to social research was lacking in the majority of the decision making literature reviewed, which adopted mainly Functionalist theory and the Positivist research paradigm in studying decision making.

The findings of this thesis were generated during the research process due to the alternating role of the researcher with periods of full involvement in the study and periods of withdrawals playing the reflective and analytical role (Blaikie, 2003). A decision making model in the form of framework was constructed to gain deeper understanding of the diverse factors and their interrelationship which influenced participants’ management decisions and their social world. This framework has implications to practical knowledge by empowering executives with the knowledge of the different aspects of their industries. Furthermore, the recommendations generated from this research can be applied at
individual and organisational level with potential to increase the longevity of for-profit hospitals beyond today’s financial performance and ensure the long term sustainability of not-for-profit hospitals and their missions regardless of changes in the external environment. (Collins & Porras, 1998: 75) were clear in their description of visionary companies:

In a visionary company, the core values need no rational or external justification. Nor even do they sway with the trends and fads of the day. Nor even do they shift in response to changing market conditions.

The tax exempt status that not-for-profit private hospitals enjoy cannot continue to be taken for granted without tangible outcomes in social capital. However, to be able to deliver their mission, executives managing these organisations need to be reminded of the core values that formed the foundation of their businesses at micro level and the social structure at a macro level.

The fine line in striking the balance between delivering the margin and the mission is best described using the basic principles set by Collins & Porras (1998) who distinguished between core values and practice. They stated that whilst with time core values do not change, practice might. This study built on Collins & Porras’(1998) work by taking their model outside the corporate world and applying it to the private hospital industry, which are in the business of ‘healing the sick’ whether the hospital was for-profit or not-for-profit. Despite the critiques that Collins & Porras (1998) would have faced after the publication of their book “Built to Last”, applying their recipe that was generated from a list of eighteen visionary companies identified during interviews with 700 chief executive
officers gives confidence when guiding executives by highlighting the path of visionary companies.

The researcher acknowledges the inability to reach consensus on attaining uniformity in the management of executive decision making. This study does not attempt to recommend a set of core values unique to the private hospital industry. However, it proposed a list of recommendations for change in practice.

Whilst the decision making framework appeared to be similar in private for-profit and not-for-profit hospitals, it was apparent the significant role of the sector in determining the weight given to certain factors such as financial performance and people factor. The individuality of the executive appeared to play an integral role in leading private hospitals.

Drawing on the two main organisational goals identified in the research findings by both for-profit and not-for-profit executives, the following conclusion can be made:

Medical specialists appeared from this study to play the primary role in delivering patient care and generating profit, which constitute the two main aims of private hospitals’ executives participating in this study. Early engagement of medical specialists in executives’ decisions in private hospitals would assist in gaining their ownership in the short-term and in increasing their commitment in the long-term, achieving therefore both margin and mission.
The fine balance between financial performance and social accountability in the management of private hospitals resides in the challenge faced by executives in generating margin for the mission.
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APPENDICES

APPENDIX A Invitation letter for Participation in the Study
"Plain Language" Written Statements

Dear Participant,

You are invited to participate in a research project being conducted by RMIT University. This information sheet describes the project in “plain English”. Please read this sheet carefully and be confident that you understand its content before deciding whether to participate. If you have any questions about the project, please ask one of the investigators.

The project investigators are:

- Malak Sukkar (Doctor in Business Administration student)
- Erica Hallebone (Project Supervisor: Associate Professor, Graduate School of Business, RMIT University, erica.hallebone@em.rmit.edu.au, 9925 5585)

The project has been approved by the RMIT Human Research Ethics Committee.

You have been approached to participate in the study because you meet the following criteria: healthcare executive working in private for profit or private not for profit hospital which is the focus of this study.

The project topic is to examine the critical factors influencing the healthcare executive decision making in private hospitals. The proposed research project is non-invasive with no risk to participants. It involves approximately one hour of face to face interviews to explore the participants’ perception of factors influencing decision making in private hospitals.

The study may have practical benefits for executives in the private acute health care sector by shedding light on the characteristics of private hospitals and the critical dilemmas that would confront hospital executives in their decision making. The study will also provide a framework for balancing the factors influencing the decision making process.

