

The influence of stakeholder groups on organizational decision-making in public hospitals

by Egil Marstein

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Egil Marstein:
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Abstract

Stakeholder pressure, sector turbulence and crisis make up the troublesome agenda within the public hospital sector. Sector deficiencies challenge the governance legitimacy and its organizational rationale. On-going political and public debates call for organizational prescriptions revising traditional institutional configurations. The thesis identifies how a multitude of stakeholder groups influence organizational decision-making in public hospitals.

Stakeholder analysis is based on the belief that certain reciprocal relationships exist between an organization and certain groups and individuals (Ginter, Swayne, and Duncan 1989). These groups and individuals are so-called *stakeholders* as they are considered to have a *stake* or claim in the outcome of decision-making. A lacking empirical foundation and an abundance of normative contentions mark the present state of affairs on stakeholder theory. This disparity in research focus curtails the formulation of descriptive and instrumental propositions tied to stakeholder management. Although an instrumental justification for stakeholder theory originally has been established by Freeman (Freeman 1984), some commentators argue that these are inadequate to serve as a theoretical basis (Ogden and Watson 1999). Donaldson advocates that managers should “acknowledge the value of diverse stakeholder interests and should attempt to respond to them within a mutually supportive framework, because that is a moral requirement for the legitimacy of the management function” (Donaldson and Preston 1995). Recent normative developments in stakeholder theory tie philosophical views into operational contexts. Proponents of the latter may be found in the *theory of the common good* (Aragandona 1998) tied to Cludt’s (Cludts 1999) *social system theorem*, both arguing for a balancing of constituent interests relative to the organization’s societal relations and the nature of its services.

The thesis presents a contextual analysis that makes an exposition of the structural contingencies of the Norwegian welfare state. A descriptive/empirical analysis of the public hospital’s decision-making processes provides insight into how stakeholder groups shape the premises of the public hospital’s value creation-process. The thesis’ theoretical propositions are vested in hospitals’ efforts to achieve a stakeholder balance between competing constituent interests. A thesis proposal on descriptive/empirical stakeholder theory is exempt from normative prescriptions on the intrinsic value of all stakeholder groups. The “stakeholder theory of detachment”¹

¹ See thesis section 11.5.3 “Theoretical contributions”.

reflects thesis findings that stakeholder management takes place in a departmentalized fashion without an integrated operations perspective. A conceptualization of “stakeholder compliance”² is introduced and visualises the embedded nature of stakeholder management in public hospitals. The model is grounded in the empirical accounts on how stakeholder management employs differentiated decision processing techniques at different organizational levels to achieve an optimum balance between competing constituent interests.

The thesis summary and conclusions culminate in a set of implications. These address the need for a renewed national discourse on the governance of public hospitals. The thesis empirical findings on the consequences of non-integrated stakeholder management, call for reviews of governance models and managerial practices. Empirical evidence confirms a pattern of decisional sedimentation in which executive-, operational- and ward hospital management work strategically detached on issues of overall strategic importance. The thesis contends that hegemonic and autonomous management make room for staged and manipulative stakeholder behavior. As generalized through this empirical field study, the operational practices of public hospitals exempts authorities from the exercise of rational choice.

² See thesis section 11.5.3 “Theoretical contributions”.

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I especially wish to credit the many informants who have shared their experiences with me. It opened up for what became an intensive investigation of such an important sector within our welfare state. I trust that the thesis contributions may have made it worth their while. It exhibits how complicated and challenging it is to fulfill the societal obligations of public health deliveries. Thesis summary and conclusions reflect a public sector in need of continued system improvements. However, the ailments diagnosed and implications outlined do not reflect negatively upon the many individuals who dedicate their careers to improve upon the quality of life of

patients and their next of kin. A continued public discourse on public health policies is the only guarantee for the best of cures for system anomalies. It is therefore hoped that the thesis may serve as a basis for public debate while also inspiring future research on the contingencies of hospital institutions and the multiplicity of stakeholder group interests.

Sandvika, 3rd July 2003

Egil Marstein

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1 Introduction

1.1 Intent of the study

“Throughout the last four years it has become even clearer to me that the public health services system may be characterized as a constituent “game” where the main actors are the patients, health personnel, administrators, politicians and the media”³

The objective of this thesis research project is to develop an understanding of public hospital stakeholder groups and how the nature of their vested interests impacts organizational decision-making in hospitals. Stakeholder analysis is based on the belief that certain reciprocal relationships exist between an organization and certain groups and individuals (Ginter, Swayne, and Duncan 1989). They are referred to as *stakeholders*, that is, actors having a *stake* or claim in the outcome of decision-making. According to Ginter, some of these stakeholders are almost always powerful or influential, others influential regarding only certain issues, still others have little influence and power.

In this thesis, stakeholders at three public hospitals will be identified and analyzed. An important goal of the research project is to arrive at a stakeholder typology fitting the category of public hospital stakeholders. To aid the understanding of how stakeholder groups influence organizational decision-making it is important to develop a conceptual model depicting their relative position and a framework visualizing their interaction.

Field data has been collected through an exploratory research process by conducting semi-structured interviews with selected stakeholder informants. Archive data such as formal minutes from executive board meetings and from meetings between the hospital directors and ward managers and administrative directors in the respective case hospitals, has been collected. A theoretical platform has been developed to guide the empirical work, and as such constitutes the conceptual framework for the research model and design.

Descriptive renderings evidenced by typologies, frameworks and models will be presented in a way so as to permit a conceptualization of the case hospitals’ organizational decision-making. Traits and other leading ends,

³ Argument put forth by professor Jan Grund in the foreword to the 2nd edition of his book “Helsepolitikk. Effektivisering, spill eller utvikling?”, Tano, Oslo, 1995. Grund’s statement is here considered a valid reference and introduction to the significance of stakeholder interests in hospital organizational decision-making.

progressively developed through a grounding method and extracted from the analysis of the empirical data, will be presented as propositions on the presence and prevalence of stakeholder groups.

The changes in medical service delivery within the last 20 to 25 years are truly remarkable. Following decades of what Scott refers to as “dynamics without change” (Scott et al. 1998 p. 1), we are today, “undergoing a period of *hyper turbulence*; a time of revolutionary change within the industry” (Meyer, Goes, and Brooks 1993). Such turbulence is manifested in our confrontation with new medical technologies, the changing nature of hospital health care, new financial mechanisms for the reimbursement of hospital performance, the introduction of cooperative and competitive mechanisms between hospitals and an institutionalization of new public management logics that govern leadership and organizational practices. These changes are occurring within a sector noted for its highly institutional character with established norms and values. Significant political risks and public resources are attached to public hospital change processes in which the stakes are high and the outcome uncertain. However, according to Greenwood, the prognosis may be better than that which history may tell us about institutional change processes; “In an arena such as health care, change does not come easily; but when it does – when the existing structures and beliefs are undermined or severely challenged – profound change can also occur rapidly” (Greenwood and Hinings 1996).

Understanding how organizations function is, according to Cyert and March (Cyert and March 1992), “more diffuse than the study of the economic activities of the firm; as a result it is harder to characterize briefly.” The very nature of public health services, as generated and disbursed by the hospital institution, attracts many constituents with differing political, institutional and societal interests. Grund’s (Grund 1995) rediscovering the relevance of hospital stakeholders, may represent a research vantage point from which stakeholder presence may be sought dichotomized. Most notably, there is a frustrated patient or next of kin with the feeling of being supervised by norms and forces outside of his or her own immediate control. Then there are the numerous other “actors” internal and external to the hospital. All seek to have their presence noted and their concern validated by the many organizational decision-makers operating within the framework of the public hospital.

The thesis research represents a preliminary culmination of a personal engagement in, and a commitment to, enhancing the theoretical and practical understanding of the management of public hospitals. The present theoretical paradigm of stakeholder theory explains the dynamics of an organization’s

interaction with its operational environment. The paradigm confirms a normative justification of the intrinsic value of all stakeholders with respect to organizational decision-making. However, as hospital sector reforms pave the way for a greater influx of both public and private constituent interests, the research departs on exploring a possible *paradigm anomaly*⁴ based on Kuhn's (Kuhn 1962) assessment criteria of *context of discovery* and *content of justification*⁵. Through the thesis' empirical/descriptive research the outcome may thus enhance our comprehension of the relevancy and merits of contributions to new stakeholder theory applicable to the public health organization within the context of the modern welfare state.

1.2 Thesis outline

The initial step in the thesis presentation is to introduce thesis focus and rationale. Theoretical objectives and potential contextual merits serving public hospital governance are presented. A rendering of the public hospital field identifies sector ramifications critical to comprehending the nature and outcome of the research project. Key stakeholder groups are introduced representing recognized constituents of governance and value creation processes. A subsequent presentation of the history of public hospitals that leads up to the present-day modern health care institutions provides comprehensive insight into the thesis' empirical field. The literature review introduces a framework for the thesis' theoretical foundation and is followed by a concretization of the research question.

In outlining the thesis' empirical work, its epistemological position rationalizes its research strategy and serves to qualify its selection of research model and design.

A chapter on research methodology details empirical sampling strategies, instrumentation and fieldwork implementation. The thesis analysis interprets field data gathered through a data triangulation process. The research

⁴ In explaining the concept of paradigm, Kuhn (Kuhn 1962) speaks of "normal science", which means to suggest that "some examples of actual scientific practice, provide models from which spring particular coherent traditions of scientific research" (p. 10).

⁵ In a second edition to his original 1962 (1st edition) publication on The Structure of Scientific Revolutions (1970), Kuhn speaks further on the subject of a "pre-paradigm period" (Postscript: p. 179). Faced with an admittedly paradigm anomaly, the scientist's task is first to isolate the "paradigm embryo" (p. 26) for further analysis where the purpose is to provide incremental data necessary to identify any fundamental paradigm shift. Kuhn goes on to underscore his theorem that "to reject one paradigm without simultaneously substituting another is to reject science itself" (p. 79). Thus, there is no such thing as research in the absence of a paradigm.

question is answered through descriptive renderings and conceptualizations that depict the presence and interactions of stakeholder groups in case hospital decision-making. The thesis' contribution to a furtherance of stakeholder theory is being discussed within the contextual framework of the welfare state. The thesis' contributory consequences are being evaluated relative to both theoretical and contextual properties.

2 Thesis focus and rationale

2.1 Introduction

Classical organization theorists have historically decomposed the organizational environment to permit the formulation of tangible instrumental propositions on organizational behavior. The interest in establishing an instrumentality connection between firm behavior and stakeholder interests seems to have remained attractive to academics and management practitioners alike. While the exact propositions seem to differ, modern stakeholder theorists seem to have a common interest in establishing a theory of the firm that is fundamentally different from the neoclassical theories depicting participants as utility maximizing constituents. Brenner and Cochran (Brenner and Cochran 1991) are concerned about stakeholder related issues in order to help predict organizations' behavior, as Donaldson and Preston (Donaldson and Preston 1995) wish to explain and guide operations of the established organization. McDaniel (McDaniel 1997) also follows the lead of instrumentalist objectives, pointing to organizations' sense-making needs in order to comprehend their environment thus to maintain operational stability and predictability.

When focusing on organizational decision-making conduct and accounting for the presence of stakeholders' vested interests, the largely normative philosophical/ethical assumptions seem insufficient for any instrumental intentions. Objections are increasingly voiced on the lacking recognition of the intricacies of the organizational context in stakeholder theory building. Proponents of contextualization advocate a stricter delineation along the lines of Cyert's (Cyert and March 1992) "nature of the firm"⁶. Cyert notes that the decision-making research approach has developed a "substantial theory of decision-making processes in an organizational context, but has not applied the theory to specific environmental conditions in which the business firm operates, nor utilized the theory in detail to the particular decision-variables that characterize the firm's operation" (Cyert and March 1992 p. 19).

When analyzing organizational behavior in public service organizations, the research community seems to advocate the relevance and accord of institutionalism. This is confirmed by DiMaggio (DiMaggio and Powel 1991), noting that the theory of institutions is concerned with political decision-making, especially the ways in which political structures or

⁶ Book title of Cyert and March's 1992 semiole textbook publication on the nature and relevancy of business organizations.

institutions shape political outcomes through their governance mechanism. The classical institutional theorists view the process of internalization of policies, ideas and values as governed by an organization's norms and myths, conditioning the formal organization's cognitive rationale (March and Olsen 1989). The internalization of these common behavioural patterns creates organizational stability over time and serves to resist change processes and intervention efforts incited by environmental stakeholders. New-institutional theory, however, introduces the concept of an active institutional environment enhancing its particular set of values and norms rooted in its cognitive interpretive patterns related to knowledge, professions, procedures and products. Through a cognitive based imitation of prevalent values and customs, new institutionalised myths may develop to form an isomorphism or likeness between organizations, parties, groups and individuals (Christensen 1994).

The application of institutionalism and new institutionalism in analyzing the effects of organizational changes introduced by political governance in public health organizations thus implies the relevance of both internal and external stakeholders as change agents. Their very presence transcends elements of new values and norms through their continual interaction. According to Meyer (Meyer and Rowan 1991), isomorphism with environmental institutions and institution agents, has some crucial consequences for organizations' continual change processes.

This chapter will introduce the public hospital sector as the thesis' empirical field representing the contextual arena for the study of the presence and prevalence of stakeholder groups. Recognized stakeholder groups in the public hospital field will be identified and discussed. The conceptualization and discussion of the public hospital stakeholder forces will represent a logical framework for the ensuing thesis research. It will furthermore serve as a rationale for subsequent models and frameworks developed that may depict stakeholder interactions with organizational decision-making.

2.2 A stakeholder rationale for the public hospital

2.2.1 The dynamism of the stakeholder "fit"⁷

There seems to be a common understanding between modern welfare states and welfare societies that health services policies should be a political responsibility even though both private and public institutions may render such services (Hallandvik 1998). Hallandvik defines politics as a system securing a distribution of a nation's scarce resources. Accordingly, goods

⁷ Term applied by Ogden in his article seeking to explain the balancing of customer interests in the US privatized water industry (Ogden and Watson 1999).

distributed through political processes are goods in scarce supply and critical to the health and welfare of the individual. The very nature of market mechanisms implies that as someone receives more of an item others will receive less. Much of the political debate centers around which goods should be allocated by the state and which goods should be distributed through open market processes. Public goods are represented by a distribution not governed by the market forces of supply and demand but by an allocation in accordance with a predefined health policy. The established prerequisites for public goods distribution is that the services should be allocated in a just and efficient manner and that the quality of services should be as good as possible (Hallandvik 1998). There is generally a uniform agreement about these service objectives. However, when seeking to specify the exact level of service, processes replace agreements where vested interest groups seek to influence priorities.

Within the conceptual confines of stakeholder theory, it is important to have a clear definition of the term stakeholder as it applies to the context of the public hospital. Freeman (Freeman 1984) defines a stakeholder as “any group or individual who can affect or is affected by the achievement of the organization’s objective” (Brenner & Cochran, 1991). By this definition, management choice is a function of stakeholder influences. Thus, in a generic sense of the stakeholder perspective organizations are required to address a set of stakeholder expectations. Freeman’s fundamental assumption of the stakeholder model, however, is that the ultimate objective of organizational decisions is a marketplace success. Firms view their stakeholders as part of an environment that must be managed in order to assure revenues, profits, and ultimately, returns to shareholders. Attention to stakeholder concerns may thus help a firm avoid decisions that might prompt stakeholders to undercut its objectives. This possibility arises because it is the stakeholders who control resources that can facilitate or enhance the implementation of corporate decisions. In short, stakeholder management is a means to an end (Berman et al. 1999). However, the end may have nothing to do with the welfare of stakeholder interests in general. Instrumental strategic ethics enter the picture only as “an addendum to the rule of wealth maximization for the manager-agent to follow” (Quinn and Jones 1995).

According to Ogden (Ogden and Watson 1999), having studied the privatization of public utility companies in the UK; “the transfer of the stakeholder concept from a private to a public sector, involves significant changes in the composition of stakeholders and in the consideration of how the interests of the different stakeholders are to be balanced” (Ogden and Watson 1999). Ogden makes reference to the organizational mandate of a

public organization to secure some “fit” between the values of its governance and its management and the expectation of its stakeholders and societal issues “to permit an achievement of optimum resource efficiency” (Ogden and Watson 1999). This balance between normative societal values and the vested interests of its environmental stakeholders is sought established through legislative measures and its sector governance. Though this argument is conceptually clear, it is particularly difficult to perceive of a stakeholder model applicable to the public service firm. Such a model needs to convert stakeholder dualism of the private sector. The latter dualism is balancing the governing forces of company shareholders with the expectations of the market place. The patient, as an end user of hospital medical services, is requesting and receiving *free and unlimited medical care*⁸. The presence of any open market mechanisms providing the opportunity for client measures to establish a client negotiating position with potential impacts on price, product, or service levels, is principally void. The contextual arena of the public hospital representative of its ideology, culture and institutional norms, is not conditioned to the modes of intervention expected in a truly competitive environment. According to Freddie “the institutional and stylistic contexts that illuminate and denote the redistribution of decisional power in the medical services delivery system, follows the rule and logic of public intervention” (Freddi 1989 p. 2). As such, the public hospital owner becomes an important stakeholder agent amidst other organizational and environmental constituents. All such constituent parties interact to strike a balance or “fit” in the composition of medical services afforded patients.

2.2.2 The conditional governance

Our public health system is subject to continual national scrutiny. According to Grimen (Grimen 2000), such focus on a major societal institution is culturally vested. “In any society, normative arguments on national values and ethics, center on the selection and maintenance of its social institutions” (Grimen 2000 p. 273). Health policy and our national health services are therefore of concern to all of us. It is grounded in our modern national history and mirrors our culture, the ethical values we wish to uphold, and in sum provide us with a sense of security and predictability.

⁸ Norwegian residents are ensured free hospital services based on a social insurance model principally built on the concept of an active State and a passive market (Erichsen 1996). The Norwegian public health model is generally referred to as “The Beveridge Model” (named after the architect of the British national health services, William Beveridge), providing universal coverage through taxation, entrusting its means of production in public ownership and governance (Erichsen 1996).

According to Erichsen (Erichsen 1996), a public health system also contains and exhibits much of society's conflicts, possibilities and dilemmas. As such, its implications attract many and diverse constituents with interests vested in the very presence, purpose and priorities of our public health resources.

The expressed political objective of the public health system in Norway is to ensure access to good medical and health care services for all inhabitants, irrespective of age, gender and residence (St.meld. nr. 50 (1993-94): Samarbeid og styring). According to these same provisions, such services are to be furnished within the framework of a publicly owned and governed health care system (St.meld. nr. 50 (1993-94): Samarbeid og styring). The overriding obligation is "to provide all residents with the opportunity to uphold one's freedom and independence safeguarded from illness and disease through a just distribution of medical health benefits governed within a welfare framework that ensures public control of funds allocation and its management" (St.meld. nr. 50 (1993-94): Samarbeid og styring)⁹.

The ensuing governance¹⁰ of the public hospitals within this framework of national public health generates an evolving constituency of formal and informal stakeholders, all with a vested interest in how the hospital organization allocates its resources. As such, the various stakeholders seek to exert their influence on decision-making issues facing the organization, competing for its share of the resources to be allocated (Blair and Buesseler 1998). Given the nature of its product and its associated constituency, managers at the various organizational levels within the hospital have to satisfy a number of public and private concerns to meet the anticipated formal and informal performance standards. An economically successful public organization will necessarily be one in which management adopts policies and applies governance strategies that facilitate the maintenance of

⁹ Translated by the thesis author from the original Norwegian wording (St.meld. nr. 50 (1993-94): Samarbeid og styring).

¹⁰ Governance is commonly defined as the relationship between the owner and the management of an organization (Preker and Harding 1999). Good governance is said to exist when managers are closely pursuing the owner's objectives or when the *principal-agent problems* have been minimized. Public hospitals are said to experience bad governance when there are (a) problems with the objectives of the hospital, (b) problems with the supervisory structure, or (c) problems with its competitive environment (Preker and Harding 1999).

Governance structure is meant to represent the formal and judicial organizational make-up of public hospitals. Williamson, in his "The Mechanics of Governance", quotes Lon Fuller's definition of "economics" to be representative of Williamson's "spirit of governance", namely "the science, theory or study of good order and workable arrangements" (Williamson 1996).

an appropriate balance between different stakeholder interests (Ogden and Watson 1999). In the context of the hospital, the sensible manager will seek to maximize the present utility of medical services for its patients. However, as the public hospital is financed partly based on its resource efficiency (ISF)¹¹, the hospital management may consider reducing expenditures not directly linked to diagnostic measures or treatment regimen. Such measures may indeed be applied to all cost and investment categories that do not ensure measurable and immediate cost savings. Hospital stakeholders are aware of this continuous resource imbalance between over all goals and the need to prioritize operational objectives. Hence, stakeholders will seek to monitor hospital operations to safeguard their vested interests.

Within stakeholder research, the descriptive/instrumental focus is on explaining and predicting how an organization functions with respect to the relationships and influences exerted by its environment (Rowley 1997). Incorporating the sphere of governance as part of the public hospital's organizational environment, calls for the recognition of the socio-political dimension in stakeholder research and analysis. An interpretation of hospital owner representatives as both a shareholder and a stakeholder is supported by Erichsen (Erichsen 1996). Erichsen defines the development of public health services in its broadest context as the sum of all of those activities and services performed by the various health professions. When confined to the context of the public hospital, this latter definition may be somewhat unconventional. It offers an interpretation of *public health services* that constitutes both the services performed by the health institution itself as well as the formal political-administrative structure. The stakeholder mandate administered by the hospital's governing bodies, is expressed in legislated principles of equal rights, fairness in practice and public governance. This public obligation and its singular vein of financing get confronted with the needs and expectations of other public accounts. The issue of competing relative merits hence limits the resource access. Hence, the hospital is put into a position to argue its needs opposite its governing bodies to ensure its vested interests. Hospital management promotes its constituent interests rooted in its operational mandate through goals and strategies. Here it seeks

¹¹ Incentive supervised financing ("Innsatsstyrt finansiering"; ISF) was introduced in 1997 (St.meld. nr. 50 (1993-94): Samarbeid og styring) as part of the total hospital financial system establishing a cost refund scheme based on the merits of the DRG-system (Diagnosis Related Group). The DRG-system is a cost refund system linking the hospital's cost reimbursement to pre-defined cost scales developed for a range of commonly occurring patient diagnosis and associated medical regimen in somatic hospitals. The system was originally developed in the 1970s at Yale University, USA (Rønning 2000).

to claim its share of scarce resources to facilitate organizational decision-making.

The present scope and magnitude of funds allocated public hospitals represents a relatively large share of the nation's national health services program. In 2000 the somatic hospital sector accounted for NOK 34,0 billion (mrd.) (Statistisk Sentralbyrå 2000) or a 42 % share of the NOK 87,5 billion (mrd.) sum total spent on public health services. The societal dimensions are equally compelling. As many as 721.458¹² patients were in 2001 discharged¹³ from our 89 (Hansen 2001) public hospitals (Rønning 2000). Obviously, treatment and rehabilitation regimen carries significant personal and public implications. With as many as 59.530¹⁴ man-years completed in the public hospital sector alone (Statistisk Sentralbyrå 2000), this underscores the magnitude of human resources required to fulfill the political commitment to public hospitals in the context of public health services.

2.2.3 The omnipresence of professions

In an integrated public health services system, the hospitals are said to be representative of what Mintzberg labels "a professional organization" which is "dominated by skilled workers who use procedures that are difficult to learn yet are well defined" (Mintzberg 1989 p. 181). Mintzberg's structural description is hardly adequate, however, to expose the complexity of the social and professional context within which the hospital functions. An ecological explanation of the hospital organization may include a whole array of elements broadly classified as structural, cognitive, institutional and cultural (DiMaggio and Powel 1983). Erichsen (Erichsen 1996) provides a more pragmatic assessment when she labels to-day's "late modern hospitals"¹⁵ as huge, complex organizations providing bureaucratically administered and distributed services. Additionally, hospitals are identified as "mostly curative rather than facilitating preventive care; technologically-oriented and suppressing personal qualifications and views if not originated and prescribed by the medical profession alone" (Erichsen 1996). This latter proposition by Erichsen on the nature of public hospitals, serves to highlight the sometimes conflicting nature of the relationships said to exist between members of professions employed in a hospital. In the public debate on hospital management, the position of professions is perceived as constituting

¹² Statistisk årbok 2000, table no. 136, p. 137.

¹³ This number does not include day care patient consultations. In all 324.652 day-care patients were treated in 2001

(<http://www.ssb.no/emner/03/02/speshelsesom/main.html>)

¹⁴ <http://www.ssb.no/emner/03/02/speshelsesom/main.html>

¹⁵ See thesis chapter 3, section 3.1.2 "From pre-modern to late modern hospitals".

both a problem and a source for better solutions to health services development and administration. Therefore, being cognizant of the significance of professions is important when seeking to understand stakeholders' influence on organizational decision-making in public hospitals.

The most general ideas underlying the concept of professions is the belief that certain work is so specialized that it is inaccessible to those lacking the required training and experience and the belief that it cannot be standardized, rationalized or, as Abbot puts it; "commodified" (Abbot 1988 p. 146). The concept of profession is generally associated with professional fields enjoying a great deal of autonomy or independence in their conduct and performance (Hallandvik 1998). Professional people generally enjoy special privileges of freedom from the control of outsiders. In Freidson's view (Freidson 1970 p. 137), their privilege is justified by three claims:

"First, the claim that there is such an unusual degree of skills and knowledge involved in professional work that non-professionals is not equipped to evaluate or regulate it. Second, it is claimed that professionals are responsible; i.e., that they may be trusted to work conscientiously without supervision. Third, the claim is that the profession itself may be trusted to undertake the proper regulatory action on those rare occasions when an individual does not perform his work completely or ethically".

"Thus, the profession is the sole source of competence to recognize deviant performance, and it is also ethical enough to control deviant performance and to regulate itself in general. Its autonomy is justified and tested by its self-regulation" (Freidson 1970 p. 137).

Freidson (Freidson 1970) labels medicine as one of the major professions of our time.¹⁶ Among the traditional professions established in the European universities of the middle ages, medicine alone developed a systematic connection with science and technology. "Unlike law and the ministry, which have had no important connection with modern science and technology, medicine developed into a very complex division of labor,

¹⁶ To-days medical doctors originate from two schools; the ones educated at a university, *the medici*, and the more vocationally trained *surgeons* (Larssen and Berge 1993). As late as in the early 18th Century, the general public in the Federation of Denmark-Norway had no opportunity to locate any trained doctor for its need for medical treatment. Hence, help was sought from local, untrained "doctors". The few formally educated and trained doctors that did exist were tied to the royal military; the latter group succeeding in 1794 in promoting the passage of a law against the malpractice by local healers; i.e., "*Quaksalbere*" (original meaning: "bad ointment").

organizing an increasingly large number of technical and service workers around its central task of diagnosing and managing the ills of mankind” (Freidson 1970 p. xvi).

The profession of medicine is thus organized around the knowledge system it applies (Abbot 1988). The status within the profession simply reflects the degree of involvement with this organizing knowledge. According to Abbot, “the more one’s professional work employs that knowledge alone – the more it excludes extraneous factors – the more one enjoy high status” (Abbot 1988). Abbot even professes that “since professionals draw their self esteem more from their own world than from the public’s, this status mechanism gradually withdraws entire professions into the purity of their own worlds” (Abbot 1988). In this latter “professional regression” (Abbot 1988) the members tend to withdraw themselves away from the task for which they claim public jurisdiction. Professionals who receive the highest status from their peers are those who work in the most purely professional environments. “They are the professionals’ professionals who do not sully their work with non-professional matters” (Abbot 1988 p. 118).

In today’s modern hospitals, the doctor is in charge of medical practice with the nurse subordinated as his assistant (Hallandvik 1998).¹⁷ Below the nurses there has been a gradual build-up of semi-skilled nurses aids and other groups providing a great variety of technical and administrative services¹⁸. The many new occupations established in the hospital and the old occupations such as nursing, subordinated relative to the medical profession, have in recent years consolidated their position through two processes. The first of these was public certification procedures governing rights to practice (nurses in 1948 and nurses aids in 1978) (Erichsen 1996). The second step taken to safeguard its professional status was the transfer of its educational supervision from the hospital to the public college/university system (Erichsen 1996). With the exception of the medical doctors and the nurses, most of these professions have come into being with the emergence of the modern welfare state (Hallandvik 1998). While doctors and nurses today constitute a relative small segment of the total hospital population¹⁹, they

¹⁷ The first Nordic historical reference to “nurses” is found in the saga of “Viga Glum” (935-1003) where women were encouraged to care for the men hurt in battle irrespective of which side these victims came from. Modern nursing has its professional roots tied to the Crimean War (1853-56) and the work of Florence Nightingale (Larssen and Berge 1993).

¹⁸ The first Norwegian learning institution, educating nurses, Diakonhjemmet, was established in 1868. The National Association of Nurses (Norsk sykepleierforbund, NSF) was established in 1912.

¹⁹ Of a total number of somatic hospital “man-years” (m/y) in 1999 amounting to 58.907, medical doctor-m/y constituted 11.7% of the total, while the representative

still represent the core of medical professions employed. As such, they are responsible for generating the resources and providing the competence necessary for the medical regimen administered. The presence of these two professions permeates the institutional structure and processes in public hospitals. This is confirmed through the hierarchical organization and functionally mandated services. One of the consequences of this latter *a priori* proposition of hierarchical order, is expressed by Selznick (Selznick 1957) in his theorem of an informal rank order system in organizations made up of highly skilled professionals. Organizations with a high representation of members of professions develop what Selznick labels “natural organizational reasoning” (Selznick 1957 p. 122). Selznick’s view is that intentionality and formal organizational structure remain in force, but are not central and foremost in the actors’ interpretation of events occurring in the organizations. Christensen (Christensen 1994) professes that this “natural” organizational reasoning limits the formal organization’s effectiveness. Therefore, in order to understand the hospital organization with its embedded professional structure, one needs to interpret events within the moral framework of norms, values and attitudes unique to the professions (March and Olsen 1989). Neo-institutionalism which focuses on field populations within an organization, emphasizes the contextual dynamics that link the organizational fields of professions and exert institutional pressure (Greenwood and Hinings 1996). Borum (Borum 1999) transgresses this logic of professions when he points out the management problems entailed with the hospital’s multiple professions. Strong professional groups are characterized by their embedded norms, integrative forces and complex linkages that exist between agents of professions dominating the hospital organization.

2.3 The influx of societal “medicalization” (Illich 1974 p. 39)

As individuals we are concerned first and foremost with the availability and quality of medical treatment and convalescence care, as this influence longevity and the quality of our lives. As residents, each one of us is a constituent with a vested interest or *stake* in the public hospital. The ultimate solution is not, according to Larssen (Larssen and Berge 1993), to make available unlimited resources for all to the expressed needs of the

m/y number for nurses was 36.2 %. Other occupational groups with work tasks related directly to patient treatment and care amounted to 5.928 or 10.1%; while “other medical service personnel” stood at 7301, or 12.4% of the total sector m/y, with “other personnel” accounted for 17.424 m/y, or 29.6%. Source: Statistisk Sentralbyrå: Nøkkeltall for somatiske sykehus 1990 – 200 (<http://www.ssb.no/emner/03/02/speshelsesom/main.html>)

public health sector. In Larssen's view, the demand for medical services will always increase corresponding to the residents' expectations at any one time as to what services may be available. Lian (Lian 1996) is supporting Larssen's contention by connecting the issue of stakeholder expectations to certain traits within our cultural norms. According to Lian, our ideological foundation, on which the public health system is based, carries significant implications as to our national perception of health matters. Our expectations are reflecting society's responsibility for bringing about solutions to our national health care issues. These societal expectations to prioritize health care issues and associated expenditures may be explained by what Illich (Illich 1974 p. 39) labels the "medicalization" of society. Illich defines *medicalization* as a broad and complex societal process leading to extensive patient consultations by medical expertise. The general public's adoption of medical terminology thus results in peoples' lives increasingly becoming defined as relevant for medical intervention. In scientific terminology, Illich views medicalization as a consequence of modern society's promotion of an instrumental rationality. Citizens are led to believe that most ailments occurring in peoples' lives may be medically resolved (Lian 1996). Such a utilitarian value trait is what Berg (Berg 1987) refers to as *heterotelic*; i.e., their very presence serving to promote individuals' efforts to improve one's material living standards such as good health²⁰.

Perhaps also serving to explain the increased demand for public health services that creates and support Illich's instrumentality proposition, are the many recent technological advances in medical research (Lian 1996). The medical profession itself may therefore be said to promote society's medicalization process through the profession's own dominating role in the continuous development of broader and better health services (Hansen 1979). As such, the development and growth of public health may be interpreted in a socio-cultural framework in which modern medicine evolves and aggregates in scope and execution (Måseide and Gjestland 1985). One may therefore say that society's medicalization processes serve to augment stakeholder calls for still better and more accessible medical services.

²⁰ In Berg's normative reasoning, an individual's consciousness of the availability of relative cost free medical assistance; i.e., the presence of public health, serves in itself as a disease preventive measure ("sykdomsforebyggende") (Berg 1987 p. 153).

2.4 The presence of “Corporatism” and other proxy agents

The presence of stakeholder groups outside the formal governance system but with a recognized mandate to interact with the hospital sector’s resources administration are the corporate channel constituents (Hallandvik 1998). Corporatism²¹ implies a constituent or stakeholder interest mandated through bona fide organizations and utilizing their formal communication channels to safeguard vested stakes. In the context of the public health sector, communication is maintained with governance system representatives where their vested interests are promulgated. Within the public hospitals, corporatism is recognized through the presence of employee federations representing the interests of the professions.

While not fitting into the bona fide mode of corporate channels tied to the public hospitals, chronic ailment and disability groups represent the constituent interests of the chronically ill. Membership is made up of individuals with a confirmed medical diagnosis²² for which no complete cure is known and or where a person is suffering from a disabling condition. The constituencies of the chronic ailment and disability groups may be dependent on permanent medication, rehabilitation and care regimen “to permit the fullest participation in all aspects of society”²³. Periodic hospital readmission may be necessary. Thus the diagnosis, ailment and disability group members represent a set of stakeholders with specific expectations from the public hospital services provider. In a listing obtained from the Internet web page²⁴ of The Norwegian Medical Association (Den norske lægeforening), May 06th, 2002, 140 chronic ailment/disability groups were listed. As many as 62 of these groups make up the constituency of “the Norwegian Federation of Organizations of Disabled People” (FFO i.e., *Funksjonshemmedes Fellesorganisasjon*). The FFO-membership represents 260.000 disabled and/or chronically ill individuals, making it the single

²¹ Corporatism is commonly described with references made to state governance levels. However, corporative tendencies are also to be found in local governance administrations (Fylkeskommuner; By-kommuner) and in institutions such as hospitals” (Hernes and Selvik 1981).

²² Groups are also established for people suffering from ailment symptoms not medically confirmed through blood sample testing or radiology (X-ray) evaluations. These conditions are labeled “diffuse ailment conditions” (“diffuse lidelser”) and require specialist’s evaluation before qualifying for health welfare payments.

²³ Quoted from the mission statement of the Norwegian Federation of Organizations of Disabled People (“Funksjonshemmedes Fellesorganisasjon”) <http://www.ffe.no>; 02.07.2002.

²⁴ <http://www.legeforeningen.no>

largest stakeholder group working on behalf of past, present and future patients. Permanent staffs in 19 counties (*Fylker*) and 50 communes (*Kommuner*) provide for a resourceful organization actively working to influence the national public health agenda. The chief objective of the FFO related to the public health sector, calls for the public health sector governance to “Provide for relevant and user-induced medical services”. As a stakeholder group, the FFO recognizes the importance of a national profiling of its causes and grievances, as confirmed in its “Working Methods”²⁵; confirming that: “the media in all its aspects and visible demonstrations can contribute to focusing attention on the problems and injustices experienced by the disabled people in Norway”; and where; “the ultimate goal of FFO’s coordinating function is to influence policy decisions by utilizing the strength of members through unity”²⁶.

An effective channel for the chronically ill has proved to be the media²⁷. The media is said to function in the capacity of a proxy agent representing an incumbent’s “stake” opposite the governance systems and sector administration of public health institutions. In a report on media effectiveness, Hallandvik (Hallandvik 1998), quotes the average frequency of public health issues making headlines in the newspapers, to ten single case personal health and medicine-issues a week. The analysis furthermore shows that a major national newspaper in Norway carries on average one major medicine related feature pr. week. Additionally, the analysis shows that one editorial review a month is being produced on the matter of medicine and personal health (Eide and Hernes 1987). There is no empirical evidence, however, to accurately determine the exact degree of media’s influence on the public health sector’s governance. However, implications of media impact may be attached to Hallandvik’s reference to analysis, documenting that half of the case questions entered into the formal debates in the Norwegian parliamentary chamber (*Storting*), originated from issues having first appeared in the media (Eide and Hernes 1987).

Traits of media’s ability to influence the public health sector agenda, is particularly evident in cases where a patient’s life-threatening situation may appear not to have been given requested medical treatment, justified either by medical judgment and/or by authorities’ reference to insufficient resources²⁸. Common to all the cited cases is the fact that media coverage

²⁵ Quoted from the “Working Methods” of the Norwegian Federation of Organizations of Disabled People (Funksjonshemmedes Fellesorganisasjon) <http://www.ffe.no>; 02.07.2002.

²⁶ Ibid.

²⁷ Plural for *medium*; i.e., “means of mass communication” (Morris 1969).

²⁸ Reference made to the cases of: “Lasse Liten Saken” 1987 (Førde and Vandvik 1998); evidence-based denial of treatment of hypoplastic left ventricle heart chamber; “Sandberg-saken” 1990 (Karlsen 1993); denied transfer of bone marrow

seems to have served to facilitate a reversal of the initial hospital decisions (Askildsen and Haug 2001).

2.5 The value chain of the public hospital

Stakeholders converging on public hospitals include not only those having a stake in its services as an end user, patient or his/her immediate family. Included are also those stakeholders maintaining their constituent interests tied to what Porter (Porter 1980) labels an organization's *value chain*²⁹ along which medical services are developed and deployed. Constituent interests are nested into every step and process along this value chain, where resources are allocated and judgment passed that impact professional selection and choice of medical regimen. The concept of *value shop*, has been developed by Stabell (Stabell and Fjeldstad 1998)³⁰ as an extension to Porter's conceptualization of the value chain. Stabell maintains that professional service organizations such as hospitals, fit the *value shop* metaphor "where intensive technologies or skills are applied and directed at a unique and delineated class of problems" (Stabell and Fjeldstad 1998). The significance of the professions employed in the hospital has been mentioned. However, by relating medical services performed in the hospital theatre to another of Stabell's conceptualizations connected to Porter's value chain methaphore, namely the *value network*, one illustrates perhaps better the hospital's broad and diverse links to its external stakeholders. This interpretation is substantiated by Stabell's application of Thompson's (Thompson 1967) "mediating technology" tied to *value network* organizations. Hospiptals' close liaison with subcontractors of medical services, suppliers of technology and strategic alliances provide required support for the totality of hospital services. Relative to these external *mediating technology* suppliers, the public hospital represents an important clinical arena within which equipment, drugs and medication are evaluated

due to lack of budgeted resources; "Matheson-saken" 1996 (Borud 1996); evidence-based denial of core cell, "high dosage" cancer treatment. All are nationally profiled confrontations between hospitals and patients, the latter supported by diagnosis/ailment groups culminating in hospitals reversing their original position, thus providing for the requested treatment.

²⁹ Porter conceptualizes elements of the value chain to represent building blocks in the value added process.

³⁰ Stabell and Fjeldstad's "Value network" links professional medical services to their "Value Shop" conception in which one relies on "intensive technology" (Thompson, 1967) to solve a client problem. The value creation logic of Stabell and Fjeldstad rests on the presumption of "value information asymmetry" between doctor and patient, and as such does not look at the institutional processes of the hospital creating the network of stakeholder connections.

and employed. External constituents within a hospital value network arena, therefore have a strategic interest in the hospital related both to research and to business development.

The concept of *value change management* implies the totality of decision-making processes related to determining the direction of an organization (Rumelt, Schendel, and Teece 1994). Rumelt refers to this as the organization's strategic responsibility. The presence of constituent interests within a *value network arena* generates a dynamic and evolving operational arena within which the hospital navigates and balances its mandate, objectives and strategies in day-to-day operations. In the context of a public hospital, the totality of the value chain management influences the choice of products and level of services offered and the strategic positioning within a quasi-market environment of public health (Fottler, Blair, and Whitehead 1989). The success of the hospital's value chain operations is thus determined by its ability to integrate such choices within the operational sphere of its value network.

2.6 Organizational decision-making in hospitals

The public hospital is the continuous meeting place and interaction point between all stakeholder groups recognizing a vested interest in hospital activities. The interests of management, professional fields and other participants along the service value chain, are directed towards the decision-making agenda, its processes and priorities. This distribution of public health services therefore carries with it traditional traits of power in its broadest sense. An ability to gain influence and impact the outcome of an organization's decision-making is recognized by Morgan (Morgan 1988) as a common source of power. Within organization theory, the conceptual definition of power is oftentimes drawn from the American political science author Robert A. Dahl (Dahl 1958), who purports that a stakeholder's power is the ability to make another party perform contrary to his original objectives. In his dissemination of the concept of power, Morgan distinguishes between the premises, the processes, the topics and goals of decision-making. These matters Morgan recognizes as important to comprehend the presence and degree of power exercised in what he labels "pluralistic organizations" (Morgan 1988 p. 205). Pluralistic frames of reference emphasize the presence of differing vested interest parties, conflict situations and sources of power that all have an impact on organizational decision-making (Morgan 1988). While Morgan contends that the concept of power is paramount in understanding exchange processes between people or parties, Østerud (Østerud 1999) has a more differentiated perception of such a uniform application. The concept of power in scientific research has,

according to Østerud (Østerud 1999), proven insufficient as a singular construct variable in studies of political governance. According to Østerud's 1999 preliminary paper on the "Analysis of Power and Democracy ("Makt- og demokratiutredningen") (Østerud 1999), the concept of power may be analyzed either in terms of *actor-agent intentions*; *structurally* through the organizational context of actor agents; *hermeneutically* through the interpretations of actor agent intentions or *post-structurally* through a discursive structure exhibiting all social relations. Freeman's (Freeman 1984) stakeholder concept may be said to incorporate Østerud's delineated approach in his search for an empirical foundation supporting an instrumentality objective. Stakeholder theory explains and predicts how an organization functions with respect to the relationships and influences existing in its environment (Rowley 1997). Decision-outcome results from selection and retention operating on internal variation associated with decision-making initiatives (Burgelman 1991). Variations in such initiatives come about, in part, as a result of individuals seeking to express their special skills and promote their special interests. According to Burgelman, the selection, or decision-making outcome, works through administrative, cultural and cognitive mechanisms regulating the allocation of attention and resources to the different areas of initiative. In this latter perspective, an organization may be viewed as an ecology of organizational initiatives which emerge in patterned ways, and compete for limited organizational resources so as to increase their relative importance within the organization (Burgelman 1991).

In a national health system, the decision-making processes are according to Hallandvik (Hallandvik 1998) of a dualistic nature. On one hand, the processes may be viewed in a professional sense in which the objective is to clarify goals, describe allocation needs and identify resource priorities. On the other hand, as modern organization research shows, goals and objectives are ultimately arrived at as a result of compromises made between various interest groups with competing vested stakes (Flaa et al. 1985). Issue conflicts between such vested interest groups become increasingly visible as issue consequences become apparent to the parties concerned (Hallandvik 1998). Mintzberg (Mintzberg 1994) in his analysis of organizational decision-making, points to the stakeholder process dynamism describing decision-making as accomplished through formal and informal bargaining among participants. Over time, the objectives of the organization evolve and change as coalition membership is altered, as the interaction among members change, and as the goals are fulfilled or not fulfilled (Mintzberg 1994).

The presence of issue conflicts and arbitrations is common in any operation, whether public or private. According to Freidson (Freidson 1970), every organization, no matter what the nature of its character and no matter how it is governed and by whom, must assign differential priorities in its allocation of resources. In a bureaucracy such as a hospital, decision-making authority may perhaps reflect the dualistic state of affairs. On one side, the managerial official expects to be obeyed by subordinates by virtue of their formal positions, not necessarily due to their personal qualities or even their competence. On the other side, however, health professionals may insist on being autonomous and self-directing, subject only to the constraint of knowledge and skills related to their task (Freidson 1970). The empirical issue is to investigate the operational reality of the hospital's decision-making as representative of either a Weberian (Weber 1947) rational bureaucracy or to find evidence of authoritative processes that deviate from the representations of the legal-rational organization. Since Weber's (Weber 1947) emphasis on the rationality of the bureaucratic organization, numerous attempts have been made to bridge the gap between classical economic assumptions and philosophical ethics (Shankman 1999). According to Shankman, "no single approach, argument or model has yet been set forth to effectively integrate competing perspectives of classical economic theory with the wider movement of sociology and politics to reassert the struggle between constituent agendas" (Shankman 1999). Etzioni (Etzioni 1971) deviates from the issues of conflict in an organization's decision-making, pointing to the significance of a mutual dependency between stakeholders calling for a participant compliance necessitated by the organization's specificity, size, complexity and effectiveness. The thesis focus on organizational decision-making will thus need to identify levels of decision-making authority and to determine presence of compliance or conflict in bridging the various constituent concerns.

3 The public hospital

3.1 A historical review of the hospital organization

3.1.1 Introduction

According to Erichsen (Erichsen 1996); “Having an understanding of the purpose and functioning of the hospital relative to place and time, may permit a better understand of the working mechanisms of its governance” The famous historian, J. Buckhardt (Carr 1961) refers to such a perspective as the dual function of history as a subject and a source of inquiry. According to Buckhardt; “The past is intelligible to us only in the light of the present; and we can fully understand the present only in the light of the past” (Carr 1961). Also Foucault supports the need for historical reviews in order to better understand the development of our public sector. Foucault calls for the need to consider under what ethical conditions it became possible for different governing authorities to consider it legitimate, feasible and even necessary to have conducted its interventions (Miller and Rose 1993). In Miller’s analysis, Foucault is credited with arguing that a certain mentality, which he terms “Governmentality” has become the common ground of all modern forms of political thought and action. According to Miller (Miller and Rose 1993), Foucault’s conception of “Governmentality” addresses political power in terms of “political rationalities” and “technologies of government” evident in regulatory mechanisms that link conduct of individuals and organizations to political objectives. Thus, governance as a conditional force influences public hospitals. It operates within a kind of political *a priori* fashion that is evident in its policy-making, supervision and administration.

To this end, this chapter will present a historical review of our medical hospital system as an outcome of our nation’s “Governmentalism”. It evolves into the operational context of our public hospitals within which stakeholder groups act and interact to influence organizational decision-making.

3.1.2 From pre modern- to late modern hospitals

Turner (Turner 1987) dates hospitals as care taking institutions as far back as to the year 400. These early hospitals, or *hospitale*³¹, were originally set up by various religious orders for traveling pilgrims. Later, during the Middle

³¹ A Latin word connoting the meaning of *guesthouse* (Morris 1969).

Ages³², there were also hospitals caring for leprosy patients and indigents. These *pre-modern hospitals*, as Erichsen (Erichsen 1996) labels them, had a minute role in what we today may consider health care, as treatment was limited to providing food and shelter but in a relatively clean environment. With the emergence of *Modernism*³³ in Europe around the 16th Century, the societal role of hospitals increased in prominence as religious orders and an aspiring middle class made up of bureaucrats and business traders, challenged the old ruling class by displaying an interest in a broader role of hospitals. The early patients were still poor people, and doctors were only infrequently associated with these early hospitals as their only therapeutic role was limited to simple care measures (Erichsen 1996). The clergy rather than the medical people were the administrators of these pre-modern hospitals.

According to Erichsen (Erichsen 1996) the inception of Norwegian modern institutionalized medical care dates back to the establishing of our national constitution in 1814. Erichsen's contention is that this historical event represented the actual beginning of Modernism in Norway following the paths of early 16th and 17th Century European enlightenment, trade growth, industrialization and significant scientific breakthroughs. This emergence of Modernism generated a societal shift towards political and cultural independence, paving the way for university-based medicine with hospitals becoming the educational centers for the teaching of medicine³⁴. According to Løchen (Lian 1996), the science of medicine was considered one of the cornerstones of a modern society, symbolizing the importance and attractiveness of Modernism. With the emergence of the 19th Century and

³² "The period in European history between Antiquity and the Renaissance, often dated from A.D. 476, when Romulus Augustulus, the last emperor of the Western Roman Empire, was deposed, to A.D. 1453, when Constantinople was conquered by the Turks (Morris 1969).

³³ The use of the term *Modernism* generates much uncertainty as to its actual meanings, not the least caused by differing interpretations within various academic fields (Fürst and Nilsen 1998). In this thesis *modernism* connotes institutional conditions within a society as opposed to the expressions of culture or esthetical values within the society. There is also a bridging of the two fields of application as modernism connotes the populace' awareness and significance of individual freedom, rationality and scientific progress (Østerberg 1999). Confirmed by studies of Italian and Swiss locations, modernism in Europe is said to have ranged from as early as the late 14th Century, later generally accepted to have generally emerged in Central Europe between the 16th and 17th Century.

³⁴ The period of the Early Modern Hospitals still entails what Berg (Berg 1987) labels *pre-scientific medicine*. Modern medicine or scientifically based medicine emerges following WW II (1945) with the early advances in diagnostic medicine applying biochemical and biophysical processes.

the period of *the early modern hospital* in Norway (Erichsen 1996), university based medical teaching and training was strengthened. Erichsen traces the characteristics of the early modern hospitals up until the early 20th century. Throughout this period, Norway followed the path of the larger European countries, systematically mapping diseases and symptoms and recording the paths and patterns of illness and diseases³⁵. As new and improved diagnostic tools and techniques were developed, hospitals became the arena for developing and endorsing still better clinical skills. This development served to strengthen the medical profession's position in the hospital. The rising domination of the medical profession manifested itself in an initial principal disparity between hospital administrators and the medical staffs. From having patients drawn to the early teaching hospitals mostly from the society's elites and occasionally from the welfare administrations' assigned indigents, pressure now came from the medical profession to select more of *the interesting cases* (Erichsen 1996). With the later introduction of national mandatory insurance schemes in the late 20th Century³⁶, the class-based system that had previously been evident in the admission and treatment of hospital patients became gradually abandoned, as did the medical profession's ability to influence patient admissions by mere reference to scientific merit.

The period of *the modern hospital* (Erichsen 1996) lasted from 1945 and up until the early 1980's, and was marked by a strong institutionalization of medical services. Public hospitals had gradually developed into large institutions with complex organizations that required rigid administrative structures and procedures³⁷. Calls for an increased number of hospital beds,

³⁵ This type of medically rooted mapping and evaluation is today referred to as the science of epidemiology (Latin: epidemia; "(illness) prevalent among people"(Morris 1969)).