Any information that you provide can be disclosed only if (1) it is to protect you or others from harm, (2) a court order is produced, or (3) you provide the researchers with written permission.
The data generated will be analysed for my thesis and the results may appear in
publications. The results will be reported in a manner which does not enable you to be
identified. Thus the reporting will protect your anonymity. The research data will be kept
securely at RMIT for a period of 5 years before being destroyed.

Participation in this research is voluntary and you may withdraw your participation and
any unprocessed data at any time.

If you have any queries regarding this project please contact me on 9411 7330 or my
supervisor Erica Hallebone on (03) 9925 1348 or the Chair of the RMIT Business Human
Research Ethics Sub-committee Prof. Tim Fry, tim.fry@rmit.edu.au.

Yours sincerely,

Erica Hallebone
B. A. (Honours), Ph.D
Associate Professor
Graduate School of Business
RMIT University

Malak Sukkar
BSN, MSHLsc
Doctor in Business Administration
Student
Graduate School of Business
RMIT University

Any complaints about your participation in this project may be directed to the Secretary, RMIT Human
Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne,
3001. The telephone number is (03) 9925 1745. Details of the complaints procedure are available from the
above address.
APPENDIX B Consent Form
RMIT FACULTY HUMAN RESEARCH ETHICS COMMITTEE

Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires or Disclosure of Personal Information

FACULTY OF DEPARTMENT OF  Faculty of Business
Name of participant: 
Project Title:

Critical Factors Influencing Healthcare Executives’ Decision Making in Private Hospitals

Name(s) of investigators: 
(1) Malak Sukkar Phone: (03) 9411 7330
(2) Erica Hallebone (Research supervisor) Phone: (03) 9925 5585

1. I have received a statement explaining the interview involved in this project.
2. I consent to participate in the above project, the particulars of which - including details of the interviews - have been explained to me.
3. I authorise the investigator or his or her assistant to interview me.
4. I acknowledge that:
   a. Having read Plain Language Statement, I agree to the general purpose, methods and demands of the study.
   b. I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
   c. The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.
   d. The confidentiality of the information I provide will be safeguarded. However should information of a confidential nature need to be disclosed for moral, clinical or legal reasons, I will be given an opportunity to negotiate the terms of this disclosure.
   e. The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to St. Vincents & Mercy Private Hospital and the Australian College of Health Service Executives. Any information which will identify me will not be used.

Participant’s Consent
Name: ___________________________ Date: ___________________________
(Participant)

Name: ___________________________ Date: ___________________________
(Witness to signature)

Any complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 1745. Details of the complaints procedure are available from the above address.
## APPENDIX C  Research Subject  Interview Questions

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<thead>
<tr>
<th>Q1</th>
<th>What are the three top goals that you aspire to achieve for your organisation?</th>
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<tr>
<td>Q2</td>
<td>In terms of recent business decisions you have made, what would be the factors that influenced your business decision?</td>
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<tr>
<td>Q3</td>
<td>What performance measure(s) do you put in place to evaluate the outcomes of your decision?</td>
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<td>Q4</td>
<td>What do you think are the criteria for an executive decision to be executed?</td>
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<td>Q5</td>
<td>How would you assess that an executive decision fits within the hospital strategic corporate goal or mission?</td>
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<td>Q6</td>
<td>What do you consider the key differences between private not-for-profit and private for-profit hospitals?</td>
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<td>Q7</td>
<td>How do you perceive the private healthcare market today compared to ten years ago?</td>
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<tr>
<td>Q8</td>
<td>Imagine you have to make an executive decision; can you describe your decision making process and list the key stakeholders who you would consider in this process?</td>
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<td>Q9</td>
<td>How do you describe private hospitals’ relationship with Medical Specialists?</td>
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<td>Q10</td>
<td>What would your advice be to a new executive member starting his career in private hospitals?</td>
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<tr>
<td>Q11</td>
<td>Would you like to add any other comments or elaborate more on any previous point discussed?</td>
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