³⁶ A State-based medical and hospitalisation insurance scheme was first introduced in 1911 (A precursory program to "Folketrygden" made universal in 1956). Autonomous County based medical insurance programs (Sykekassen; later labelled Trygdekassen) represented localized schemes distinguishing between regionalized conditions.

³⁷ Foucault (1914 – 1986) ties the development of modern societal institutions to the governing states' call for efficiency and control. In an analysis of Foucault's writings, Dingstad (Fürst and Nilsen 1998) connects a *Panoptic logic* (From Jeremy Bentham's (1748 – 1834) design of a new type prison called Panopticon) to the emerging modern hospitals seeking to contain the spreading of contagious diseases, the confinement of indigents, and the mentally ill. The "*Panoptic logic*" manifested itself in the institutions' architectural design stressing the interest in close governance systems, supporting a Weberian bureaucratic administrative control pattern (Fürst and Nilsen 1998).

laboratories, outpatient treatment areas, examination and treatment facilities contributed to further expansion of the physical structures. It was also a generally accepted theorem at the time that larger scale hospital units were the most cost effective structural solutions to institutionalized medical treatment (Hansen 2001).³⁸ The simultaneous transition of medical knowledge from the previous *pre-scientific level of medicine to a scientific based level*,³⁹ (Berg 1987) opened up for medicine to become a precision-based applied science. Consequently, an increasing relative share of medical doctors became tied to the hospitals as the increase in the number of medical specialty fields and corresponding sub-specialties were recognized and departmentalized within the hospitals. In the latter part of era of *the modern hospital*, hospital medical doctors emerged as the elite within the medical profession. The national health financing, now channeled through the public hospital system, further served to strengthen the public hospitals' already unique position for medical practice, research and teaching.

With the emergence of the *modern hospital* came the growth of nursing as a profession increasingly recognized in its own right. As the hospitals catered to a diversified and growing elite of the medical profession, there was a corresponding growth in the need for qualified nurses. This latter claim is supported by the findings of Erichsen (Erichsen 1996). She draws a parallel between the Norwegian and British National Health Service (NSH), citing Stacy's (Stacy 1988) contention that the modernization of medicine and hospitals was contingent upon the growth in the number of nurses and in the enhancement of the profession of nursing.

While the modern hospitals grew in scope and scientific significance, hospitals came to represent an important factor in the operationalization of what Halvorsen labels (Halvorsen 1996) *societal engineering*. According to Halvorsen, "social engineering" signifies the relationship between expertise of certain professions and the *societal governance*. Hirdman (Hirdman 1989) depicts societal governance as the relationship between populace education, science and politics during the early pioneering stages of establishing the Scandinavian welfare model. The inception of a bona fide societal engineering philosophy is credited Alva and Gunnar Myrdal's work in which they express a need for having politicians and expert professions

³⁸ Quoting Aletras' survey from 1997 (Aletras 1997), Hansen (Hansen 2001) implies that such benefits of scale seem no longer to apply in hospitals with more than 200 beds, and generally records a negative cost efficiency to scale in hospitals with more than 600 beds.

³⁹ Berg (Berg 1987) defines the pre-scientific period of medicine to be represented by "a low level of decomposition of the patients and his environment as opposed to the modern medicine applying a sub-cellular level of medicine in which somatic processes could be specified bio-chemically and bio-physically" (Berg 1987 p. 78).

unite, developing social political reforms to secure the welfare and continuity of society (Myrdal and Myrdal 1936)⁴⁰. Halvorsen (Halvorsen 1996) exemplifies the relevance of Myrdals' theorem at the time, by making reference to the period's increased political initiatives to govern housing, health, education and family planning. Here, the knowledge and schools of thought of architects, medical doctors, teachers and psychologists were incorporated in the political planning process and the development of subsequent control schemes. The Scandinavian governance model inspired by trains of thought from social engineering follow the traits of European Modernism. According to Dingstad (Fürst and Nilsen 1998), the people in a modern society, with its transformative behavioral tendencies, need to be supervised closely. The conformance must be encouraged and promoted, non-conformance confined, freedom structured and creativity channeled and standardized⁴¹. In Norway, social engineering influenced the governance of public health through its focus on hygiene and associated disease-preventing public health measures. Within the science of medicine, the new focus was seeking not only to diagnose illness in the patient but also to identify disease within *the social soma*; i.e., the society. The difference between illness and health, previously understood in terms of medical diagnosis and scientific categorization, now became integrated and judged in political terms as to what constituted good and evil, right or wrong for the society. The modern hospital became an important building block in what Dworking (Munson 1979) refers to as social paternalism. Social engineering engaged the capacity of the medical profession and major hospitals to develop standards and norms for public health and its governance. While social engineering represented a new political trait in the 1930's, its influence on public health policy and hence, its impact on hospital governance, is evident well past WW II and into the present period of *the late-modern hospital*.

The hospital institution as we know it today in Norway is referred to as the period of *the late modern hospital* (Erichsen 1996). These hospitals were essentially shaped through the 1960's when increased medical specialization caused hospital capacity growth fuelled by a centralization of health services production (Hallandvik 1998). A strong impetus in this development was the national government's promotion of new hospital construction in its policy of securing its geographically disbursed national population pattern

⁴⁰ See particularly chapter no. 7: "“Sosialpolitikken og folkets kvalitet”, p.p. 258-337.

⁴¹ Reference is here made to Dingstad's *Panoptic logic* drawn on Foucault's "Discipline and Punish" (Foucault 1977). Foucault's interest in hospital architecture came out of his study of how "the medical gaze was institutionalised, how it was effectively inscribed in social space, how the new form of the hospital was at once the effect and the support of a new type of gaze" (Foucault 1980).

(*distriktpolitikk*). In this societal perspective of the modern welfare state, the public hospital is the foremost arena where ideology and national policy convene and manifest itself into practice. To perform the expected services of a medical hospital within the national ramification as prescribed, today's late modern hospitals have been developed along a functional and a geographical dimension (Hansen 2001). The functional dimension addresses the hierarchical structure and differences in specialization and differentiation between hospitals, whereas the geographical dimension addresses questions of geographical distances and accessibility (Hansen 2001). It was not until 1970, however, when the first national law on hospitals (LOV av 19. juni 1969 nr. 57. Om sykehus (Sykehusloven) 1969)⁴² was implemented, that the national coordination of hospitals along this structure was made possible. This new law confirmed the principal responsibility for hospital development to be placed with the County administrations (*Fylkeskommunene*). As late as at the beginning of the 20th Century, most hospitals were owned and managed by city communities (*By-kommuner*). Additionally, there were a small number of hospitals run by independent humanitarian and religious organizations (Hansen 2001). This early differentiated and fragmented structure complicated any effort to develop a coherent national medical hospital services system. With the legislated expansion of county governance and a broadening of their geographical scope, the counties assumed ownership and supervisory control of all public hospitals. A *government provision*⁴³ introduced in 1975 (St.meld. nr. 9 (1975): Sykehusutbygging i et regionalisert helsevesen) subdivided the public hospital functional distribution system into five regions within which medical services specialization became distributed between the respective county hospitals. Any effective governance of county hospitals, however, did not take place until 1976, when all the respective county administrations become independent political entities (Hansen 2001).

⁴² The Ministry of Health- and Social administration (Sosial- og helsedepartementet) is vested the executive rights of supervising laws governing public health administration. This executory responsibility is mandated through the Law on Public Governance (Forvaltningsloven 1970) safeguarding the individual's right of expedient administration and due process.

⁴³ A government provision is here defined as a Government proposal submitted to the legislature containing either a proposed constitutional amendment; i.e., "Odelstingproposisjon" (Ot.prop. no.), or another proposed non-constitutional governance prescription submitted the parliamentary open/plenum session ("Stortinget"); i.e., "Stortingsmelding" (St.meld. no.); "provision" = "preparatory measure" (Morris 1969).

3.2 The governance model

Providing health services in Norway is a legally established responsibility with its executive power vested within the Government's political administrative system. All public health related services are therefore organized, financed and administered by the State through its public agencies set up for that purpose. While the State retained the over all governing responsibility established through laws, regulations and control mechanisms, the majority of its operational management was delegated to the administrative units of the counties (*Fylkeskommuner*) and cities (*Bykommuner*) as supervised by the corresponding political governance structure⁴⁴ (Larssen and Berge 1993). The Department of Social- and Health Services (*Sosial- og helsedepartementet* SHD) represented the State's executive arm in the governance of the public health system and its mandated functions. The mandate of the SHD entails conducting several auditing programs such as county disease prevention programs, hospital efficiency and effectiveness schemes and continuously assessing new measures and methods to improve institutional public health services. The State did also, prior to January 1, 2002, through the SHD, retain a direct management role of twelve (12) specialized medical clinics, amongst them Det norske radiumhospital (an oncology clinic) and Rikshospitalet (one of the country's five regional hospitals and incorporating Oslo University's medical school). Through the National department of health and its office of the National Board of Health (*Statens helsetilsyn*) and its County doctor general (*Fylkeslegen*), all county and city commune hospitals and their certified medical officers are audited with respect to state board certifications, performance records, facilities' standards and clinical procedures. As this thesis research project addresses issues within the public hospital sector during 2001, the public hospital law and its governance structure in force at that particular time, shall apply⁴⁵.

The inception of a new law on public hospital ownership became effective January 1, 2002 (LOV av 15. juni 2001 nr. 93 (Helseforetaksloven) 2001). The reform measure transferred public hospital ownership from County and

⁴⁴ Reference is here made to governing statutes as outlined in Government provision: No. 9 1974/75 (St.meld. nr. 9 (1975): Sykehusutbygging i et regionalisert helsevesen).

⁴⁵ Reference is here made to the new health law proposals put into law January 1, 2001: (1) Ot prp Nr 10 (1998-99) "Om lov om spesialisthelsetjenesten m.m." (law governing the somatic health services); (2) Ot prp Nr 11 (1998-99) "Om lov om etablering og gjennomføring av psykisk helsevern (Psykiatriloven)"; (3) Ot prp nr. Nr 12 1998-99) "Lov om pasientrettigheter (Pasientrettighetsloven)"; (4) Ot prp Nr 13 (1998-99) "Om lov om helsepersonell m.v. (Helsepersonelloven)".

City Communes to a system of State based hospital governance⁴⁶. The thesis empirical/descriptive data may thus provide for a later comparative analysis of possible consequences generated by the structural reform. It may here be important to heed the words of Christensen (Christensen 1994), who questions the impact and effectiveness of institutionalized change processes due to low integrative abilities of public organizations. March and Olsen (March and Olsen 1989) contend that all organizational change processes take place through slow integrative processes due to strongly embedded institutionalized norms and values. As documented herein, the development of the public hospital system has engaged interactive public and political processes through nearly 150 years. The ideas for a nationally governed regionalized public hospital system, were first proposed as early as in 1934, when professor Johan Holst made his academic inauguration speech as a professor at the University of Oslo (Holst 1935). Holst's ideas seem to have strongly influenced the ensuing political legislation on hospital governance. According to Hansen (Hansen 2001), the core of the ideas introduced by Holst, was not principally different from the structural scheme implemented in 1970 (LOV av 19. juni 1969 nr. 57. Om sykehus (Sykehusloven) 1969) and the later provision about a regionalized hospital structure (St.meld. nr. 9 (1975): Sykehusutbygging i et regionalisert helsevesen). The reference to Holst's promotion of the regionalized distribution of institutionalized medical services may serve to demonstrate the diffusion of a new governance logic (Hansen 2001). Applying Kuhn's (Kuhn 1962) metaphor of scientific paradigms, one may say that it took between 30 to 35 years to operationalize the paradigm of a regionalized public hospital structure (Erichsen 1996).

3.3 Organizing for medical services

3.3.1 Hospital services functions

It is generally accepted that public hospitals are to serve three main functions, namely: (1) *performing diagnostic and medical treatment services*, (2) *educating medical staff* and (3) *conducting medical research and development* (NOU 1997:2: Pasienten først! Ledelse og organisering i sykehus)⁴⁷. Outside the specific mentioning of patient diagnostic treatment

⁴⁶ The new structural reform establishes health regions and hospitals within them into special public health corporations as outlined in: Ot prp nr 66 (1998-99) "Om lov om helseforetak m.m. ("Helseforetaksloven")".

⁴⁷ An "NOU" is the abbreviated form of "Norwegian public assessment"; i.e., a report requested by the Government (Regjeringen) and later handed over to the executive branch of the Government (Departementene) for an assessment. The executive Government may later submit its recommended course of action on the

(§ 7) and the education of health staff (§8), the original law on hospitals (1969) is not specific on public hospitals' research and development duties. The law does, however, provide for prescriptions on specific additional functions to be assigned (§9a.). Sector prescriptions following over the next thirty years all make mention of the need for hospitals to be involved in medical research and development programs⁴⁸. These prescriptions do not distinguish between type of hospital, location or scope of operations⁴⁹. However, it is generally understood that research and development and the education of medical specialists and other medical support staff are vested particularly in hospitals with university clinic activities⁵⁰. The inclusion of medical research in all public hospitals is finally confirmed in the new law on public hospitals effective January 1, 2002 (LOV av 2. juli 1999 nr. 61: Om spesialisthelsetjenesten (Spesialisthelsetjenesteloven)).

The regionalized public hospital system as introduced in 1975 (St.meld. nr. 9 (1975): Sykehusutbygging i et regionalisert helsevesen) distinguished between four hospital categories determined by their functional scope; i.e., each hospital being responsible for either (1) national functions (*landsfunksjoner*); and/or (2) regional functions (*regionsfunksjoner*); and/or (3) county- or central hospital functions (*sentralsykehusfunksjoner*); and/or (4) community – or local hospital functions (*lokalsykehusfunksjoner*). As a general rule, the national, regional and central medical services are vested in the largest hospitals, such as the regional hospitals and the county hospitals, whereas the community hospitals perform general medical services (*lokalsykehusfunksjoner*). One will see that the local hospitals are the most numerous whereas the regional and central hospitals treat the greatest number of patients⁵¹.

particular issue matter as either a “Stortingsmelding” or an “Odeltingsproposisjon” (See footnote no. 35, page 45).

⁴⁸ Particular reference is here made to St.meld. nr. 41 (1987-88) “Helsepolitikk mot år 2000. Nasjonal helseplan”, chapter 9, “Styrking av forskning”, p.p. 88-90; St.meld. nr. 50 1993-94 ”Samarbeid og styring. Mål og virkemiddel for en bedre helsetjeneste”, chapter 4.3 ”Forskning og utviklingsarbeid (FoU) i et styrings- og prioriteringsperspektiv”, p.p.69-70.

⁴⁹ NOU 1997: 2 “Pasienten først! Ledelse og organisering i sykehus” specifically states that research and development (R&D) are the responsibilities of all classes of public hospitals (section 5.5.3 “Forskning og utvikling”, p 32.). However, only hospitals with university and regional functions, as well as some county hospitals are provided the special funds to support their R&D activities.

⁵⁰ This is evident also in the interpretation provided in NOU 1997:2, “Section 5.5 “Sykehusenes oppgaver i Norge”, p.p. 31-32.

⁵¹ Pls. view NOU 1997:2, Chapter 5, “Sykehusenes funksjoner, organisering og ledelse”, p. 29. Numbers listed here are reported by SINTEF/UNIMED, 1995.

3.3.2 Professions employed

Even though the hospitals may vary in size in specialist functions offered and in the number of *wards*⁵², hospitals are organized quite similar around their functional operations (NOU 1997:2: Pasienten først! Ledelse og organisering i sykehus)⁵³. According to the latter NOU, public hospitals are commonly organized around the functions of (1) *medical services*; (2) *hotel services* and *technical functions* and (3) *the administrative, economic and other functional support units*. The following table shows the personnel categories commonly found in a public hospital and reflects the large number of professions and vocations represented in the organization.

Table No. 1: Personnel employed in a public hospital⁵⁴

Medical functions	Service and technical functions	Administrative functions
<ul style="list-style-type: none"> • Medical doctors • Nurses • Nurses aids • Child care staff • Midwives • Dieticians • Physiotherapists • Psychologists • Social workers • Ergo-therapists • Social workers • Pharmacists • Bioengineers • Radiographers • Ambulance personnel 	<ul style="list-style-type: none"> • Kitchen personnel • Dietician economists • Ward Facilities' staff • Laundry staff • Cleaning personnel • Engineers • Technicians • Maintenance staff • Transportation staff • Warehouse staff • Security staff 	<ul style="list-style-type: none"> • Managers • Accountants • Personnel staff • Purchasing staff • Organizational staff • Auditors • Office staff • EDP-and IT-staff • Switchboard staff • Messengers • Priests • Education office personnel • Librarians

3.3.3 The medical services

The medical services provided by the hospital constitute the hospital's core activities. These services are conducted within the clinical wards, intensive care units and the medical services departments. A clinical ward commonly includes bed units, outpatient units (normally day care treatments; i.e., not requiring over-night stays) and medical examination rooms. The purpose of the clinical ward is to conduct specialized medical services that correspond

⁵² The ward is "A division in a hospital for the care of a particular group of patients" (Morris 1969).

⁵³ See specifically section 5.6 "Sykehusenes interne organisering", p. 33.

⁵⁴ (NOU 1997:2: Pasienten først! Ledelse og organisering i sykehus p. 33).

with its specialist medical field or sub-specialties contained within the medical services framework of the ward.

The clinical wards produce the services as prescribed by the hospital law; i.e., to examine, treat and care for patients. Within a particular ward there are staffs representing a number of different professions and vocations from both health professions and administrative support functions. The intensive care units are wards providing medical care for the critically ill patients. The medical services departments are specialized units supporting the clinical wards in the examination and/or treatment of patients. Medical services departments may include a radiology (x-ray) unit, a clinical-chemical unit (laboratory services), a microbiological unit, a pathology unit, a physio-medical unit, a pharmacy unit, reception and specialized surgery units.

3.3.4 The hotel- and technical functions

As the hospital caters to patients or clients with various durations of stay and medical diagnosis, the hotel- and technical functions (HTF) are organized to provide the clinical wards with equipment, facilities and related services. The continuing development of improved medical technology and administrative technology solutions call for personnel qualified to employ and service costly and complex equipment. The HTF-services also include building maintenance, security services, postal and courier services, kitchen and cafeteria services and the linen and laundry services.

3.3.5 Hospital management and the administrative functions

As hospitals have developed into large and complex institutions employing a large number of employees representing a range of medical services and professions, the relative share of administrative staff has increased (NOU 1997:2: *Pasienten først! Ledelse og organisering i sykehus*)⁵⁵. The administrative departments today include personnel with professional expertise on salary administration, personnel management, accounting, purchasing, and information services.

Until the mid 1970's, the Norwegian public hospitals were managed through a shared management model ("*todelt ledelse*"). Here the chief medical officer supervised the hospital's core medical functions while an administrative manager was in charge of administrative matters. Since that time, most hospitals employ one managing director (*enpersonsledelse*), selected for his/her administrative and managerial qualifications. Within the clinical wards one has largely retained a consensus management model (*konsensusmodellen*) where the medical doctor and the chief nurse have been accountable for their respective professional service functions and speaking

⁵⁵ See specifically section 5.6.3, "Administrative, økonomiske og andre funksjoner", p. 37.

with a unified voice within the ward and in reporting to top management (Hallandvik 1998).

The question of managerial staffing has been an issue highlighted between the various health professions arguing in favor of their members' unique qualifications vested in their particular professions. Based on recurring and serious staffing conflicts, particularly within the regional hospitals⁵⁶, the SHD published a white paper on the organization and management in public hospitals recommending the implementation of unitary line management (*enhetsledelse*) at all supervisory levels within the hospital (NOU 1997:2: Pasienten først! Ledelse og organisering i sykehus). Candidate selection should not be based on mere health professional group association (*profesjonsnøytralitet*).

As laws and regulations have opened up for the posting of non-medically trained management candidates within the hospital, a new medical advisor function has been established. Within the hospital management regime prior to 2002, the chief medical director (*sjeflegen*) and the chief nurse (*sjefsykepleier*) were placed within the administrative staff reporting directly to the managing director. The role of the chief medical director is to advise the managing director on medical matters, as the role of the chief nurse is to advise on professional nursing matters (NOU 1997:2: Pasienten først! Ledelse og organisering i sykehus). The future role of these latter two staff positions was, prior to the introduction of the new hospital law, unclear as to both their functional merit and reporting relationships.

3.4 The emergence of a corporate logic

As public health care budgets over the past two decades have routinely exceeded inflation, cost containment ideologies based on efficiency and effectiveness have increasingly gained prominence. This development is parallel to that which has taken place in all industrialized societies where this new logic has become the driving force in changes introduced in health care management (Takagi 1999). Within the public health sector in general, and in the hospital sector in particular, efforts have been made to align itself more with the wider societal ideology of the effectiveness of market forces (Greenwood and Hinings 1996). Many of these ideas are based on new models drawing on deregulation and privatization (Bentsen et al. 1999). Hunter (Hunter 1994) cites the following distinctive features or doctrines of

⁵⁶ Particularly the ward management staffing project at Tromsø Regional Hospital in 1989 and the reorganization project of Rikshospitalet in 1996 (Hallandvik 1998).

New Public Management (NPM)⁵⁷, as “the model of management to which government have become wedded” (Hoggett 1991): (1) explicit standards and measures of performance; (2) greater emphasis on outputs and results; (3) de-segregation of public bureaucracies into agencies operating on a user-pay basis; (4) greater competition through use of quasi-markets and contracting; (5) subscription to private sector styles of management practices; (6) emphasis on performance incentive for managers; (7) discipline in resource use and cost improvements; (8) recognizing the user of public services as a client or customer. According to Hunter, managers are seen as the agents of central government and derive their legitimacy from the requirements on them to do the Government’s bidding aided by various instruments at their disposal.

Proponents of NPM hold public administration to be inefficient, overly bureaucratic and poorly managed. While NPM is not recognized as either a theory or a model, it is generally considered a strategy incorporating a number of different mechanisms rooted in theoretical economic rationality and cost inducement methods (Pettersen and Stenland 1999).

As a consequence of this ideological transformation process, partially set in motion by the governance system as well as by managerial actions, the political dimension of the hospital organization is changing character as well (Borum and Bentsen 1998). In Norway, the political measures to supervise hospital capacity growth and capital spending have been a national concern. The law on hospital governance introduced in 1970 (LOV av 19. juni 1969 nr. 57. Om sykehus (Sykehusloven) 1969), was both a measure to secure the planning of hospital capacity coverage as well as to supervise operational spending. Initially, the law provided for strong incentives for operations growth separated from the planning side of the law calling for over-all longer term public health considerations (Hansen 2001). However, lawmakers soon came to realize the need for stricter measures to curb capital expansion and to contain cost expenditures. Throughout the 1970’s Norwegian hospitals were refunded operational expenditures based on a rate per patient-day spent in the hospital (Pettersen 2000). In 1980, a revised funding system was implemented. The objective was here to curb spending through a demographically linked lump-sum budget allocation (*rammefinansiering*) combined with an activity based refund scheme (*kurpenger*). In an effort to improve patient treatment output, the Government introduced in 1997 an incentive based cost refund measure. Here one combined hospital financing (*Innsatsstyrt finansiering*; ISF) using

⁵⁷ Sognstrup (Sognstrup 1999) professes that the term: “*New Public Management*” (NPM) is a commonly applied nomenclature of this new wave of measures for improved governance.

a patient diagnosis refund scheme (*Diagnoserelaterte grupper*; DRG) along with a lump sum budget allocation⁵⁸.

Other, more market-based NPM-measures have been introduced. A trial-based regulation introduced in January 2001, opened up for patients to choose the institution for a particular medical treatment or intervention. Recent structural measures see the merging of county hospitals and the subdivision and incorporation of county hospitals. Through this reform, hospitals are placed outside the direct political-administrative control of the county (Hagen, Iversen, and Magnussen 2001).

In a major governance revision effective January 1, 2002, the ownership and governance of all public hospitals were transferred from city and county governance (*By- og fylkeskommuner*) to the State level (Staten). This latest reform has been partly justified by an argued political uncertainty concerning the ultimate financial responsibility of the public hospital sector (Hagen, Iversen, and Magnussen 2001). Frequent cost deficits have periodically rendered counties unable to guarantee continued financing, thereby creating calls for State funding guarantees. Also adding an uncertainty to the counties' governance capabilities has been a presumed lack of interest in guaranteeing an effective resource allocation across counties and across public hospital regions (Hagen, Iversen, and Magnussen 2001). Furthermore, the Prospective Payment System (PPS) in force prior to the State taking over hospital ownership, has invited county strategies undermining the intent of the public hospital system through either (1) patient "skimming", i.e., electing patients based on best possible reimbursement options; (2) "skimping", i.e., downgrading treatment options or (3) "dumping", i.e., defer or reject patient treatment to avoid unfavorable cost/refund rates (Hagen, Iversen, and Magnussen 2001).

Today's debate on public hospitals is lesser a discourse on the fundamental views of national health policies, as it is arguments on how public hospitals may become more cost effective. Hildebrand (Hildebrandt and Schultz 1997) here argues the significance of hospital management. According to Hildebrand "To-days limited resources, changes in patient demographic makeup, shift in medical technology, advances in medical knowledge and the development of new skills along with higher patient expectations, dramatize the need for reviewing the conceptual foundations of hospital management" (Hildebrandt and Schultz 1997). While few have questioned

⁵⁸ A detailed account of the development of the DRG system is presented in Government white paper NOU 2003:1 "Behovsbasert finansiering av spesialisthelsetjenesten"; see chapter 9: "Finansiering av pasientbehandling i helseforetakene", p.p. 88-113.

the need for competent management, however, the debates have reflected differing views as to how management should be interpreted in the context of the public hospital and hence how one should improve its governance structure and leadership role.

3.5 Prioritizing health resources

The objective of Norwegian health policy is detailed in “*Nasjonal helseplan*” (St.meld. nr. 41 (1987-88): Helsepolitikk mot år 2000), representing the Government’s provisions for the national public health program and its governance. The document outlines the national goals for improving the public health services. If one was to define health as the individual’s ability to sustain and fight disease, then it is evident that all available health services may only marginally serve to enhance the health of the population (Larssen and Berge 1993). However, only a small portion of our resources is applied towards supporting peoples’ own ability to prevent disease and to develop resistance towards contracting illness and developing disabling conditions. The major share of the nation’s resources is allocated to general health maintenance and the development of curable measures for already diagnosed illness and its continued treatment and care (Larssen and Berge 1993).

Within the law on hospitals (LOV av 19. juni 1969 nr. 57. Om sykehus (Sykehusloven) 1969) and the law supervising its governance (Forvaltningsloven 1970), the public hospitals constitute an important building block to secure the realization of the objectives of the national public health plan. Hospital services performed influence people’s living conditions and have significant socio-economic implications. However, the health policies governing the allocation of resources develop within an arena made up of competing vested interest. The outcome is determined by the constituents’ relative power (Hallandvik 1998). The thesis does not address the democratic processes leading up to legislation and regulations governing public health and hence, supervising hospital management. Rather, the thesis objective is to identify and to analyze how stakeholder groups influence the respective hospital’s organizational decision-making relevant to its vested interests.

The focus of decision-making in public hospitals centers on the allocation of resources channeled through the organizational decision-making processes. According to Larssen, the issue is not how much is spent, but how resources are being allocated (Larssen and Berge 1993). The nature and background of health resource allocations are seldom distinctively segmented along the bureaucratic axis of public hospital governance. The political issue of prioritizing public health resources in Norway has centered on what medical

services to perform and which patients or patient groups to be prioritized (Hallandvik 1998). Wildavsky (Wildavsky 1977) argues that health institutions counts only for 10% of the population's well being, while 90% is determined by other factors. Another issue health resources prioritizing is represented by the funds allocations made between the various health services sectors. Hallandvik's (Hallandvik 1998) proposes that such decisions may actually be influenced by the general *popularity* of a particular diagnosed ailment. Such popularity is largely determined by the professional merits a particular disease may be attracting (Album 1991). Hallandvik (Hallandvik 1998) professes that there is a correlation between the prestige associated with a particular disease and the priority of resources allocated by the health sector administration. Still a third health resources priority level is engaging special patient characteristics. A common governing policy is to weigh the patient's demographic profile and to calculate the likelihood of successful rehabilitation and re-entry into the working ranks of society. Finally, the issue of prioritizing health resources is also addressed at a fourth level, when health personnel considers patient regimen based purely on the medical merits of recovery (Tranøy 1992). However, according to Hallandvik (Hallandvik 1998), even the medical officer's professional judgment at the hospital level may be influenced by any one of the above mentioned priority concerns, acting singularly or in union as priority judgment conditioners.

Scott (Scott 1992) views organizations as rational-, natural- or open systems. The rational organization is governed by a goal orientation in which all resources are allocated to support prioritized objectives. In a natural systems organization goals may be contradictory and/or vague with a little reliance on formalized systems. Here operations may be sustained by strong organizational cultures with a firm desire to succeed and survive. However, it is Scott's contention that within both the formal and natural systems, the organization may become a closed system where all participating actors are easily identifiable. The need for modern organizations to consider themselves part of an open and a dynamic system, calls for continuous negotiation processes with its stakeholders. Clients, employees, sub-contractors and other constituents must agree on terms and conditions. Scott's open system definition of organizations is "a system of interdependent activities linking shifting coalitions of participants who are dependent on continuing exchanges with the environments in which they operate" (Scott 1992 p. 28).

4 Literature review

4.1 The emergence and direction of stakeholder theory

Modern stakeholder theory owes its intellectual development to Freeman's seminal work: "Strategic management: A stakeholder Approach" (1984). (Shankman 1999). According to Freeman, the word *stakeholder* was used for the first time in 1963 in an internal memorandum at the Stanford Research Institute (SRI); when the much quoted SRI definition of stakeholders was reported to be: "those groups without whose support the organization would cease to exist". (Donaldson and Preston 1995). However, as early as 1950, Robert E. Woods, at that time Chief Executive Officer of Sears & Robuck Co., in Chicago, listed "four parties to any business in order of their importance": "customers, employees, community, and stockholders" (Hummels 1998). Wood maintained that if the appropriate needs and interests of the first three groups were looked after effectively, the company's stockholders would benefit in the long run. Freeman did not originally appear to portray the stakeholder concept from a broader philosophical or ethical basis. He has later pointed out that the term "stakeholder" actually was meant to generalize the notion of stockholder as the only group to whom management needed to be responsive (Freeman 1984). Freeman was of the opinion that the modern organization is affected by a large set of *forces*. At minimum, these forces comprise stockholders, customers, employees, suppliers, and management, which summarily are referred to as the *primary stakeholders*. Characteristic for these groups of stakeholders is that they are vital to the survival and success of the organization. He enlarged, however, the list of stakeholders with other possible *secondary stakeholders*, such as the local community, the media, the courts, the government, special interest groups, the general public, and society (Hummels 1998). From this observation, Freeman (Freeman 1984) derives his contention from the belief that "the responsibility of management is to take into account the different views and interests of any group or individual who can affect or is affected by the achievement of an organization's purpose" (Hummels 1998). Freeman stated that systematic managerial attention to stakeholder interests is critical to firm success, a claim, however, not yet tested in the literature (Berman et al. 1999). According to Berman (Berman et al. 1999), Donaldson and Preston (Donaldson and Preston 1995) have best framed much of the recent dialogue on stakeholder theory. Donaldson's and Preston's *taxonomy of stakeholder theory*, where they distinguish between normative, instrumental, and descriptive/empirical theories, has required other authors to become more

precise in their terminology and more coherent in their thinking about stakeholder theory (Berman et al. 1999).

4.2 A taxonomy of stakeholder theory

According to Donaldson, one of the central problems in the evolution of stakeholder theory has been confusion about its nature and scope (Donaldson and Preston 1995). Brenner and Cochran (Brenner and Cochran 1991) offered a stakeholder theory of the firm for two purposes; namely: (1) to describe how organizations operate and (2) to help predict organizations' behavior. In Donaldson's broader perspective, he contends that stakeholder theory differs from other *theories of the firm* in fundamental ways. Different theories have different purposes and therefore different validity and different implications. For example, according to Cyert and March (Cyert and March 1963), *the neoclassical theory of the firm* attempts to explain the economic principles governing production, investment, and pricing decisions of established firms operating in competitive markets. Aoki's *cooperative game theory of the firm* (Aoki 1984) attempts to explain internal governance, particularly the balance between owners' and workers' interests. In contrast, Williamson's (Williamson 1987) *transaction cost theory of the firm* attempts to explain why firms exist; i.e., why economic activities are coordinated through formal organizations rather than simply through market contacts (Donaldson and Preston 1995).

According to Donaldson, stakeholder theory differs from these and other theories of the firm in fundamental ways. It views the organization as an entity through which numerous and diverse participants accomplish multiple, and not yet always entirely congruent purposes. Donaldson's typology of stakeholder theory as being either descriptive/empirical, instrumental or normative in nature, is an important contribution towards clarifying the dual purposes intended both to explain and to guide the structure and operation of the established organization.

4.2.1 Normative stakeholder theory

The normative basis for stakeholder theory involves its connection with more fundamental philosophical concepts. Here, the theory is used to interpret the function of the corporation, including the identification of moral or philosophical guidelines for the corporation and the management of it. According to Donaldson, the correspondence between theory and the observed facts of corporate life is not a significant issue, nor is the association between stakeholder management and conventional performance measure a critical test. Instead, the normative theory attempts to interpret the function of, and offer guidelines for the organization on the basis of some underlying moral or philosophical principles.

4.2.2 Descriptive/empirical stakeholder theory

This particular vein of stakeholder theory is used to describe, and sometimes to explain, specific organizational characteristics and behavior; i.e., the nature of the firm, the way managers think about the firm, how board members think about the interests of corporate constituencies, and how some corporations actually manage. The descriptive aspect of stakeholder theory reflects and explains past, present and future states of affairs of organizations and their stakeholders.

4.2.3 Instrumental stakeholder theory

This version of stakeholder theory, in conjunction with descriptive/empirical data, where available, is used to identify connections between stakeholder management and the achievement of corporate objectives. Many instrumental studies of corporate social responsibility make explicit or implicit references to stakeholder perspectives. Instrumental uses of stakeholder theory make a connection between stakeholder approaches and commonly desired objectives such as profitability.

4.3 Connecting the organizational paradigms

Employing stakeholder theory in seeking an understanding and an explanation of managerial behavior in the public service organization, requires an awareness of the evolution of organization theory paradigms. Three of the most prominent of these paradigms are particularly relevant. In *the rational-economic paradigm* the organization members are viewed as utility-maximizing individuals. The assumption of *the social man paradigm* is that people are motivated primarily by their social needs, and that people need to find satisfaction and build their identities in their work place through their relationships (Cludts 1999). Argyris (Argyris 1964), McGregor (McGregor 1960) and Likert (Likert 1961) all support a paradigm that man by nature needs to realize himself and to use his skills in a mature and productive way; i.e., assuming the need for personal growth and self-actualization (Cludts 1999).

As these static assumptions of the past are being questioned, individuals and organizations are now viewed as complex, dynamic networks, and are assumed to live in a state of permanent ambiguity (Cludts 1999). According to Grielens, "Individuals are conceived of as polyphonic, speaking different voices according to the varying contexts and narratives of which they are a part" (Grielens and Berg 1983).

These leadership and organizational paradigms suggest that hospital managers may need to pay more attention to sense-making through learning and designing relational patterns rather than only focusing on planning, organizing and controlling (McDaniel 1997). Because the world is

unpredictable, meaning cannot be gained through efforts of rational behavior. Rather, meaning must come through the making of sense. “The goal of organizations, viewed as sense-making systems is to create and identify events that recur and to stabilize the environment and make it more predictable.” (McDaniel 1997).

Within the hospital sector, the sense-making process has been one of rationalizing and making predictions about the future based on various internal models of the world (McDaniel 1997). The models of relationships among health care professionals may serve to determine which professional groups are involved in which decision situations. Legitimizing myths or institutional logic is embedded in the institutional environment. According to Takagi (Takagi 1999), institutional environments give support and legitimacy to an organization when it conforms to rules and other requirements determined by environmental elements. Stakeholder participants make up such an environment.

Within systems theory attempts are made to model the sense-making complexity on an organizational level. Here the corporation is said to be a social system, in which people individually and collectively play the major roles. Behavior of individuals, subsystems and total organizations are interrelated, and each part in the set can affect the behavior or properties of the whole (Cludts 1999). When conceptualized exclusively as a social system, the business’s functioning is no longer assessed by the growth of its input or profits, but by the capacity to adapt and maintain itself through the development of the capabilities of its parts (Cludts 1999). This latter theorem ties in with post-modern ethics theory (Yuthas and Dillard 1999). According to Yuthas, the post-modern perspective is of particular relevance to the normative stakeholder theory of business ethics, as the proponents reject the perspective which privileges reason and rationality over values, emotion and desire. A modern perspective relies on the capacity to reflect, represent, or model the world without presuppositions. Postmodernists reject the belief that the world can be objectively represented or measured and suggest that interpretations of facts are not objective. Such interpretations are guided by the beliefs and attitudes of the social systems in which they are embedded. Postmodernists also reject the notion that the universal theories can be developed and applied on the basis of reason but are seen to be contextualized by their historical and cultural natures. Therefore the skeptical postmodernists tend to view the world as chaotic and uncertain.

Another group of postmodernists, the affirmative group, agrees that modernity has reached a point where it can no longer equate economic and technological progress with social and moral progress (Yuthas and Dillard 1999). Yuthas proposes *a postmodern stakeholder theory of enabling* as one way to make the risks and moral concerns associated with business more

visible. From the affirmative postmodern perspective, being able to understand the interests and concerns of others, being in a face to face interaction with others, and being able to experience others as part of “us” allows us to empathize with those “Others” (Yuthas and Dillard 1999).

4.4 Extending stakeholder theory; a discussion

4.4.1 Intrinsic value of stakeholders

The effort to strengthen the theoretical foundation of the stakeholder theory of the firm has led to a taxonomy of multiplicity perhaps negating its original drive for precision and contextualization. It is therefore important to view modern stakeholder theory from the theoretical view mentioned by Donaldson and Preston (Donaldson and Preston 1995). In their view, all of the three major aspects of stakeholder theory, the deterministic/empirical, instrumental and normative/ethical ones are nested within each other. The external shell of the theory is its descriptive aspect; the theory presents and explains relationships that one observes in the external world. The theory’s descriptive accuracy is supported by its instrumental and predictive value. However, the central core of the theory is the normative dimension (Donaldson and Preston 1995). The descriptive validity of such a theory presumes the truth of the core normative conception, insofar as it presumes that managers and other agents act as if all stakeholder interests have intrinsic value. A recognition of these ultimate moral values and obligations give stakeholder management its fundamental normative base.

Donaldson’s view of justifying the integration of descriptive, instrumental and normative aspects of stakeholder theory of the firm is also supported by Goodpaster who sees stakeholder theory expressed in a firm’s operational context (Goodpaster and Holloran 1994). Goodpaster talks of three levels in the stakeholder theory: (1) *The strategic level*, in which he advocates “taking into account the non-owner stakeholders’ interests as a means of achieving the company’s economic goals but without any moral content. (2) *The multiple-trustee approach* which, on a moral level, attributes a fiduciary responsibility to the company’s managers towards all of the stakeholders alike, whether they be owners or non-owners. (3) *The “new synthesis”* which distinguishes between certain fiduciary responsibilities towards owners and other restricted, non-fiduciary responsibilities towards other stakeholders.

Goodpaster’s normative justification is taken from the background of the *theory of the common good* (Aragandona 1998). It is possibly within this aspect of the common good theory that one may see a possibility for extending stakeholder theory to encompass the complexities of the public hospital. According to Argandona, the concept of the common good extends

beyond the ramifications of the firm. Aragandona contends that if the common good comes from human sociability, all the company's relationships will carry an element of common good. Subsequently, one has to extend the list of stakeholders to include customers (patients), suppliers, banks, unions, the local community, the public authorities at different levels, interest groups, real and potential competitors, and so on, until it encompasses all men of all times (Aragandona 1998). The important thing is to consider what kind of social relations the company and its internal members maintain with the various internal and external stakeholders, in order to identify the common good of the society (Aragandona 1998).

A stakeholder theory of the firm as approached from the basis of the theory of the common good is in agreement with Donaldson's view that all stakeholders have an intrinsic value to managers, and Goodpaster's "new synthesis" of fiduciary and non-fiduciary stakeholder responsibilities of managers giving stakeholder management its fundamental normative base. Aragandona, supporting this latter view, states that: "The theory of the common good offers a sufficiently solid basis for the theory of stakeholders, and also the means for determining, in each specific case, the rights and duties of the participants, in accordance with the common good of the company, of the particular society it has with its stakeholders, and of society as a whole" (Aragandona 1998).

In summary, one may state that a stakeholder theory encompassing the common good perspective becomes even more affirmative when heeding Cludts' social system theorem (Cludts 1999) and Yuthas' (Yuthas and Dillard 1999) affirmative post-modern perspective of a stakeholder theory of enabling.

4.4.2 Watching out for paradigm anomaly

In seeking to develop a typology of public hospital stakeholders and to determine the nature of stakeholders' influence on organizational decision-making, it is important to remain attentive to the very nature of prevailing paradigms. Heeding the warnings of Kuhn, it is particularly important for all researchers to be cognizant of *the context of discovery* and *the content of justification* (Kuhn 1962). This literature review suggests that the prevailing stakeholder paradigms are nested closely to organization theory models. The emphasis is on *justifying* a balance between normative/philosophical stakeholder theorems supporting on the one hand, the intrinsic values of all stakeholders with the organization's members' need for sense making through established logic and legitimizing myths, while on the other hand trying to appease the uncertainty created by the changing and the temporary. This situation may appear somewhat paradoxical and may call for research follow-up to examine the largely normative principles governing present paradigms.

Particularly, in the present *context* of public hospitals, it is also important to address Borum's contention of the emergence of a new hospital archetype (Borum 1999). As current stakeholder theorems lack any precise and far reaching implications which take into account ongoing organizational transformations, such as those recorded in the hospital field, the situation could in the words of Kuhn, be an indicator of anomaly in existing paradigms (Kuhn 1962).

4.5 Cognition and organizational decision making

4.5.1 Relevance of judgmental logic

Looking at organizational decision-making in hospitals from a stakeholder perspective presupposes an analytical approach going beyond the theories of rational, anticipatory, calculated and consequential action. This is in part implied by Mintzberg, when he describes that the hospital as a professional type organization, is "distinguished by the fact that the determination of the basic mission, the specific services to be offered, and to whom, in good part is left to the judgment of professionals as individuals" (Mintzberg 1989 p. 184). However, other writers have traditionally associated professional organizations with a collegial model, where decisions are made by a community of individuals and groups, all of whom may have different roles and specialties, but who share goals and objectives (Mintzberg 1989 p. 186). Both sides of the argument as to how management is practiced in a professional organization need to consider *cognitive implications*.

In Guillen's (Guillen 1994) analysis of organizational paradigms, it is claimed that varying structural and institutional conditions governed by industry and ownership have historically produced different models of organizational management. Guillen's main contention is that models of organizational management do not necessarily follow from their scientific credibility and are not solely determined by economic and technological factors. Rather, managers perceived as practitioners of management may express their ideas by acting, by implementing policies, and by applying knowledge to practical situations. One may also find, in the words of Guillen, a few *management intellectuals* or *true believers* in a prevailing dominant managerial and organizational ideology. Guillen is professing that "most practicing managers will subscribe to an ideology as a matter of course in order to promote their own interests and facilitate cognition" (Guillen 1994, p. 5) .

In the view of Austin (Austin 1997), cognitive theory supports the contention that managers apply greater contextual awareness in assessing decision making situations where established mental models or schemas are unable to fit a situation into any of their existing schemas (Austin 1997).

Therefore in analyzing issues identified by stakeholders as critical to the hospital organization, it is important to determine the significance of the judgmental logic behind constituent perceptions.

4.5.2 Epistemology of cognitive science

Over the last decade cognitive researcher has sought to develop a viable alternative to the rational explanations of firm performance, which traditionally has dominated instrumental stakeholder theory and stakeholder management (Stimpert 1999). According to Eden (Eden and Spender 1998 p. 47), our cognitive processes mediate significantly between what we take to be the facts and our behavior. “Since the facts alone do not determine our perceptions, the cognitive problem is to find out what else influences their shape” (Eden and Spender 1998). Organization theorists seeking to find out how organizations work and reflect management’s intentions, do so by clarifying the implications of cognition. The objective is to find “conceptually related representations of objects, situations, events and of sequences of events and actions explaining managerial action” (Eden and Spender 1998 p. 47).

The theoretical background of cognitive science in organizational theory dates back to Kenneth Craik (Posner 1989). In his book, “The Nature of Explanation” (Craik 1943), he argued that human beings translate external events into internal mental models and reason by manipulating their symbolic representations. Most cognitive scientists following Craik have adopted the basic tenet that the mind is a symbolic system. According to Johnson-Laird (Posner 1989), explanations of visual perception, the comprehension of discourse, reasoning, and their representation of knowledge and expertise, have invoked versions of the mental-model hypothesis. Johnson-Laird here defined a model as any physical or chemical system, which has a similar relational structure to that of the process it imitates. Hence, for Craik, a mental model was a dynamic representation or simulation of the world.

The epistemological basis for today’s cognitive science evolved, according to Posner and Kaplan (Posner 1989), around various exclusive theories. In a psychometric sense, cognitive science is the study of intelligence and intelligent systems, with particular reference to intelligent behavior such as computation. Neurophysiology brought knowledge of the biological structures that supported thought. Experimental psychology brought information about speed and limitations of simple sensory, perceptual, motor and memory processes. Gestalt psychology brought hypothesis about processes that occur in complex thinking. The shift came with the so-called information processing period of the 50’s and the 60’s which viewed thinking as a symbol-manipulating process and used computer simulation as a way to build theories of thinking (Posner 1989). In economics and

statistics, one saw, during the same period, the rapid development of formal theories professing the right reason in the form of the theories of utility maximization and of Bayesian inference (Posner 1989). Posner regards these theories of rationality from logic, economics, and statistics as forming an important part of the normative theory of intelligence and hence of cognitive science.

4.5.3 Cognitive mapping and decision-making

Different approaches to decision making are by Kleindorfer (Kitchin and Freundsuh 2000) labeled normative, prescriptive, and descriptive. The normative theories exemplified by economic choice theory aim at determining optimal decisions. The goal of prescriptive theories is to advise decision makers about how to make optimal decisions given that they possess a limited cognitive capacity to do so. Descriptive theories have centered on human decision-makers as adaptive systems with limited capacity to adapt. Because of this limited capacity, adaptation is achieved by approximation, or heuristic methods. Gärling and Colledge (Kitchin and Freundsuh 2000) make a distinction between structural and process models of decision-making. The *structural models* focus on how observed choices or preference judgments are related to the attributes of the different choice alternatives, characteristics of the decision maker, and possibly situational factors. In contrast, *process models* attempt to specify the different cognitive and affective processes regulating the choice.

The thesis project has a research question that makes it particularly relevant to concentrate on *the process of decision-making* measured in terms of the stakeholders' rationales. A crude representation of this process includes the stages of generating the decision alternatives by (a) retrieving information about the environment (b) evaluating the decision alternatives and (c) implementing the decision (Kitchin and Freundsuh 2000). Gärling and Golléde labeled this the hierarchy or stages of *spatial decision-making*.

In its original conception, cognitive mapping concerns how we think about space, and how those thoughts are used to be reflected in human spatial behavior (Downs and Stea 1973). Cognitive mapping research seeks to comprehend how one comes to understand spatial relations gained through primary experience and secondary media such as maps. In other words, how people learn, process and use spatial information that relates to the environment which surrounds them (Kitchin and Freundsuh 2000). The term *cognitive mapping* has been used in three different ways. *First* as a descriptive title for the field of study that investigates how people learn, remember and process spatial information about an environment. *Second*, it has been used as a descriptive phrase for the process of thinking about spatial relations. *Third*, it has been used as a descriptive name for a methodological approach to understanding cognition in general, consisting

of the construction of “maps” of cognitive processes (Swan and Newell 1994). Toleman (Toleman 1948) who was the originator of the term *cognitive maps* hypothesized that we construct a map-like representation within the “black box” of the nervous system, which is then used to guide our everyday movements. In this instance, the representation is structured in the same way as a cartographic map (Kitchin and Freundschuh 2000). The implication, then, is that the cognitive map acquires geometric properties with repeated experience. Toleman applied this conceptual view of cognitive mapping as an analogical device where spatial knowledge was assumed to be like a cartographic map and as a metaphorical device to label spatial knowledge as functionally equivalent to a map. We act as if we have a map-like representation in our minds, although it is acknowledged that here a map is a hypothetical construct (Moore and Golledge 1976; Newcombe 1985; Eerbaum 1985). *Finally*, in some cases the term *cognitive map* has been used as a descriptive term for a conceptual drawing of an individual’s cognitive processes.

In trying to trace the cognitive reasoning of organizational decision-making of key stakeholder groups in a cross-sectional research as the one outlined in this thesis proposal, the question becomes one of using comparative causal or cognitive mapping. According to Lukkanen (Lukkanen 1994), causal mapping studies have no direct objective access to the neuro-physiological representations of the subjects’ knowledge or thinking, irrespective of whether one terms them cognitive or mental maps, rule systems, ideology or knowledge systems. Therefore “the medium of natural language must serve as a proxy and provide the raw data of the unseen target phenomena” (Eden and Spender 1998).

5 Research question

There is presently a widespread academic recognition of the complexities of organizational behavior. In parallel, one may say that there also is a great deal of frustration within the public sector as regards the operationalization of public health policies. Cost overruns, system inefficiencies and resource deficiencies call for a continuous re-examination of sector governance. The commitment to general health maintenance and curable measures always needs to be balanced against limited resources. As such, the struggle to match scarce funds with organizational objectives and expectations represents the epitome of stakeholder management. The organizational “fit” sought to recognize constituent expectations (Ogden and Watson 1999), presupposes a comprehension of the significance of stakeholder presence. The present paradigm of philosophical/ethical views within the field of stakeholder theory provides little descriptive insight into the importance of stakeholder representation. Certainly, a universal theory of the public service organization in lieu of the classical “A Behavioural Theory of The Firm” (Cyert and March 1992), would have been useful when seeking to comprehend organizational decision-making in public institutions. Thus, where health services are developed and distributed within a framework of public governance, the sensitivity to stakeholder influence needs to be evaluated.

The thesis is seeking an understanding of how stakeholder groups are being recognized in the public hospitals’ decision-making. The underlying premises of this latter issue concern stakeholder influence. The governance of public hospitals is exercising its mandate governing hospital operations. By virtue of its position and vested authority, decisions are being made that discriminate between issue matters relevant to hospital functions. However, governance actions are also conditioned by the presence of a diversity of constituent interests. Such interests range from the positions of governance representatives themselves to the interests of constituent group interests external to the hospital. Within public health institutions influence is sought through issue promotion or by investing in measures opposing the implementation of decisions (Guldbrandsen et al. 2002).

In order to gain an understanding of stakeholder group influence, the following research question has been formulated:

“How do stakeholder groups influence organizational decision-making in public hospitals?”⁵⁹

In approaching the rich and complex empirical field of public hospitals, the thesis draws its research contention from Burrell (Burrell and Morgan 1979) who suggests that all approaches to social sciences are based on interrelated sets of assumptions regarding ontology, human nature, and epistemology. In delineating a research approach along the axis polar points of the subjectivistic and objectivistic approaches, Morgan’s (Morgan and Smircich 1980) *core ontological assumption*, considers “reality as a contextual field of information”; *human nature* to be representative of “man as an information processor” and the basic *epistemological stance* to signify the need “to map context” (Morgan and Smircich 1980). Morgan’s position emphasizes the importance of understanding the empirical context in a holistic fashion. Emphasis is placed upon participant actors or actor groups, their vested nature and integrative processes.

As the research question addresses the problem of explaining *how* stakeholder groups influence decision-making, the descriptive analysis applies the prescriptive logic of hermeneutics. Hermeneutics addresses the issue of what understanding is and how one should go about attaining it⁶⁰. The natural sciences hypothesize that causal processes govern construct interaction. Hermeneutics, on the other hand, considers constructs as meaningful inputs into a process that ultimately leads to an explanation about people and groups existing within a special context. The principle of hermeneutics considers the empirical field’s actors and constructs as meaningful input. Actor agent language, symbol systems and other contextual characteristics are viable proponents within the hospital field. Hermeneutics, presupposes a contextual understanding. Thus, in order to answer the research question, the thesis will identify key stakeholder groups with vested interests in hospital decision-making. To understand the nature and position of these constituents, it becomes necessary to learn the true nature of their vested interests as expressed by the groups’ formal objectives and records of interaction. Consequently, in order to fully explain *how* their influence is attained, it becomes necessary to find out the type of power they

⁵⁹ Decision-making levels relevant for the thesis research are identified in thesis section no. 8.3.3 “Decision-making levels”.

⁶⁰ Hermeneutic is the science and methodology of interpretation. (Føllesdal and Walløe 2000).

represent through their structural and/or relational positions opposite organizational decision-making levels.

Thus, from a hermeneutical position, one may surmise that the instrumentality of influence, or the how in the research question, is explained by the nature and application of stakeholder power in hospital decision-making.

6 The importance of the study

6.1 A state of mutual dependency

Stakeholder pressure, sector turbulence and crisis are common denominators within the public health arena in all Scandinavian countries as well as within the modern industrialized world (Vrangbæk 1999). This turbulence and dynamism in hospital environmental conditions serve to impact the public hospital's legitimacy and archetypical organizational structure (Borum 1999). According to Borum, the public hospitals are already undergoing an organizational transformation that may bring into being a totally new institutional configuration. Vrangbæk's contention is that the on-going political-ideological debate will produce entirely new governance models perhaps as a precursor to this new hospital archetype. The emergence of changing governance is already evident. Exemplifying this latter contention is the fact that the established political/administrative system rationale is yielding to market-induced mechanisms to secure an improved maximization of public health (Vrangbæk 1999).

All governance actors are presumed to work in order to fulfill their respective mandates and to meet constituent expectations. The research community has an interest vested in the nature of their occupation to observe, investigate and to promulgate its findings and contentions. The thesis aspires to contribute in these two distinct, but still mutually dependent, arenas.

Within the field of public governance, the analysis and findings are attributable to the sector of public hospital governance. Current descriptive accounts on the management of stakeholder relationships are attractive to all governance actors wishing to improve their performance. Within the community of researchers, development of descriptive/empirical stakeholder theory represents a much called for contribution. Instrumental propositions on public sector governance are in minority in an organizational field dominated by normative/philosophical/ethical prescriptions. The nature of mutual dependency is apparent in the application of contextual accounts. Practitioners request guidance by concepts, models and theories rooted in relevant observations and analysis. The nature of instrumental organization research presupposes access to and comprehension of the empirical richness of the organizational environment. The nature and scope of stakeholder theory is to describe how organizations operate and to help predict the organization's behavior (Brenner and Cochran 1991).

6.2 A pathway to a new paradigm on public hospital governance

The governing rationale of the hospital sector in Norway may reflect an inert faith in Weberian (Weber 1947) prescriptions for the rational bureaucracy. According to Christensen (Christensen 1994) public health authorities in Norway have consistently over the past 150 years relied on organizational measures at ministerial levels to best ensure a constituent balance. In his analysis, Christensen shares his findings of a governance preoccupation with structuralism. Here, the formal organization is considered a critical part in controlling decision-making behavior. However, Christensen's (Christensen 1994) analysis of the public health administration concludes that governance through structural measures alone is difficult. Williamson (Williamson 1996) in his enrichment of transaction cost economics, professes that the study of hierarchical failures is seriously underdeveloped. Quoting Herbert Simon, Williamson subscribes to the former's promulgation that nothing is more fundamental in setting our research agenda and informing our research methods than the view of the nature of the human beings, whose behavior we are studying.

The recognition of the nuances the organizational field, contradicted with the record of reliance on structural governance, may make the hospital sector susceptible to what Borum (Borum 1999) refers to as a *learning paralysis* or *panic reactions* in its reform initiatives. The recent public health reforms in Norway, in which structural measures represent core change properties, have generated a national debate on their ideological justification and operational relevance. In a newspaper article published in *Aftenposten*, 13th July, 2002, Kjell Møller Pedersen at the Syd-Danske Universitet, is quoted as calling the recent Norwegian structural reform an outcome of political panic and lacking any relevant descriptive/empirical reference (Vogt 2002).

The issue of reform measures in the public hospital sector is a classical one in terms of its prescriptive intent to fairly allocate scarce public resources. Funds distribution and its management are constantly evaluated in terms of how stakeholder demands are satisfied. At the core of any public and political debate, is an interest to determine if one practices what one preaches. All public health policies as expressed in the modern laws on hospitals and public governance, advocate a normative/ethical approach promoting the intrinsic value of all stakeholders. Given the essential nature of the product, one would therefore expect that all governance measures be designed to have public hospitals consider all stakeholders in their decision-making. However, the institutional governance system presumes otherwise. Present-day sector governance rewards resource efficiency and clinical

production. The incentives and sanctions are all designed to operate on the assumption that hospitals act opportunistic and in conflict with the sector interests.

The thesis research provides a descriptive/empirical basis of how public governance impacts the mechanics of public health value creation. As such, the thesis findings may serve as a pathway to generating an improved rationale for future governance interventions. An empirical reference to stakeholder influence may furnish an account of the costs of opportunism in terms of how decision-makers depart from altruistic behavior. Findings confirming stakeholder influence will provide a basis for developing stakeholder management in line with sector objectives while balancing the interests of stakeholder merits. The thesis findings may thus serve to make public policy actors cognizant of the governing mechanics of the hospital institution as induced by the many and diverse constituent interests. As such, a set of empirically documented stakeholder theory propositions on the instrumentality of organization behavior, may shift the present governance discourse. A subsequent broadened public and political debate may bridge the gap between classical institutional assumptions and the importance of the theories of decision-making behavior. The thesis' intellectual and operational contributions are depicted in the following table.

Table No. 2: Importance of the study. A shift in discourse

Contributory Focus	Contributory Aspect	Contributory Insight	Contributory Outcome	Contributory Consequences
Governance audit	The mechanics of institutional governance	Costs of instrumental sector governance	Shift in discourse on hospital sector governance	A new paradigm on public hospital governance

6.3 Entering: A theory of the public service organization

A lacking descriptive/empirical basis and an abundance of contributions on the relevancy of normative/philosophical theorems mark the present state of affairs in stakeholder theory. This disparity in research focus curtails any theoretically sound instrumental propositions tied to stakeholder management. Although an instrumental justification for stakeholder theory originally has been established by Friedman (Freeman 1984), some commentators argue that these are inadequate to serve as a theoretical basis (Ogden and Watson 1999). Donaldson advocates that managers should “acknowledge the value of diverse stakeholder interests and should attempt to respond to them within a mutually supportive framework, because that is a moral requirement for the legitimacy of the management function”

(Donaldson and Preston 1995). Recent normative developments in stakeholder theory seek to lock the philosophical views into an operational context. Proponents of the latter may be found in the theory of the common good (Aragandona 1998) tied to Cludt's (Cludts 1999) social system theorem, Both argue for a balancing of constituent interests relative to the organization's societal relations based on the nature of its services. Still, a relevant descriptive account on the instrumentality of stakeholder management is lacking.

The instrumental perspective of stakeholder theory carries its contextual references to a public health framework different from the Norwegian public health system. The socially insured distributive system characteristic of the Scandinavian welfare state differs from the corporate and liberal societal welfare systems found in other European countries. Our universal coverage of hospital costs is secured through general tax funds, public ownership and public sector governance. This is contrasted with social insurance models requiring universal membership and where the financing of hospital costs is secured through employer contributions and mandatory hospitalization insurance. In the latter model, sector governance diverges between public and private solutions, as does the extent of mandatory medical insurance. The universal generalizability of stakeholder theory arising out of an organizational field vested in the societal characteristics of the "Beveridge Model"⁶¹ is at best marginal and has yet to be proven in the research literature. It is presumed that theoretical discussions must be rooted in a logic corresponding with the public sector model rationale. Thus the revelations of new organizational configurations (Vrangbæk 1999) or a new hospital archetype (Borum 1999) may not effectively evolve outside the socio-cultural framework in which the sector system is embedded, unless governance authorities resort to the "panic actions", as cautioned by Borum (Borum 1999).

A targeted stakeholder typology is intended to measure phenomenon characteristics and their interrelationships in the epistemological context of the public service organization. The Norwegian public hospital sector has since the early 80's continuously been seeking workable solutions to accruing sector governance problems. Institutional measures vested largely in classical theoretical assumptions on institutional governance, have proven inadequate to curb the imbalance of output costs relative to the adequacy of patient treatment and care. Politically induced measures to govern the management of hospital resources are vested in classical theories on contractual relationships. The contemporary forms of such prescriptions

⁶¹ Pls. View thesis section 2.2.1 "The dynamism of the stakeholder *fit*".

materialize in NPM-type governance initiatives. According to Eisenhart (Eisenhart 1989), NPM has as its moral discourse that of classical economics: self-interest versus duties, thus prescribing to the contractual principles rooted in agency theory. Agency theory, as part of New Institutional Economics, assumes that economic actors are motivated by self-interest, and will act opportunistically towards each other whenever such behavior is possible or profitable (Eisenhart 1989). The focus of the theory is on deciding the organization of a particular relationship, provided the characteristics of the relationship and the parties involved (Jensen and Meckling 1976).

Sector governance interests in contract-management principles governing hospital budgets and patient treatment requisitions are all remanence of contractual prescriptions. The normative condition here is that managers, as agents, must act only in such a way as to maximize cost efficient behavior, since that is presumed to be the goal of the sector governance, or the principal. Kenneth H. Wathne (Wathne 2001), in his recent doctoral thesis at the Norwegian School of Business BI, notes that incentive and monitoring systems rewarding prerequisite behavior and/or penalize non-compliance, are limited to governance relationship in a dyadic context. According to Wathne (Wathne 2001), agency based contractual relationships do not presuppose governance of a larger network context within which such dyadic relationship exist. An important thesis contribution may thus be to document how multiple dyadic relationships are being managed between decision-makers and multiple stakeholder groups.

The significance of the public hospital sector both in terms of the nature of the product as well as the scope of resources involved, calls for an active engagement by organizational researchers. Reform measures nested closely to classical institutional theories and lacking the complexities of multiple exchange relationships, may point to a paradigm anomaly within *the content of discovery* (Kuhn 1962)⁶². Lacking deterministic theories rooted in relevant descriptive/empirical accounts, call for a paradigm audit within *the context of justifications* (Kuhn 1962)⁶³. New descriptive/empirical theory on stakeholder management represents an important step towards developing theoretical propositions on the nature of the public service organization. The thesis contribution towards such an end is depicted in the following table.

⁶² See thesis section 4.4.2 "Watching out for paradigm anomaly".

⁶³ Ibid.

Table No. 3: Importance of the study.Theory development

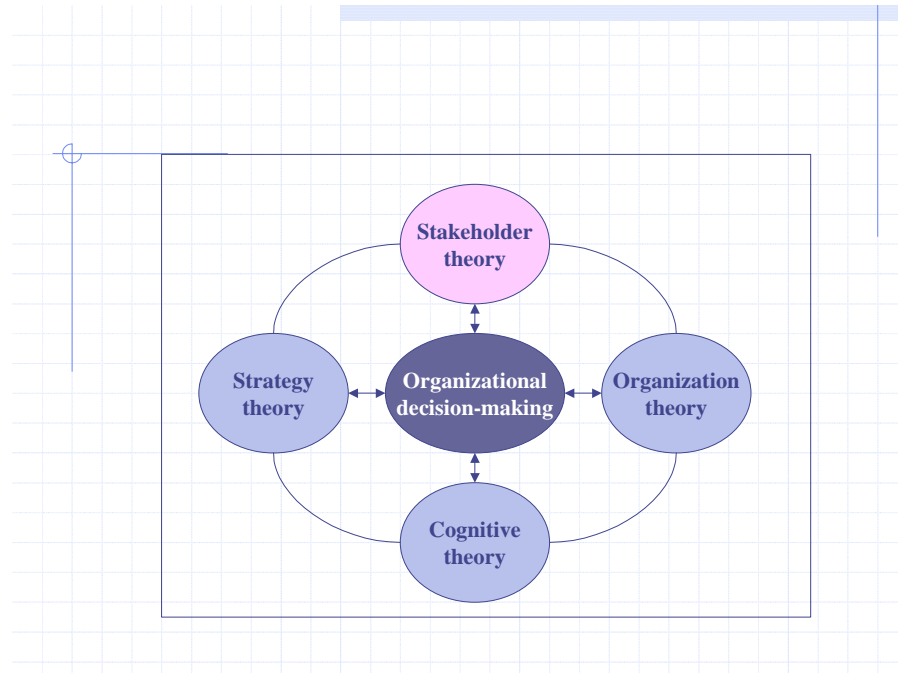
Contributory Focus	Contributory Aspect	Contributory Insight	Contributory Outcome	Contributory Consequences
Theory development	Stakeholder typology	Descriptive/ empirical findings on stakeholder influence on organizational decision-making	Propositions on stakeholder theory	Future research towards developing “A theory of the public service organization”

7 Research strategy

7.1 Towards operationalizing the theoretical constructs

While the thesis research process is put together by means of a combination of data collection techniques, the research procedure remains vested in a comprehensive theoretical framework. According to Judd (Judd, Smith, and Kidder 1990), theoretical constructs represent the starting point for all research measurement. The thesis challenge is to operationalize selected constructs to permit measurements as they relate to organizational decision-making. The thesis' theoretical vantage points is in the following model depicted as constructs pivoting round the hospital's organizational decision-making, here representing the thesis research focal point:

Illustration No. 1: Model of theoretical templates



In seeking to explicate the relationship between stakeholder groups and organizational decision-making in public hospitals, one has followed the recommendations of Smith and Heshusius (Smith and Heshusius 1986) who advise that procedural focus be placed on the elaboration of logical issues and not on a single research method or technique. While heeding the

cautions made against rigorous methodology, one remains cognizant of the fact that the crafting of research procedures should not be done in an epistemological vacuum (Piantanida and Garman 1999). A research approach along the lines of Piantanida’s “logic of justification” (Piantanida and Garman 1999 p. 105) is here subscribed to in order for the results of the empirical inquiry to be generated and supported.

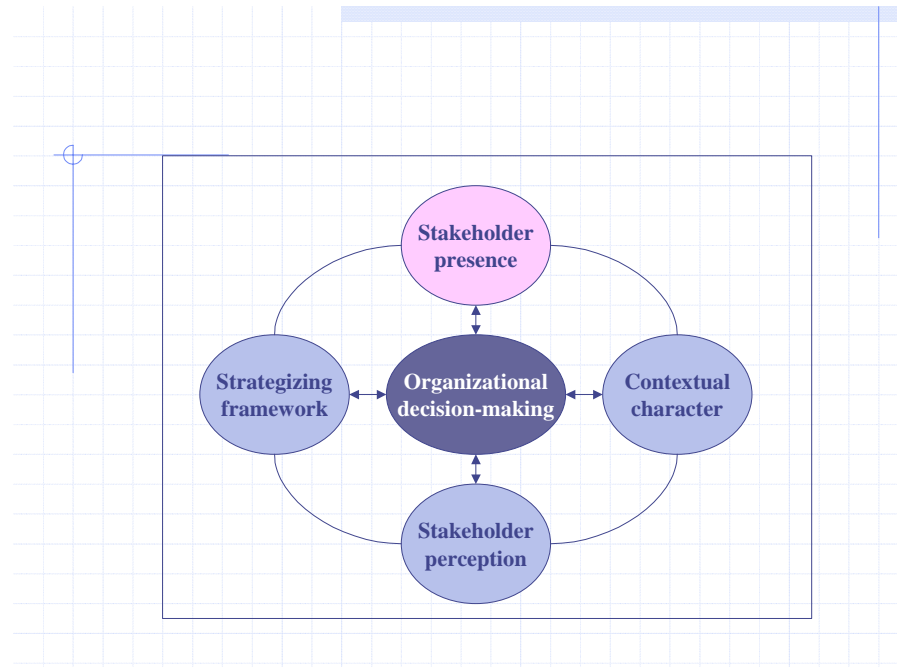
The following statements as shown in Table 4, emphasize the sequential nature of the fieldwork, implicating the need for a differential approach to data collection and analysis. The theoretical vantage point, column (1): *theoretical template* connects with column (2): *construct selection* to be operationalized and validated through statement made in column (3): *logic of justification*. The degree, to which the theoretical templates serve to answer the research question, reflects the selected constructs’ validity.

Table No. 4: Construct selection

(1) Theoretical templates	(2) Construct selection	(3) Logic of justification
Stakeholder theory	Stakeholder presence	The research question addresses the issue of how constituent interests influence organizational decision-making by virtue of <i>stakeholder presence</i> .
Organization theory	Contextual character	Information critical to answering the research question will be collected from within the selected hospitals representative of its institutional <i>or contextual character</i> .
Cognitive theory	Stakeholder perception	The empirical data and other field information will be interpreted within a theoretical framework seeking to determine <i>stakeholder cognition</i> .
Strategy theory	Strategizing framework	Stakeholders’ cognition employed in organizational decision-making may become revealed when applying a <i>strategizing framework</i> that exposes stakeholder reasoning.

To visualize the above selected theoretical constructs in terms of measurable operations, the following “nomological net” (Judd, Smith, and Kidder 1990 p. 46) has been established. A nomological net, as advocated by Judd, displays the interrelationship of the relevant thesis constructs and represents an important vantage point towards establishing the thesis research model of operationalized constructs. A conceptually well related set of constructs makes reference to their operational validity (Peter 1981).

Illustration No. 2: Nomological net



As is evident from this latter model, an operationalization of the theoretical constructs contained in the nomological net, requires the development of an integrated set of research procedures. The challenge is to establish a methodological framework that manifests the informants' rationale as it pertains to hospital issue matters. The relevance of the nomological net is evidenced by the constructs' integrative qualities as is later sought incorporated in the thesis' empirical research model.

7.2 Developing a research model

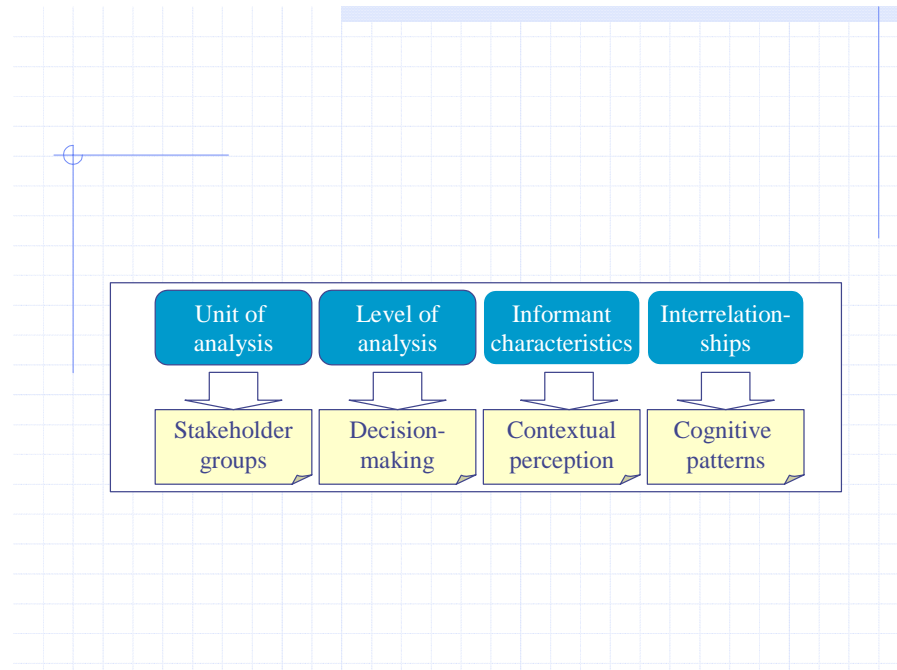
7.2.1 Procedural prerequisites

Before transporting the justifying logic of the nomological net into a final research model, the sequence of empirical fieldwork needs to be established. In illustration no.3, stakeholder informants are representatives of the thesis' *unit of analysis*. Stakeholder informants are to be analyzed both within a particular hospital and as units of analysis between hospitals. To avoid what Judd labels an "ecological fallacy" (Judd, Smith, and Kidder 1990 p. 405),

the unit of analysis needs to be at the same level as what is to be generalized. A brief procedural review safeguards this concern as follows. At the research project's *level of analysis*, construct variables are applied that identify issue matters relevant to stakeholders' vested interests in the hospital decision-making environment. The stakeholder informants' *informant characteristics* are established to help trace the stakeholders' perception relevant to issue matters. Finally, to ascertain construct *interrelationships*, stakeholder group cognition is to be analyzed in terms of how these differ as units of analysis, within and between case hospitals.

This procedure is visualized in the following illustration:

Illustration No. 3 Procedural steps in field data development



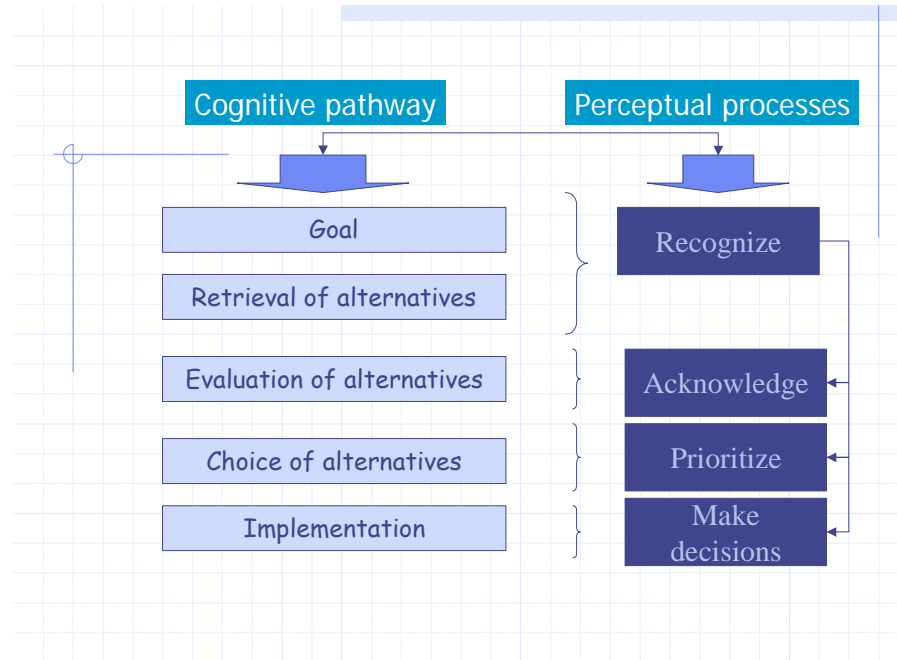
7.2.2 The logic of spatial decision-making

The challenge of working with field informants is one of replicating a real life contextual setting. If successful, the ensuing responses may portray a perceptual process representative of how constituents may act in decision-making situations. Explaining such a process may be accomplished by applying what Gärling and Golledge (Kitchin and Freundschuh 2000) refer

to as spatial decision-making. Spatial decision-making offers an instrumental promise of projecting stakeholder action. Cognitive maps are considered metaphors of cartographic or spatial maps. In the thesis research model one has applied the logic of spatial decision-making. A successful mapping of the informants' patterned perceptions thus implies how people reason to respond to certain decision issue matters. Individuals are believed to have some type of cognitive structure in which information is assimilated and organized, operating as interpretative frameworks. According to Hellgren (Hellgren and Melin 1993), organizational research supports a tight connection to exist between actors' mental structures, their interpretations of the world, and their actions. Thus, responses to questions put forward in the interviews, may be representative of the informants' "wayfinding" (Golledge 1999) pathway logic. The so-called "spatial products" (Liben 1982) representative of construct variables are modified by the informant's screening abilities.

The research model that addresses informant field data is developed based on the logics of cognitive strategizing. Here, decision-making situations are sought replicated where the informants are exposed to issue matters relevant to hospital operations. Cognitive strategizing recognizes actor agents' limited cognitive capacities when faced with complex issue matters. Informants' perceptual abilities may, according to Simon (Simon 1957), be governed by a *bounded rationality* representative of how an individual may cope with complex and dense environmental matters. Still, there is much uncertainty as to an actors' ability to handle problem issues. In the opinion of Roos (Roos, Krogh, and Roos 1994) this uncertainty might be rooted in the shortcomings of research methods rather than in the incumbent's ability to handle information. Thus to arrive at a workable research model, the thesis has as its first step transposed Golledge's (Golledge 1999) *cognitive pathway* into a *perceptual process* replicating a cognitive strategizing framework, as presented in Illustration no. 4. This cognitive framework is in this model remnant of Selznick's (Selznick 1957) *design school* structure, emphasizing the mental process of organizational decision-making.

Illustration No. 4: Processing pathway



In converting the structure of the *cognitive pathway* into a *perceptual process* structure, the stakeholder informant will, in the interview be exposed to relevant hospital issue matters as follows:

- *On Recognition*
 - The informant is confronted with critical issue matters generated by the hospital environment. The objective is to bring about the informant’s attentiveness to competing stakeholder issues relative to the hospital’s operating environment.
- *On Acknowledgement*
 - The informant is confronted with operational issues related to hospital resources management. The objective is to bring about the informant’s awareness of stakeholder expectations perceived relative to the hospital’s operating objectives.
- *On Prioritizing*
 - The informant is challenged to share his/her stakeholder preference on issue matters critical to hospital operations. The objective is to bring about a stakeholder selection based upon a synthesis of issue matters raised in the interview.

- *On Decision-making*
 - The informant's preferred position on the hospital's organizational decision-making situation is identified. The objective is to learn the informant's position representative of the particular stakeholder group being represented.

According to Downs and Stea (Golledge 1999), cognition is a process "composed of a series of psychological transformations by which an individual acquires, codes, stores, recalls and decodes information about relative locations and attributes of phenomena in the everyday spatial environment". The research instrument developed for the informant field data collection seeks to take on these properties. It replicates the mental process of cognition through a series of questions that emphasize an urgency to express one's perceptual preferences. The procedural logic draws on Selznick's (Selznick 1957) contention to the effect that commitments to ways of acting and responding have been built into the organization, intrinsic to its very character. Thus, the induced process of perceptual selection established in the interview, replaces the rigor of real life planning in order for the process of cognition to evolve and manifest itself.

7.2.3 Thesis research model

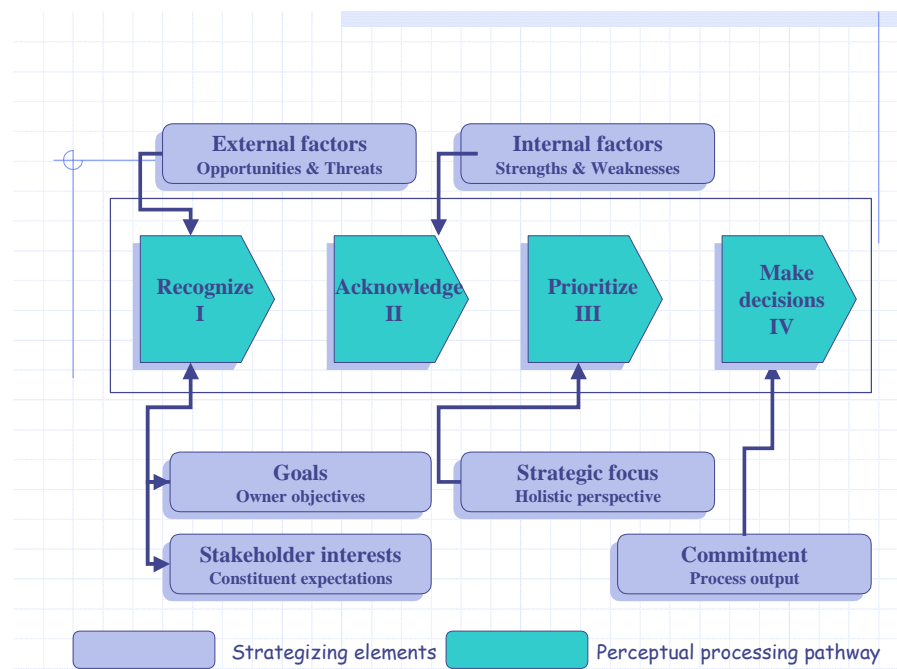
7.2.3.1 Informant interviews

Collecting informant data through empirical fieldwork requires a heuristic model that mobilizes the informant's cognitive processes when introduced to complex issue matters. The thesis research model combines structural and process approaches to facilitate informant feedback. A structural logic has been interjected in the informant questioning precisely to expose informant rationale. The model applies its process qualities when introducing and bridging cognitive and affective issue matters. The approach of triggering both the informant's cognitive rationale and affective perception is supported by Hellgren (Hellgren and Melin 1993). In the latter's opinion, individuals do not act purely as cognitive beings in the narrow meaning of rationale logic. Stakeholder informants are influenced by both patterned values and other factors triggering their emotions. Choice or action therefore takes place in the interplay between rationale and emotions. As is evident in Illustration no. 5, one has superimposed the structure and logic of Selznick's (Selznick 1957) design school model of strategizing onto the perceptual process framework. The uniqueness of this approach is that it challenges the informant to think and respond in a holistic framework, and not to be driven by any single map or scheme (Hellgren and Melin 1993). The thesis

research model thus conceptualizes the cognitive and emotional structures represented by competing stakeholder issues within the public hospital.

The thesis research model illustrated next, identifies constructs connected to the cognitive processing pathway.

Illustration No. 5: Thesis research model: Informant interviews



The issue matters raised in the informant interviews will consist of “thematic sets of values” (Hellgren and Melin 1993). These are composed of assumptions, beliefs, ideas, and thoughts relevant to the public hospital. All are believed to be representative of today’s contextual field and commonly known to all stakeholder group representatives. Dominating informant orientations may be representative of stakeholder groups’ “way-of-thinking” (Hellgren and Melin 1993).

7.2.3.2 Archival records information

As part of the fieldwork, the thesis will also collect hospital archival data. This will consist of formal records documenting organizational structure,

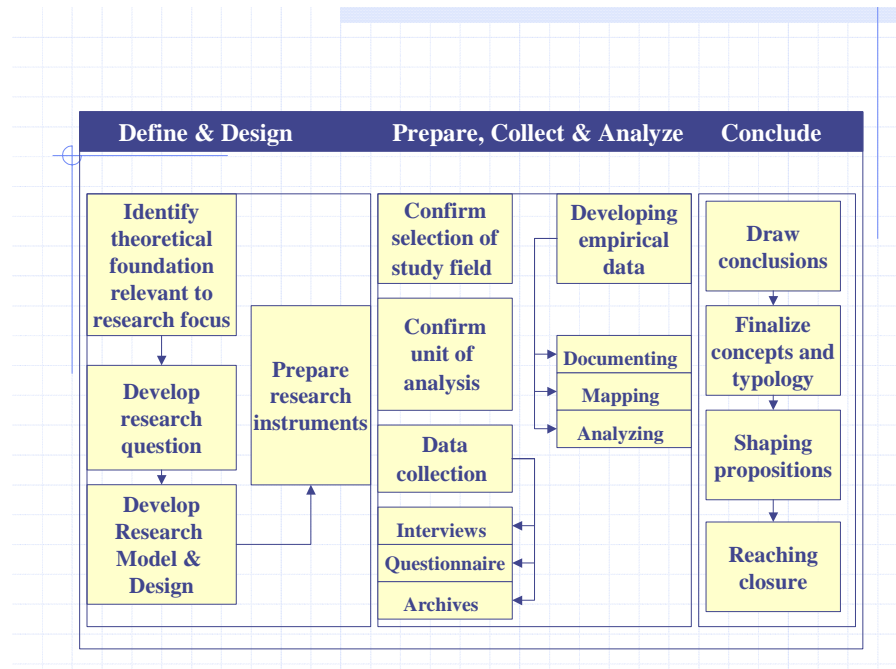
managerial processes and process outcomes. Such data is considered important to the thesis as it provides insight into the nature of a hospital's formal decision-making. Participant actors will be identified and their priorities analyzed as records of formal management meetings confirm the decision-making agenda and the ultimate priorities. Efforts are made to delineate records obtained from the various archival data base sources to depict contextual nuances at different decision-making levels. Properly construed, the combined analysis of informant data and archival records may bring the thesis closer to an answer as to how stakeholder groups influence organizational decision-making in the public hospital.

8 Research design and methodology

8.1 Research orientation

The project work design as shown in illustration no. 6, outlines the major research phases leading up to thesis closure. The model draws its schematic support from Yin's (Yin 1994) single case replication logic, visualizing a preference for theory development prior to data collection. Yin's contention is that theory development, as part of the research design phase is essential in case studies.

Illustration No. 6: Project work design



Conducting a study of stakeholder groups in a public hospital, conceptually qualifies as a within-case research approach. Adding multiple cases, as the thesis research will, permits between-case analysis. This is expected to add confidence to findings, strengthening validity and stabilizing generalizations. Thus, the thesis research subscribes to a strategy of employing *multiple comparison groups* (Miles and Huberman 1994). The mere use of multiple cases still does not provide for any stronger grounds for improved generalization per se. However, as will be shown from the thesis' selection

of sampling boundaries, the choice of cases is to be made on conceptual grounds, not based on statistical merits.

Yin's emphasis on the role of theory development prior to collecting data, is opposed to the *theory building* approaches as prescribed in *grounded theory* (Bryman and Burgess 1994). However, according to Bryman, there are few genuine cases of "grounded theory" using the approach as originally conceptualized by Glaser and Strauss (Glaser 1967) and Strauss and Corbin (Strauss 1996). The relative position of theory preceding research design has in this thesis project been applied as an inductive agent to direct the thesis research. The identification of the thesis' theoretical templates makes up the conceptual foundation of the nomological net. As such, the approach serves to sharpen the thesis' analytical scope. Framing the study through empirical field boundaries facilitates the analysis of informant feedback. The research framework is considered theory driven while empirical data is progressively collected. The general sampling methodology thus allows for the identification of phenomena crucial to subsequent theoretical propositions.

8.2 Epistemological and ontological considerations

8.2.1 Competing arguments on methods and methodology

The research approach does not ascribe to the laws of classical deductive positivism. Thesis explanations are derived from how different empirical field structures reflect the events observed and how this is analyzed. One looks for individual rationale and affective perception patterns indicative of cognitive processes explaining contextual processes. As expressed by Howe (Howe 1988), one ought to be wary of abstract epistemological arguments that do not connect operationally with the actual practices used to gain knowledge (Miles and Huberman 1994). The way in which a research question is asked determines the research method that needs to be applied in order to answer it (Strauss 1996). The "how"-question calls for explanatory type research strategies (Yin 1994). According to Yin, this justifies dealing with operational links rather than mere frequencies or incidence. Thus, determining whether to apply a qualitative or a quantitative approach depends upon the challenges contained in the research problem. The thesis works with small stakeholder populations within a few cases of public hospitals. This research setting does not lend itself to quantitative methods where the purpose is generalizations for universal applications. Nor does the research question entail making direct statements about relationships between a dependent and an independent variable. The purpose is not hypothesis testing. However, any thesis research requires a method that

takes a basic epistemological stance relative to the research objective. Morgan (Morgan and Smircich 1980) reject the idea that the world can be represented in terms of deterministic relationships. In their contention, it is emphasized that “social situations should be researched in a manner that reveals their inner nature” (Morgan and Smircich 1980). The knowledge and findings developed in the thesis’ empirical fieldwork need to be seen as relative and specific to the immediate context and situation from which it is generated. In this way one may build what Glaser calls “substantive theory” (Glaser 1967 p. 32) developed from a contextual inquiry and grounded in empirical data.

8.2.2 Conceptual understanding of organizational choice

To uncover the presence of stakeholder influence necessitates a conceptual understanding of what constitutes organizational decision-making. From the thesis’ contextual analysis one may surmise that the allocation of health resources seldom follows the bureaucratic axis of hospital governance. Cyert and March (Cyert and March 1992) argue that decision-making should be analyzed in terms of the variables that affect organizational goals. These are variables that influence organizational expectations that again impact organizational choice. As previously argued in the literature review, affirmative post-modern ethics theory relies on the organization’s capacity to reflect, represent or model the world without supposition. In other words, organizational solutions may be perceived in the context of the organization’s cultural nature (Cludts 1999). Selznick (Selznick 1957) labels this the significance of institutional norms and values. In Argadona’s (Aragadona 1998) theory of the common good, emphasis is made on the importance of learning the company’s social relations maintained by its members with internal and external stakeholders. One may therefore say that the nature of the hospital’s operations culminate in organizational decision-making. Such decision-making emanates from an interpretation of participating actors’ vested interests. Organizational members will seek to find appropriate solutions applying an institutionalized rationale linked to fundamental communication processes within the organization (Blegen and Nylehn 1969). Having stakeholder informants display their patterns of cognitive logic offers a promise of identifying an empirically sound basis for answering the research question.

8.2.3 Epistemological stance

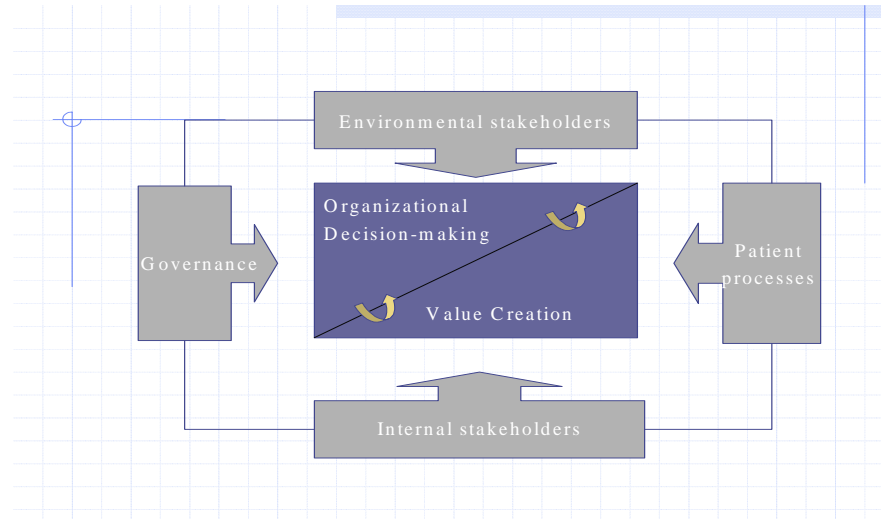
The knowledge of the world of the public hospital as it relates to stakeholder interaction implies the need to understand and map its structure. The interaction between stakeholder groups in the context of decision-making, gives rise to positivism, with emphasis on the empirical analysis of concrete relationships. However, such a research methodology encourages an

objective form of knowledge specifying the precise nature of laws, regularities and relationships among the phenomena measured. With respect to the thesis project, it is therefore important to revert to the epistemological stance of Morgan (Morgan 1988) advocating a move away from the conception of the world as a closed system, to a conception of the world as an organism or an open system. Morgan's core ontological assumption favors "a reality as a realm of symbolic discourse" (Morgan 1988 p. 195). This epistemological position rejects the idea that the organizational environment can be represented in terms of deterministic relationships. One may therefore say that knowledge, understanding, and explanations of organizational affairs must take account of how participant order is fashioned in ways that are meaningful to the organizational actors.

8.3 Stakeholder framework

As previously outlined in the literature review, the stakeholder perspective on decision-making rests with the individual. However, this is to be perceived of from the perspective of goals and objectives shared within the stakeholder group. The presence of stakeholder groups convening on the hospital's value chain operations generates a dynamic and evolving arena. Stakeholder interests are sought balanced or complied with by the decision-making actors. In illustration no. 7, a stakeholder framework for the public hospital as a generic class, has been developed. The model depicts constituent representations converging on the point of decision-making. This particular scheme draws on the contextual significance of the hospital and dramatizes the diversity and scope of constituent presence.

Illustration No. 7: A framework of stakeholder forces



No distinction is made, as with Freeman’s model (Freeman 1984), classifying stakeholders into primary and secondary constituents. In a managerial and instrumental perspective, Freeman’s stakeholder segmentation has as its ultimate goal to serve the interests of company shareholders. Nor is the proposed stakeholder model making any effort to distinguish, as does Porter (Porter 1980), between primary and secondary value chain processes. Porter’s value chain analysis is intended to strengthen the organization’s competitive position in the market place.

Within the thesis research framework, all decision-making in the hospital may in principle be considered viable processes. According to Ogden’s (Ogden and Watson 1999), the organization needs to maintain a certain “fit” between the mandate of its governance and the expectation of its shareholders. This position is representative of the normative prescription of the intrinsic value of all stakeholders with regards to public goods (Donaldson and Preston 1995). The lack of countervailing forces, parallel to the private sector’s dynamic interplay between company shareholders and market forces, opens up for a more unpredictable influx of stakeholder groups in organizational decision-making.

8.3.1 Informant approach

Conducting intra-organizational analysis poses a challenge to the methodology of informant selection. The viability of constituent interests

vested in the mandated functions of the public hospital has been confirmed in the thesis' contextual analysis. Analyzing how stakeholder groups may influence decision-making outcome rests on information collected from representatives of key stakeholder groups. The selection of the unit of analysis rests on the assumption of a specific dyadic relationship between constituent interests and decision-making actors.

The selection of stakeholder groups and stakeholder group informants represents a challenge with respect to informant bias. Informant methodology represents at the outset a potential for validity drawbacks. The selection problem is represented by identifying informants competent to report on dyadic relationships (Kumar, Stern, and Anderson 1993). A second problem also pointed out by Kumar, is the challenge of potential dissimilarity on perceptual agreement between competent multiple informants. Therefore, when addressing the thesis research question, one will seek to address how stakeholder groups convene on organizational decision-making at specific organizational levels. To resolve this challenge, one will be pooling stakeholder informants operating tangent to the organizational positions to record their issue focus. The following key informant methodology is subscribed to in order to resolve the challenge of informant bias.

Table No. 5: Informant selection methodology

Key informant methodology	Method rationale
A consensual approach	Multiple informants to be selected from constituent groups sharing positions on items relevant for organizational decision-making.
An approach of aggregating responses	Multiple informant responses to be pooled relative to organizational level indicators

8.3.2 Stakeholder selection

8.3.2.1 Methodological approach

To describe the relationship between stakeholder groups' vested interests and decision-making outcome, the thesis ascribes to the existence of a dialectic relationship between deductive and inductive research. The hospital's operational arena provides a basis for a field-directed *a priori* assumption with respect to the identification of stakeholder groups to be recognized in the context of the thesis research. This deductive approach serves to reduce the scope of stakeholder groups to be represented. The

project's inductive approach aims at establishing the nature of relationships between stakeholder group interests and their capacity to influence decision-making. Instead of having to choose side with the methodological arguments of "theory first or theory-later" (Wolcott 1992), one has sided with the argument that both the deductive and the inductive approach support each other in establishing a cause-and-effect relationship (Miles and Huberman 1994).

The stakeholder model shown in illustration no.8, establishes a conceptual construct abstraction of the interaction between representative groups of constituent interests (Judd, Smith, and Kidder 1990). The model itself does not preclude any one particular constituent stakeholder group. It merely depicts a generic representation or a typology of constituent classes. Through the preceding contextual analysis, one has identified those stakeholder groups that command the attention of hospital decision-making. The relative constituent position is shown in the circular matrix. Here, internal and external stakeholder groups convene on the particular decision-making arena within the public hospital. The empirical analysis will evaluate how internal and external stakeholders operate in a particular matrix relationship to reach closure. The external stakeholder groups are visualized in the model's outer circle. These groups have a vested interest in keeping contact with internal counterparts to induce action on their behalf. This is accomplished by virtue of mandate, or through corporate channels. Suppliers of items critical to clinical activity may have as their most common tangent point the ward directors or the supervisors of clinical activity. Hospital boards maintain their executive dialogue with hospital's operations management. Next, professional affiliations, or membership organizations representing various medical type professions, have a direct access to membership representatives within the hospital's clinical environment. The so-called proxy agents are seen to speak on behalf of patients or patient groups classified by common medical diagnosis. As previously outlined in the thesis, such proxy organizations are established outside the hospital but keep a visible profile within the particular hospital. Internal stakeholder groups are shown in the model's inner circle convening on the decision-making arena. The thesis objective is to find an answer as to how external stakeholder groups influence decision-making either through or in competition with their tangent internal counterparts in the context of decision-making.

Illustration No. 8: A model of public hospital stakeholders



8.3.2.2 A descriptive stakeholder account

The thesis' contextual analysis represents the basis for the following descriptive accounts of hospital internal stakeholder groups⁶⁴. These descriptive accounts will be applied in the analysis of informant interviews.

8.3.2.2.1 Hospital internal stakeholder groups

8.3.2.2.1.1 Hospital management

The following table outlines the constituent platform of hospital management as an internal stakeholder group critical to hospital performance.

⁶⁴ Hospital external stakeholder groups are descriptively analysed in thesis section 10.3.2.2 "At operations management level".

Table No. 6: Stakeholder group: Hospital management

Stakeholder class	Stakeholder group	Group objectives	Group's significance to hospital operations	Group's collaboration with hospital interests
Hospital management	<p>Hospital top management (TM) made up of managing director and the directors of key staff positions such as Personnel, Finance and including the director's medical advisor ("Sjeflege") and advisor on nurses activities ("Sjefsykepleier").</p> <p>Also at times including staff directors on HMS (Health, Work environment and Safety), Information.</p>	<p>The TM seeks to maintain its decision-making process by creating a best "fit" between recognized constituent interests.</p>	<p>The TM, as a group, acts as gate keeper and facilitator for hospital operational activities</p>	<p>The actions of hospital management influences how the hospital may accomplish governance objectives.</p>

8.3.2.2.1.2 Work force representation

The next table depicts the stakeholder group position of "Work force representation" groups. The significance of the "Work force representation" groups is evident in their call for frequent consultations, information exchanges and negotiation processes with hospital management. Within the case hospitals, hospital internal employee federation representatives of Dnlf (Norwegian Medical Association) and the NSF (Norwegian Nurses' Association) work full time to ensure hospitals' abidance by their collective arbitration agreements and to promulgate federation issues.

Table No. 7: Stakeholder group: Work force representation groups

Stakeholder class	Stakeholder group	Group objectives	Group's significance to hospital operations	Group's collaboration with hospital interests
Work force representation groups (WFRs)	Employee affiliation groups recognized by the hospital's governing bodies.	To ensure that the hospital upholds negotiated agreements governing the members' employment rights and duties.	The hospital's abidance by negotiated agreements is important to avoid costly labor conflicts.	Strategies and actions by the National WFRs for both doctors and nurses impact how hospitals work to achieve its objectives.

8.3.2.2.1.3 Patient client groups

The following table identifies patient client groups acting as representative of patients generally admitted to the hospital without any initial collaboration with formal patient group organizations. The issue of patient rights has been argued politically and in the national media particularly since the mid 1980s⁶⁵. Augmented by the Norwegian Patient Association (Norsk Pasientforening), patient rights were put into a new law January 1, 2001 (LOV av 2. juli 1999 nr. 63 (Pasientrettighetsloven) 1999). Also international declarations on human rights, such as The World Health Organization's "The Declaration on the Promotion of Patient Rights in Europe (Amsterdam 28.-30 March, 1994) and "The Ljubljana Charter on Reforming Health Care", approved by WHO's European Office, June 18th, 1996 serve to promulgate patient rights within a European context. In Norway, the issue of patient rights culminated in incremental legislation prior to the aforementioned comprehensive new law on patient rights. Particularly, the law permitting patient choice of hospital treatment institution⁶⁶ and providing for a patient waiting list guarantee⁶⁷ have served to bring the issue of patient rights into a collective stakeholder perspective opposite the public hospital sector.

⁶⁵ A historical account of the legal process culminating the law on patient rights ("Lov 2. Juli 1999 NR. 63 Om Pasientrettigheter"), is outlined in Government white paper Ot prp nr 12 Lov om pasientrettigheter 1998-99, p.p. 14-30.

⁶⁶ Government white paper: St meld nr 24 (1996-97), Innst S nr 237 (1996-97).

⁶⁷ Government white paper: St meld nr 44 (1996-97), Innst S nr 27 (1996-97).

Table No. 8: Stakeholder group: Patient-client groups

Stakeholder class	Stakeholder group	Group objectives	Group's significance to hospital operations	Group's collaboration with hospital interests
Patient -client groups	By virtue of the patients' uniform expectancy of immediate access to professional, timely and courteous treatment, make hospital patients part of a virtual but still potentially powerful stakeholder constituency.	To ensure that the patient receives necessary medical attention.	To exert their rights, hospital patients may call on sector audit groups to argue their grievances.	Satisfied patients represent an important testimony to the qualities of a particular hospital. Patient-doctor collaboration is important also to secure empirical accounts of treatment regimen critical to medical research.

8.3.2.2.1.4 Clinical supervisors

The following table identifies clinical supervisors critical to the hospital's core medical services. Clinical supervisors are generally in charge of a medical ward. The government white paper NOU 1997:2 makes reference to the clinical ward as a major organizational unit within the hospital⁶⁸. A clinical ward may be defined as an organizational unit within the hospital. The purpose of such a unit is to conduct highly specialized medical sub-activities as part of the hospital's comprehensive medical services. The specialized medical services function is part of a wider medical field possibly having several tangent specialties and other subordinate medical specialty fields⁶⁹. All case hospitals include ward managers in the hospital director's top management team. One may, however, also talk of the clinical

⁶⁸ See particularly section 5.6.1.1 "De kliniske avdelingene", p.p. 33-34.

⁶⁹ Ibid; "En klinisk avdeling kan defineres som en organisatorisk del av et sykehus, hvis oppgave det er å utføre en spesialisert medisinsk delfunksjon av sykehusets totale virksomhet. Denne funksjonen omfatter vanligvis et fagområde som er identisk med en medisinsk hovedspesialitet, evt., med en eller flere grensespesialiteter og sjeldnere en eller flere subspecialiteter. En klinisk avdeling vil som regel omfatte sengeposter, poliklinkker, undersøkelsesrom og -fasiliteter".

directors as a cohesive constituent group. In as much as its members commonly include medically trained staff, their professional uniformity add to the constituents' common traits and characteristics. Another factor unifying ward managers is the call for professional autonomy in organizing and performing clinical activities. This is particularly promulgated in the law on medical doctors calling for professional duties to be organized in accordance with medical prerequisites⁷⁰.

Table No. 9: Stakeholder group: Clinical supervisor

Stakeholder class	Stakeholder group	Group objectives	Group's significance to hospital operations	Group's collaboration with hospital interests
Clinical supervisors	The clinical supervisor works within a managerial echelon but acting in unison as a stakeholder group.	To ensure the continuance of resources, staff and facilities necessary to fulfill ward objectives.	The ward director supervises all medical activities and as such commands the resources application critical to the achievement of hospital objectives.	Hospital management is dependent on ward managers' capacity to effectively apply allocated resources in line with hospital objectives.

8.3.3 Decision-making levels

The most commonly found functional organization model of public hospitals is described in chapter 3, "The public hospital"⁷¹. Erichsen's (Erichsen 1996) contention on hospital organization, is that health institutions operate within various degrees of established formal and informal jurisdiction. The continuous challenge has always been to balance converging interests arising in a multi- functional institution. Public hospitals have, since the general acceptance of the governing logic of New Public Management (NPM), been seeking to balance formal supervision and operational autonomy. According to Christensen (Christensen and Lægveid 2001), structural transitions within public organizations introduced along the analogy of NPM, have produced disintegrated and fragmented organizational hierarchical structures. Thus, a formal organizational framework of the public hospital does not lend itself to

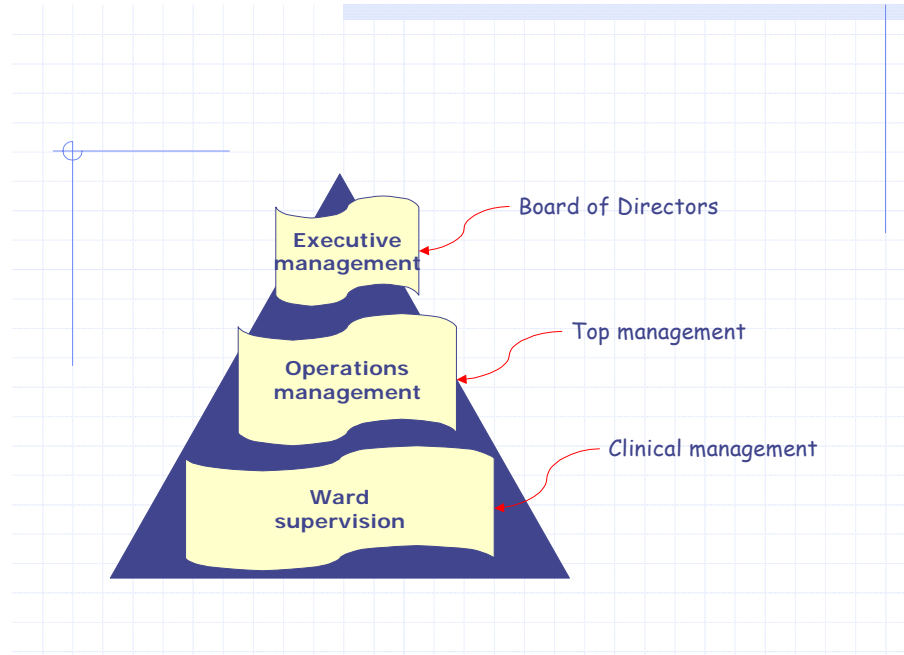
⁷⁰ Lov av 13 Juni 1980 Om Leger (as amended July 30th, 1992); specifically section II, §§ 16, 17 "Legens rettigheter".

⁷¹ See specifically thesis section 3.3 "Organizing for medical services"

any clear-cut illustration of its true operational dynamics. However, as the thesis research model addresses the question of how organizational decision-making is conducted, it becomes necessary to identify where decisions are made that are most critical to hospital value creation.

Within the context of the hospital ward, present-day organizational structures exhibit a pattern of horizontal specialization and vertical differentiation much along the development of medical fields. This latter pattern is evident in the hospital's formal hierarchical structure. The managerial jurisdictions within the public hospital distinguish between the executive authority as represented by the hospital board, hospital administrative management and ward operations. The thesis research will hence address the tri-level hierarchical organizational levels in its efforts to identify organizational decision-making in public hospitals.

Illustration No. 9: Hospital decision-making sectioning



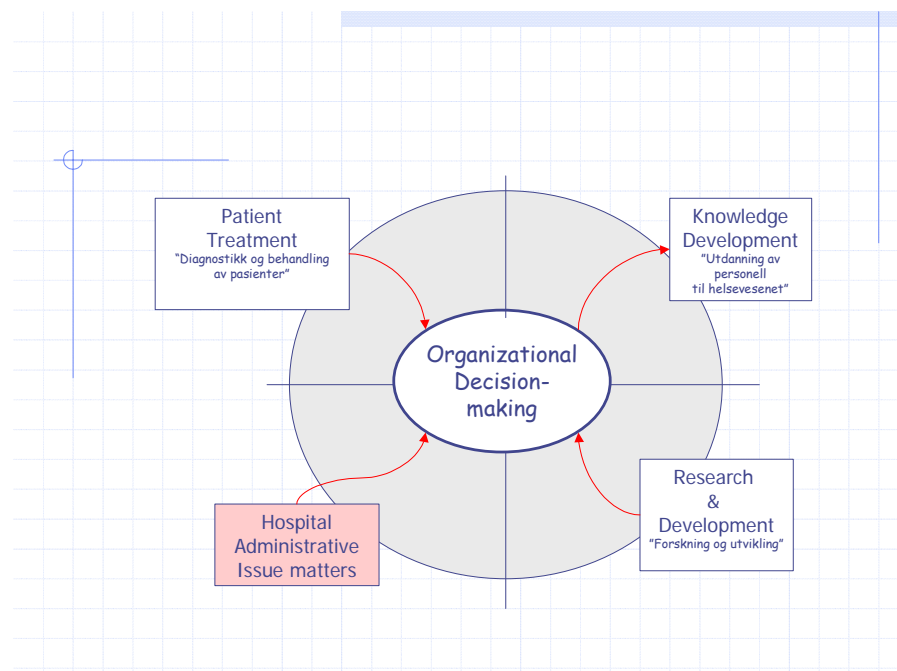
8.3.4 Decision-making properties

In the thesis project, stakeholder groups' influence is to be measured in terms of their relative influence on decision-making outcome. The analytical vantage point therefore is the public hospital's core functional tasks. These

are stated in legislation on hospital activities and sector prescriptions⁷². To accomplish this analytical objective, and hence answer the research question, the thesis will seek to determine what issue matters are addressed at what management level.

Illustration no. 10 depicts the public hospital's functional obligations relevant to the analysis of its decision-making. Decision-making matters addressed, but falling outside the three core hospital functions, will be recorded as "hospital administrative issue matters".

Illustration No. 10: Analytical framework: Stakeholder influence



8.3.5 Case sampling properties

The sampling technique applied with respect to locating stakeholder groups within the hospital institution, may be representative of what Kuzel (Kuzel 1992) labels *purposive*. This connotation refers to a limited sampling

⁷² See thesis section 3.3.1 "Hospital services functions".

population explained by the logic and coherence of particular properties governing the targeted empirical field.

Hospitals are to be selected based on properties qualifying for contextual richness and case category representation. The purpose is to secure the presence and interplay of constructs as identified in the nomological net and as specified in the sampling properties. Stakeholder groups (admitted into the unit of analysis' sample population) may reveal common as well as differentiated characteristics on properties relevant to the research question. As such, the sampling technique is conceptually driven and should follow boundaries established in the construct variables. To ensure that sampling supports the thesis research strategy, the following sampling properties have been selected to serve as guideposts to the selection of case hospitals.

Table No. 10: Sampling properties

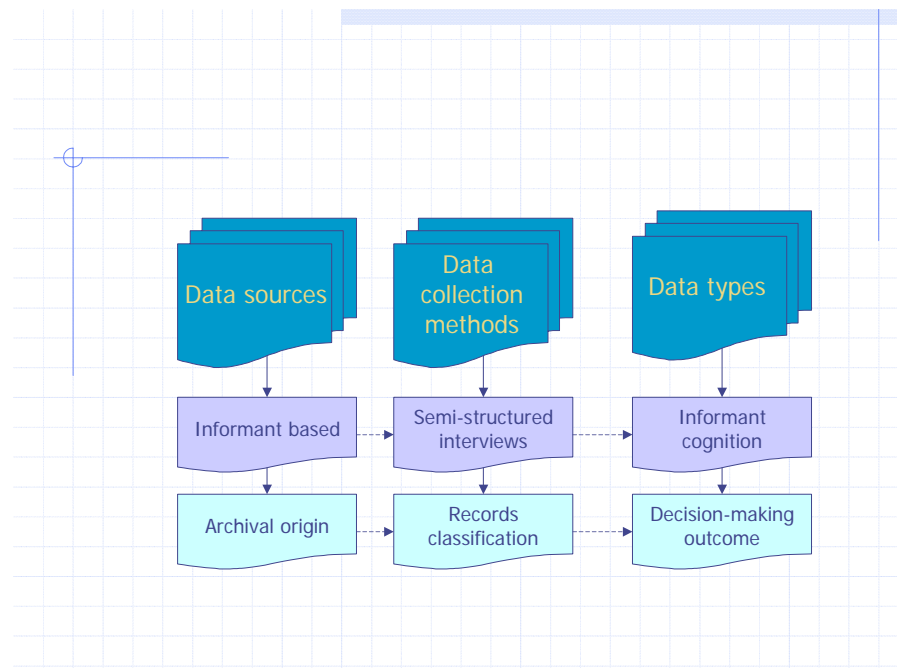
Case sampling prerequisites	Purpose
Theory based	To find examples of theoretical constructs and associated variables.
Critical case	To permit logical generalizations as per research questions based on case properties present.
Typical case	Should be representative of class hospital throughout the population universe of public hospitals in Norway. Permits logical generalization.
Politically important case	Case hospital to be representative of case properties important to sector governance.
Opportunistic case	Case hospital to be representative of properties tied to new law on hospital governance. This creates an opportunity for later comparative analysis of stakeholder relationships
Stratified purposeful	Case hospital to be representative of diversified population of stakeholder groups
Method's conformity	Empirical methods' uniformity between case hospitals

8.4 Data collection methods

The diversity of stakeholders and their presumed multiplicity of interests necessitate a uniform approach to data development. This is to establish a best possible foundation for data analysis and empirical generalizations. To answer the research question, a multiple source approach method is employed to obtain the empirical evidence.

The methodological triangulation employed in the thesis research involves collecting differentiated (1) *data sources* and applying (2) different *data collection methods* as well as (3) developing different and unique *data types*. This triangulation method is expected to yield a set of synergistic data. Thus, it may be said that the validity support resulting from the use of the triangulation strategy provides a better basis for *generalizations* in the interpretation of the data (Eisenhart 1989).

Illustration No. 11: Data triangulation



In Bryman’s view (Bryman and Burgess 1994), triangulation is not merely a method condensation to have one single research method checking the validity of another. Each data source and collection method yields data about different phenomena. The purpose of triangulation, as done in this research project, is to enhance the quality of the overall analysis. The analytical challenge is to combine static archive information with responses to questions engaging the informant’s intellect. The challenge is sought resolved by making the qualitative components reveal the processes and perspectives of those actually involved in decision-making with the principles applied to rationalize ultimate priorities evident from documented records.

9 The research setting

9.1 The national population of public hospitals

The national population of public hospitals in Norway, as organized into formal entities⁷³, consisted in 1999, of 67 such institutions⁷⁴. A public hospital's functional classification serves as a distributive guideline for sector resources' allocation. Table no. 11 lists the population of public hospitals by functional category and their corresponding employment of medical doctors and registered nurses.

Table No. 11: National population of public hospitals (1999) (Rønning 2000).⁷⁵

Type hospital (Excluding 8 smaller State-owned speciality clinics and Det Norske Radiumhospital; i.e., an oncology hospital)	Number of hospitals in each category	Number of medical doctors employed within each hospital category (%-share of national population category)	Number of registered nurses employed within each hospital category (%-share of national population category)
<u>Regional hospitals:</u> (Rikshospitalet is classified as the Regional hospital for Health Region East. Ullevål sykehus is classified as the Regional hospital for Health Region South. Haukeland sykehus is classified as the Regional hospital for Health Region West)	5	2441 (37.5%)	7032 (33.5%)
<u>County hospitals:</u> (Inclusive of hospitals owned and run by the city and county of Oslo)	12	1862 (28.7%)	5926 (28.2%)
<u>Community hospitals:</u> (Inclusive of hospitals owned and run by the city and county of Oslo)	50	2202 (33.8%)	8050 (38.3%)
Sum	67	6505 (100%)	21008 (100%)

⁷³ In several health regions, county administrations have merged hospitals and thus report on them as consolidated units.

⁷⁴ As outlined in thesis chapter 3, "The public hospital", and detailed in section 3.2, "The governance model", a hospital institution's scope of operations is prescribed by its functional classification; i.e., hence the thesis applied term: class hospital.

⁷⁵ (Rønning 2000). Table developed by using data from table 8.2 "Antall årsverk etter sykehuseier, sykehus og personellkategori", p. 126. Somatiske sykehus 1999.

As shown in table no. 11, the nation's five regional hospitals account for the employment of approximately 1/3 of all medical doctors and nurses.

The next table shows the relative representation of employment groups working in public hospitals.

Table No. 12: Sum m/y (man year) by employment category (1999) (Rønning 2000).⁷⁶

Sum man-years (m/y) by employment category	m/y	% of total m/y	% Accumulated
Sum m/y medical doctors ⁷⁷	6692	11.8%	11.8%
Sum m/y registered nurses ⁷⁸	21699	38,4%	50.2%
Sum m/y other patient treatment personnel	11501	20,4%	70.6%
Sum m/y administrative personnel	7710	13,6%	84.2%
Sum m/y other personnel employed in the hospital	8926	15.8%	100.0%
Sum m/y all categories	56527	100%	

Looking at the employment structure making up the public hospitals' working population as denoted by m/y, shows that medical doctors and registered nurses account for approximately 50% (50.2%) of the total m/y recorded. The development trend for professions employed in public hospitals between 1993 and 1999 confirms that the number of medical doctors and registered nurses grew by 4.3% and 4.2% respectively (Rønning 2000)⁷⁹. The growth in administrative staff in the same period was 6.8%⁸⁰.

9.2 Sampling characteristics

To create a case sample population it is necessary to determine how the various hospital types fit the sampling property requirements. In table no. 13, the functional characteristics for each hospital category are listed and evaluated in terms of their sampling significance.

⁷⁶ Table developed by using data from table 2.5 "Antall årsverk – nasjonale tall", p. 31. Somatiske sykehus 1999.

⁷⁷ Inclusive of the state owned specialty clinics.

⁷⁸ Inclusive of the state owned specialty clinics.

⁷⁹ Table developed by using data from table 2.5 "Antall årsverk – nasjonale tall", p. 31. Somatiske sykehus, 1999.

⁸⁰ Ibid.

Table No. 13: Sampling significance

Hospital category	Functional characteristics	Sampling significance
Regionspsykehus (Regional hospital)	<ul style="list-style-type: none"> • Larger scale clinical operations (400 beds +) • Performing national and regional clinical functions requiring larger scale resources operations • University based functions • Both State and County governed units • Limited to five such units in the Country⁸¹ 	<ul style="list-style-type: none"> • Medical staff closely linked to university functions • Special national status afforded on research projects • Larger scale planned clinical operations relative to other hospitals' share of elective patient cases
Sentralspsykehus (County hospital)	<ul style="list-style-type: none"> • Larger scale clinical operations (200 to 400 beds) • Maintains one or more assigned national and/or regional levels of medical field/clinical specialities ("Sentralspsykehusfunksjoner" – "Universitetsspsykehusfunksjoner") 	<ul style="list-style-type: none"> • Large population of doctors and nurses. • Arena for medical research projects.
Lokalspsykehus (Community hospital)	<ul style="list-style-type: none"> • Clinical activity scaled to fit population scope and local epidemiological characteristics • Scope of clinical activities commonly limited to the four-functioned hospital structure ("Det fir-delte psykehus"; i.e., surgical unit, internal medicine, maternity, emergency unit) • High rate of acute based admissions. 	<ul style="list-style-type: none"> • Staffing closely matching scope of clinical services.

As expressed in the above table, the national hospital classifications distinguish between scopes of clinical operations. The county and community hospitals combined employ 2/3 of doctors and nurses. The amount and type of resources allocated to regional institutions, serve to further distinguish between the natures of operations. Regional institutions

⁸¹ (St.meld. nr. 9 (1975): Sykehusutbygging i et regionalisert helsevesen).

are by their very operational scope, administration and university-linked activities, clearly an *a-typical* case in the population of public somatic hospitals.

Relating the hospital case category of regional hospitals to the criteria of sampling properties as specified in table no. 10, shows that case sampling pre-requisites are not satisfied. Clearly, examples of theoretical constructs may be identified as prescribed in the nomological net as depicted in illustration no. 2. Relative to the selected key sampling properties, it is apparent that only county and community hospitals meet a set of desired case sample standards.

The outcome of a sampling conformity control is listed in table no. 14, in which case hospital categories are checked relative to case sample properties.

Table No. 14: Sampling conformity test

Hospital category	Theory based	Critical case	Typical case	Politically important case	Opportunistic case	Stratified purposeful	Method's conformity
Regional Hospital							
County Hospital							
Local hospital							



Satisfied



Not satisfied

9.3 Case sample development

9.3.1 Case study tactics

The very nature of the phenomenon under study challenges the utility of methodology. According to Eisenhardt (Eisenhardt 1989), case studies' focus is on understanding, and thus exemplifies the dynamics present within single settings. In order therefore to secure the quality of data necessary to establish a complete statement in response to the research question, Yin (Yin 1994) proposes that a set of *case study tactics* be established. Consequently, table no. 15 has been developed as a reference instrument. The purpose is to identify the type of quality assurance control in order to meet validity standards relevant for the thesis' case study research.

Table No. 15: Validity assurance control

Quality assurance focus	Case study tactic
Construct validity	Uniform operational measures to be established for the concepts being studied at all case hospitals.
Internal validity	Strengthening data explanatory power through patters identified within and across case hospital comparisons.
External validity	Strengthening data explanatory power through patterns identified in case replication logic.
Reliability	Demonstration of the operations of the study to be repeated at the various case hospitals producing similar results.

To follow Strauss and Corbin’s (Strauss 1996) assessment of case study generalization, the purpose is to establish a case sample validity that provides a basis for explanatory power rather than that of generalizability. In the opinion of Strauss and Corbins, the explanatory power is directly attributable to the data’s predictive ability or instrumental properties. As such it provides a better basis for answering the research question.

9.3.2 Case hospital selections⁸²

The mapping of stakeholder groups converging on public hospitals’ organizational decision-making, calls for methodological choices suited to carry out what Grimen labels “intensive research” (Grimen 2000 p. 192). Common to intensive research projects is working with few cases and many variables. According to Yin (Yin 1994), a single case setting may be appropriate under a number of circumstances. A regional hospital alone may provide a research arena for a holistic study, or otherwise be representative of embedded properties but with multiple units of analysis. Also, being able to observe phenomena of particular interest at one hospital may make it a revelatory case, otherwise inaccessible to scientific investigation. Single case designs “require careful investigation of the potential to minimize the chances of misrepresentation and to maximize the access needed to collect case study evidence” (Yin 1994 p. 41).

According to Herriott (Herriott and Firestone 1983), evidence from multiple cases is often considered more compelling. In accordance with the sampling logic of multiple case studies, one will identify a certain number of cases that represent a large pool of case respondents. The logic transported to data collection of multiple cases, is that data from a small number of hospital

⁸² Due to the nature of data to be collected, an application for the approval of data collection and retention has been forwarded the Norwegian Social Science Data Service (NSSDS) (“Norsk samfunnsvitenskapelig datatjeneste”). A conditional approval from NSSDS was received, dated 07.12.01.

cases is assumed to represent data that might have been collected from the entire population of category hospitals. However, the issue is not to identify and aggregate responses. The objective of the case study research approach is to access phenomena that yield observable context variables. Employing the categories of county and community hospitals offers the most distinct advantages from a replication point of view.

The following three case hospitals have been selected to represent the sample population of the thesis study of multiple cases. Information about the case hospitals is listed in the next table.

Table No. 16: Selected case hospitals

Hospitals	Functional status	Sampling significance	Operational Scope ⁸³
Case hospital no. 1. (In the analysis, referred to as <i>the university hospital</i>).	Community hospital within the Commune of Oslo. Has status as university clinic. Limited regional functions.	<ul style="list-style-type: none"> • Satisfies sampling conformity test as per criteria spelled out in table no. 14. • <u>A strong “opportunistic case”</u> • <u>A strong “political case”</u> Has drawn political attention to its governance practices due to ownership structure. 	<ul style="list-style-type: none"> • 567 beds for somatic patients • 3.500 employees • 250 doctors • 1100 nurses • Operational budget in 2000: NOK 1.051 mill. • Operations deficit in 2000: NOK - 9.4 mill.
Case hospital no. 2 (In the analysis, referred to as <i>the community hospital</i>).	Community hospital within the County of Akershus.	<ul style="list-style-type: none"> • Satisfies sampling conformity test as per criteria spelled out in table no. 14. • <u>A strong “typical case”</u> Is representative case of community owned and administered hospitals; i.e., the hospital category with the highest class population (75% of all single case hospitals) 	<ul style="list-style-type: none"> • 283 beds for somatic patients • 1.500 employees • 112 doctors • 358 nurses • Operational budget in 2000: NOK 550 mill. • Operations deficit in 2000: NOK- 4.0 mill.
Case hospital No. 3. (In the analysis, referred to as <i>the county hospital</i>).	County hospital also serving as community hospital for a limited number of local communes in the County of Buskerud.	<ul style="list-style-type: none"> • Satisfies sampling conformity test as per criteria spelled out in table no. 14. • <u>A strong “opportunistic case”</u> Has since 2001 been an incorporated hospital; i.e., “Fylkeskommunalt foretak”⁸⁴. • <u>A strong “typical case”</u> By its size, scope and nature of operations quite representative of the community hospital category 	<ul style="list-style-type: none"> • 518 beds for somatic patients • 2.700 employees • 229 doctors (m/y) • 646 nurses (m/y) • Operational budget in 2000: NOK 1.191 mill. • Operations deficit in 2000: NOK – 57.6 mill.

⁸³ Information obtained from annual reports of the respective hospitals. Annual reports are part of research project’s archive information on each case hospital.

⁸⁴ Established as a “Fylkeskommunalt foretak” March 1st, 2000, Case hospital no. 3 is subject to structural mechanisms much alike those construed for the public hospitals incorporated January 1, 2002.

9.4 Collecting the evidence

9.4.1 The logic of instrumentation

One key contributory effect of the research model is its structural properties. Through the model's construct operationalization one has provided a foundation for a sophisticated study of the sociology of the hospital organization. The thesis' empirical venue consists of collecting evidence through semi-structured, in-depth interviews. Information feedback from a relatively small number of knowledgeable informants is expected to reflect stakeholder relationships in their interaction with hospital decision-making. Stakeholder groups' patterns of perception relative to hospital issue matters represent important input to identify stakeholder positions and to understand thesis rationale. As implied in the research model, the approach to obtain both rational and affective perceptions presumes a structural approach that facilitates cognition. Informant interviews are thus expected to yield important insight into the dynamics of stakeholder interaction surrounding the decision-making processes.

Archives from management meetings represent a reliable source of information on the hospital's formalized decision-making. Implicit in the records of ultimate decision-making, one may ascertain the relationship between stakeholder group cognition and a capacity to exert influence on ultimate decision-making outcomes.

An overview of the properties data collection methods is introduced in the following table.

Table No. 17: Sources of evidence⁸⁵

Instrumentation	Sources and prerequisites	Empirical focus
Semi-structured interviews	<ul style="list-style-type: none"> • Identification of informants • Access to informants • Informant acceptance 	<ul style="list-style-type: none"> • To have a targeted focus on case study issue matters
Archival records	<p><i>PRIMARY FOCUS:</i></p> <ul style="list-style-type: none"> • Official records from board meetings • Official records from top management team meetings <p>Supportive documentation:</p> <ul style="list-style-type: none"> • Operational charter • Ownership structure • Organizational charts • Functional charts • List of organizational records • Strategy documents and other planning documents • Financial records 	<ul style="list-style-type: none"> • To represent precise and formalized data • To contain exact; accurate and precise references • Unobtrusive

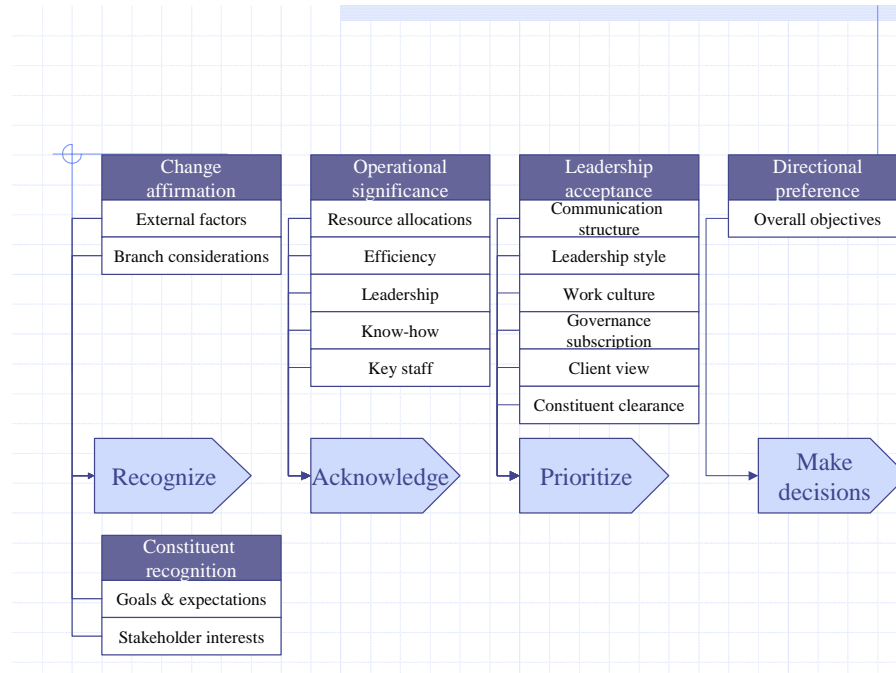
9.4.1.1 Semi-structured interviews

The interview generally is open-ended. Interviews representing a verbal report are subject to the common problems of informant bias, poor memory recall and poor or inaccurate articulation (Kumar, Stern, and Anderson 1993). The solution here has been to subscribe to the structured questioning format as laid out in the research model. The logic of the issue matters has previously been introduced in the discussion on cognition and spatial decision-making. The informant interview's questioning structure is displayed in the next illustration. Depicted herein are the conceptual categories and their properties connected to each level along the processing pathway⁸⁶. Related to each conceptual property issue, questions are raised on contextual issue matters. Complex contextual issue matters brought forward in the interview are expected to mobilize the informant's cognitive processes.

⁸⁵ Developed from Yin's "Six Sources of Evidence" (Yin 1994).

⁸⁶ See thesis illustration no. 4: "Processing pathway".

Illustration No. 12: Informant interview structure: analytical constructs and corresponding properties



The interview structure is based on the thesis' cognitive strategizing model and follows a perceptual process along the logic of Golledge's (Golledge 1999) cognitive pathway⁸⁷. This technique has been directed to make the respondent conscious of a legible path associated with a particular issue matter. Golledge (Golledge 1999) speaks of a mental cognition path or route between an origin and a destination. The semi-structured informant interviews employ contextually familiar issue matters to trigger the informant's spatial navigation. Guided by the issue matters' internal representation, respondents interact with questions, triggering the spatial or "route-based knowledge" of reasoning (Golledge 1999).

The previously described contextual ramification of the public hospital supports a picture of a culturally embedded organizational field. By virtue of one's organizational position, each respondent is expected to exhibit institutionalized values and embedded norms. These reflect the logic and attitudes of ones interests and vested position. As such, one hopes to avoid the potential for intentional misrepresentation. The informant is taken

⁸⁷ See thesis section 7.2.2 "The logic of spatial decision-making" and illustration no. 4.

through the structured questionnaire that requires the cognitive processes of (1) issue matter interpretation; (2) memory recall (when reflecting and replying); next going through a process of (3) integrating expressed views into a single judgment; finally to (4) identify an affirmative position on a particular decision-making issue.

A common methodology bias related to informant interviews, is the problem of informant selection and the related issue of perceptual agreement (Kumar, Stern, and Anderson 1993). To conquer this bias obstacle, knowledgeable respondents have been ensured through the verification of the informants' inter-organizational relationships. This is demonstrated through organizational position and stakeholder group confirmation. The thesis selection of informants for the semi-structured interviews is listed in the following table.

Table No. 18: Informants selected: Case hospitals

Informant position	Hospital no. 1	Hospital no. 2	Hospital no. 3
Board director	1	1	1
Hospital director	1	1	1
Chief medical director	1	1	1
Head nurse		1	1
Chief accountant	1	1	1
Personnel director		1	1
Leading representative of the national federation of medical doctors; (Dnlf), Snr. department doctors (avdelingsoverleger”).	1	1	1
Leading representative of the national federation of medical doctors; (Dnlf); Jr. medical doctors; (Yngre leger).	1	1	1
Leading representative of the national federation of registered nurses (Norsk sykepleierforbund; NSF)	1	1	1
Ward/dept. manager; medical doctor	4	2	3
Ward/dept. manager; nurse	2	-	2
Leader, local hospital patient support group		1	
Leader; Patient Ombudsman (County)	1	Same as for Hospital No. 1	1
Sum total informants	14	12	15

 Informant unavailable

The organizational informants selected and interviewed are key decision-makers at executive, managerial and ward decision-making levels. While a broad field of these informants represents administrative and medical staff,

staff nurses are relatively few in numbers. The thesis recognizes the significance of a confined field of nurse informants. As such, associated findings take on a hypothetical form, thus signifying a need to pursue future research to verify the thesis' empirical findings and generalizations.

9.4.1.2 Documents; archive data

The most compelling cause for employing document data is the potential for having inferences made to the research question. Therefore, documentation has been secured in a systematic manner to employ relevant information throughout the various stages in the data collection process. Particularly, the need to secure case hospital approval and cooperation with key informants has been important to safeguard a systematic and efficient empirical field process. The time and resources required to identify and to generate relevant documentation data, have necessitated a structured project administration. As per Yin (Yin 1994), the most important use of formal records is to corroborate this with evidence from multiple documentation sources. A broad scope of archive data here provides the background to ensure correct information. A thorough analysis of the data collected has served to verify evidence and uphold a critical interpretation of documentation contents. Particularly relevant here is the task of classifying issue matters introduced in the formal board meetings and management group meetings. Each agenda case matter has been placed relative to the public hospital's mandated functions⁸⁸. The capacity to place issue matters formally processed in the subject meetings has in great part been based on assessment of the particular issue matter's contextual character.

The following table depicts the sources of official records utilized and the particular research purpose served.

⁸⁸ See Illustration no. 10: "Analytical framework: Stakeholder influence".

Table No. 19: Archival records 2001

Sources of official records	Particular focus and usefulness
Governance records	<ul style="list-style-type: none"> • Formal governance structure and listing of administrative officers <ul style="list-style-type: none"> ○ Access to members • Listings of executive board members <ul style="list-style-type: none"> ○ Access to members
Annual reports of case hospitals	<ul style="list-style-type: none"> • Annual reports 1999 <ul style="list-style-type: none"> ○ Confirmation of activity and costs
Organization chart and employee listings	<ul style="list-style-type: none"> • Identification of key organizational positions and their member staffing <ul style="list-style-type: none"> ○ Access to key members ○ Securing of approval of case hospital status
Minutes from the board meetings	<ul style="list-style-type: none"> • Access to minutes from all board meetings conducted in 2001 <ul style="list-style-type: none"> ○ An overview of issue matters confirmed as cases for discussion and decision-making
Minutes from top management meetings	<ul style="list-style-type: none"> • Access to minutes from all management meetings conducted in 2001 <ul style="list-style-type: none"> ○ An overview of issue matters confirmed as cases for discussion and decision-making
Membership listing of employee federations	<ul style="list-style-type: none"> • Develop questionnaire mailing lists <ul style="list-style-type: none"> ○ Survey respondents
Financial statements and records	<ul style="list-style-type: none"> • Records for 2000 and 2001 (if available) <ul style="list-style-type: none"> ○ Confirmation of key figures relating to decision-making ○ Confirmation of investments and purchases of external supplies

9.5 The nature of analytical focus

The thesis does not involve itself in an analysis of the merits of the classical schools of thought on fieldwork methodology and their analytical properties. According to Bryman (Bryman and Burgess 1994), progress has been achieved in this regard by having method giving way to the discussion of

methodology. Thus, a combination of methods and the application of several methodologies have been applied. Analytical inductions are in research literature closely associated with research approaches to sociological problems. In the thesis, the sociological problem has been inverted and stated as the thesis' research question. Appropriate cases have been examined and possible explanations sought through inductive techniques. Qualitative data is being applied to determine the structural properties of cognitive relationships. The inductive evidence is developed through the dynamic questioning of selected stakeholder informants.

In a parallel process, data comprehension is developed through a reflectivity approach to pattern making and theory propositions. Here, inferential techniques are applied to determine structural properties of archive data. Sorting and categorizing data through coding processes allow a synthesis of the various types of empirical field data to be developed.

Throughout the research design work, the awareness and knowledge of scientific discourse has been paramount. According to Potter (Potter and Wetherell 1994), "studies of scientific discourse have shown the way it is constructed out of a combination of an empiricist and a contingent repertoire, and that both are necessary for the interpretative tasks that constitute scientific practice". In practical terms, Potter's emphasis marks the importance of being cognizant of articulation in the field instrument design and analysis. The hospital's operational environment consists of a multitude of professions with their respective occupational terminology applicable to both specific and common contextual scenes. The awareness of health professions' semantics and social practices and how these influence both language content and form, is important. The latter is precursory to preparing and participating in rhetorical or argumentative discourse. The distinguishing feature here will be to succeed in factoring descriptive and conceptual data categories. Mason (Mason 1994) places the focus on data indexing. Conceptual categories are in the analysis grounded in both the theoretical perspectives applied in the research design and the data collected. A salient issue about conceptualization may therefore be related to the question of how far concepts in qualitative data analysis are to emerge out of the research context. To this end, the doctoral candidate's own extensive contextual field knowledge may serve to overcome some of the obstacles to discourse comprehension.

10 Analysis and findings

10.1 A cohesive analytical framework

The thesis research model is rooted in the logic of spatial decision-making as expressed by Liben (Liben 1982)⁸⁹. The research model is thus intended to help gain insight into how the informant reasons on specific issue matters in a given organizational context. The perceptive position represents the crest of reasoning when stakeholder interests convene to cause affirmative action to be taken on issue matters. The theoretical underpinnings of the cognitive approach are vested in the previously discussed Kitchin's (Kitchin and Freundschuh 2000) process model of decision-making⁹⁰. The thesis also draws its conceptual support from Burgelman's (Burgelman 1991) contention of cognitive and affective mechanisms. According to Burgelman, these mechanisms regulate the allocation of organizational attention and resources relative to different areas of stakeholder initiatives. Decision-making processes thus take place in an ecological fashion in response to a steady flow of constituent initiatives. These are said to emerge in patterned ways, the presence and outcome of which imply their relative importance in the organizational arena.

The subsequent unravelling of empirical accounts obtained from in-depth interviews and archival records calls for a data decomposition approach. The objective here is to ensure the development of descriptive stakeholder accounts of *process, actions and reason*. Working with different classes of data necessitates a differentiated but cohesive analytical framework. When employing qualitative methods of different origins, Malterud (Malterud 2001) refers to these as naturalistic or interpretative inquiries. Such inquiries require a broad scope of collection strategies merged into a systematic method of organizing and interpreting the data. The analytical framework has been developed specifically to accommodate the two particular sets of data. Care has been taken to consider the different phenomena offered by each account. The approach facilitates the identification of construct variables as these relate to organizational decision-making.

The following table outlines the analytical focus relevant to each set of data and an associated interpretative framework.

⁸⁹ Pls. view thesis section 7.2.3 "The thesis research model".

⁹⁰ Pls. view thesis section 4.5.3 "Cognitive mapping and decision-making".

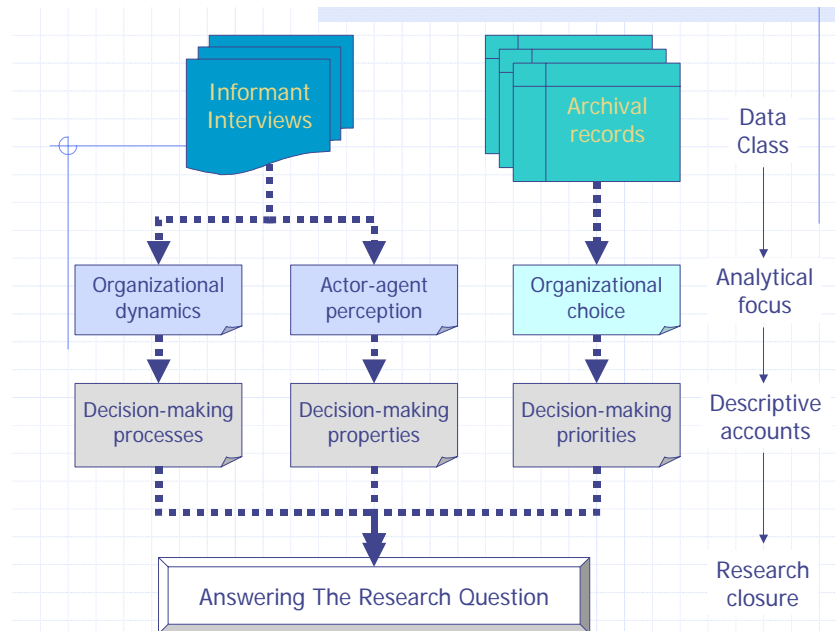
Table No. 20: Differentiated analytical framework

Data classes	Analytical Focus	Interpretive framework
Informant interviews	Organizational dynamics	Organizational dynamics as framework for decision-making processes.
	Informant perception	Informants' issue matter perception related to organizational decision-making
Archival records	Organizational preference	Properties of decision-making focus and ultimate priorities

The cohesive character of the analytical framework helps to establish a comprehensive account of organizational decision-making. Each of the two selected analytical focus areas is expected to render important empirical substance to the descriptive accounts of stakeholder group categorization.

The following illustration depicts a conceptual framework of the analysis outlining (1) data class, (2) analytical focus and (3) descriptive accounts. Through such a comprehensive and cohesive analytical process, (4) research closure emerges as a descriptive rendering of the public hospital's organizational decision-making.

Illustration No. 13: Answering the research question: Empirical venue



Firstly, informant feedback is analyzed relative to the hospital's operational properties at the pre-selected decision-making levels. Through the analysis of the informants' shared experience in working within the hospital, the significance of decision-making *processes* is expected to appear. Stakeholders' interaction on case matter issues, may in part offer a rationale as to the composition of the hospital's agenda items. Here, the presence of each stakeholder group in a decision-making setting may be recognized through its constituent interest and subsequent influence.

Secondly, these same informant statements obtained along the research model's interview structure, is analyzed as to their cognitive character. Stakeholder groups' cognitive traits are expected to offer an insight into the constituents' perceptive rationale associated with key *decision-making issue matters and their properties*. Here, emerging patterns of spatial logic may offer instrumental evidence of decision-making outcomes. The stakeholders' process-oriented behavior may serve as a precursor to agenda item composition and decision-making.

Thirdly, the protocol analysis of the organization's affirmative decision-making measures is to confirm the hospital's ultimate operational *priorities*. Thus, archival records combined with process accounts of informant cognition may offer compelling evidence of stakeholder groups' influence on hospital decision-making.

The summary perspective of the thesis' analytical model, recognizes the significance of Morgan's (Morgan 1988) interactive perception of stakeholder power⁹¹. The interpretative approach is thus to view stakeholder group influence expressed through the hospital's organizational decision-making. The latter is herein considered as property functions of institutional premises, governing processes, system priorities and actor-agent rationale.

10.2 Mediating a potential interpretative bias

The qualitative empirical data obtained is by its very nature contextualized. Each particular document or set of records validates issue matters, their respective origin, relevance, process and associated actor participants. In qualitative data validation, Malterud (Malterud 2002) subscribes to a methodological inference in which a document's "internal validity" is interchangeable with its contextual "credibility". Furthermore, an item record's "confirmability" may be transposed by its "objectivity", while data "generalizability" or "external validity" may be considered equal to its

⁹¹ Pls. view thesis section 2.6 "Organizational decision-making in hospitals".

“transferability”. Ultimately, archival records’ “reliability” is strengthened by the contextual prerequisites apparent in the particular record item⁹².

The approach of equating data validation techniques from different schools of scientific inquiry may be said to rest on an assumption of reflexivity. The call for the researcher to be attentive to contextual information is based on the presumption that such insights act to shape the analyst’s interpretative perspective. According to Berger (Berger 1981), a researcher’s reflexivity promotes self-awareness and serves to establish a role distance between the researcher and the qualitative data source⁹³. Reference to the application of reflexivity therefore serves to underscore the importance of being aware of the role that the researcher plays in the analysis and interpretation of qualitative data. Giddens’ (Giddens 1991) contention is that all researchers at all times are concept bearing animals. In a conscious and methodological sense one therefore heeds the call for reflexivity, as the knowledge generated is injected back into the realism developed as descriptive accounts.

This concern for potential analytical biases refers back to the thesis introduction of Potter’s (Potter and Wetherell 1994) reference to interpretive prerequisites connected to scientific inquiry⁹⁴.

10.3 Informant interviews: An analysis of the hospital’s organizational dynamics

10.3.1 Interpretative framework

As outlined in table no. 18 “Informants selected: Case hospitals”, in all 41 interviews have been conducted. The interviews were taped and later transcribed. Interview accounts have been filed and will, based upon a request from the Norwegian Social Science Data Services, be stored for safekeeping and ultimate destruction⁹⁵. Each scheduled interview typically required between 70 and 90 minutes of dialogue and was carried out at the informants’ case hospitals. A transcribed interview represents between 15 and 20 pages of typewritten text, thus rendering a library of interviews

⁹² Ascribing to Malterud’s contentions brings the thesis in alignment with its quality assurance focus as outlined in thesis table no. 15 “Validity assessment control”.

⁹³ In Giddens’ analysis of post-modernism or what he terms “high modernity”, Giddens (Giddens 1991) also talks of “institutional reflexivity” in which the regularized use of knowledge about circumstances of social life represents a constitutive element in its organization and transformation.

⁹⁴ Thesis section 9.5 “The nature of analytical focus”.

⁹⁵ A request dated November 12, inst., has been received from the NSSDS in which qualitative data is sought transferred to its national library of research information.

numbering between 600 to 800 pages. All interviews have been coded applying the thesis research model constructs as coding nodes⁹⁶. A commercial data program developed for qualitative data processing, NVIVO⁹⁷ has served to facilitate interview data management. The program features have made possible subsequent pattern coding, storing, retrieving and visualizing by text referenced to selected constructs. The NVIVO has also provided the basis for conceptual network building by allowing connections to be made between information groups.

In line with the analytical focus, interview data is firstly to provide a comprehension of the nature and dynamics of organizational decision-making. To accomplish this objective, the analysis has focused on developing conceptual categories that render insight into the informants' decision-making accounts, values and opinions. Structural conditions and stakeholder perceptions that are believed to be instrumental in the hospitals' decision-making processes have been identified. By applying a set of conceptual categories and their properties, explanatory power may evolve relative to the research question. In sum, the empirical analysis of each conceptual category facilitates an improved understanding of the contextual field later to function as elements of theoretical propositions. Careful considerations have gone into arriving at categories that sensitize construct characteristics. Such categories need to be abstract enough to develop descriptive renderings of the contextual accounts. It is here relevant to note that the selected conceptual categories or constructs, have emerged throughout the research process, comparable to what is outlined in grounded theory (Glaser 1967)⁹⁸.

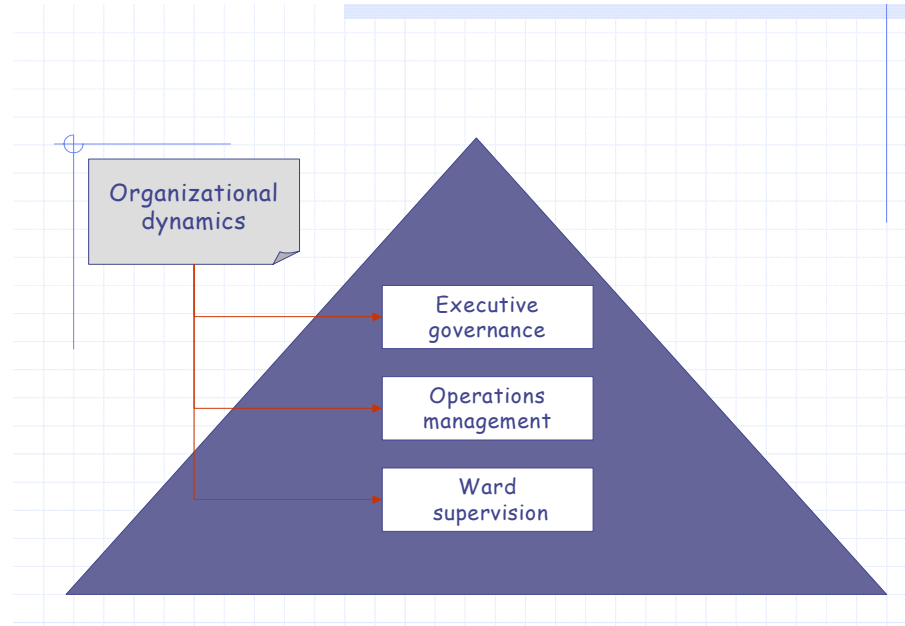
The following *conceptual focus areas* have been identified relative to the hospital's organizational dynamics.

⁹⁶ See thesis section 7.2.3 "Thesis research model", and Illustration no. 5.

⁹⁷ NVIVO source: Richards, Tom and Lyn, Qualitative Solutions and Research Pty Ltd., 2 Research Drive, La Trobe University, Melbourne, Vic. 3083, Australia.

⁹⁸ Glaser and Strauss makes credits Leonard Schatzman who termed this field experience as "the momentum effect" (Glaser 1967).

Illustration No. 14: Conceptual focus areas: Organizational dynamics



As presented in thesis section 8.3.3 “Decision-making levels”, and as referenced in section 9.5 “The nature of analytical focus”, one has determined that there is a clear hierarchical structure segmenting major decision-making levels within the public hospital⁹⁹. The most distinguishable governing decision-making levels related to hospital operations are (1) the *executive* level, (2) the *managerial* level or the hospital’s *top-management* group¹⁰⁰ and (3) ward level.

The hospital’s board of directors represents the governing authorities’ formal executive body. Its mandate encompasses directing over-all goals, standards of performance and resource allocation¹⁰¹.

⁹⁹ This contention is also supported by NOU 1997:2; specifically section 5.6 “Sykehusets interne organisering”, p.p. 33-38.

¹⁰⁰ Considered here to be the hospital director and his/her formally established management team. Top management is also the term employed in NOU 1997: 2; see section 10.3 “Toppledelsesfunksjonen i sykehus”; p. 95; particularly sub-section 10.3.2 Toppledelsens ansvar og ledelse”, p.p. 95-97.

¹⁰¹ Hospital specific document will be referenced relevant to the analysis of each case hospital.

The hospital's top management team made up of the director and his/her administrative staff plans, facilitates, controls and follows up hospital performances. As with the hospital board of directors, all formal hospital decision-making processes are entered into meeting protocols verifying case matter issues called and their affirmative outcome.

Hospital ward management supervises clinical activities but does not practice an equally formal and well-documented decision-making process. However, over-all clinical goals are presumed presented, promoted, and processed by ward supervisors in other decision-making arenas in the hospital. Thus, ward-planning processes ascend from clinical unit levels and culminate at management or board levels.

The interview informants which have been selected are representative of these key organizational positions within the hospital's hierarchical structure as depicted in illustration no. 12: "Hospital decision-making sectioning"¹⁰².

10.3.2 Analysis and findings

10.3.2.1 At executive governance level

10.3.2.1.1 Analytical approach

All board directors at the respective case hospitals have been interviewed. Transcribed interview records provide important insight into board logic. All board directors are senior executives and range in age from the mid 50's to the late 60's. All three have previously been active in city and county political affairs.

Board informant interviews provide insight into how the board perceives its role in the hospital's chain of command. The conceptual categories selected are to function as analytical constructs. As such, they serve as analytical parameters indicative of the boards' inductive power in their respective hospitals' organizational decision-making.

The conceptual categories and property focus are shown in the next table.

¹⁰² This tri-level chain of command within the hospital is also supported in literature by (Abbot 1988),(Erichsen 1996), (Friedson 2001), (Freddi and Björkman 1989), (Gordon 1980), (Harrison and Pollitt 1994).

Table no. 21: Conceptual analysis: Organizational dynamics (1)

Conceptual focus area	Conceptual categories	Conceptual property focus
Executive governance	Branch sensitivity	The informant's perception of the board's over-all position in representing and ensuring hospital services delivery
	Mandate interpretations	The informant's perception of the board's mandated scope of responsibility
	Authority assessment	The informant's perception of the board's decision-making authority.
	Impact recognition	The informant's perception of impact generated through the board's decision-making actions.

10.3.2.1.1.1 Branch sensitivity

The board model selected for all three case hospitals, are boards staffed with members external to sector governance¹⁰³. As such these members are expected to bring forth their external leadership experience and managerial know-how. The boards are to conduct executive-oriented leadership with particular focus on establishing over-all strategic objectives and securing the management of the hospital's resources allocations¹⁰⁴.

A common trait for the board directors appears to be their uniformly expressed concern for efficient resource administration. Their views of future hospital challenges relate to operational, organizational and leadership issues.

The board chairman of hospital no.3 particularly underscores this. A recently completed hospital strategy plan is cited as having been instrumental in bringing about an improved hospital focus on effective operational measures. An important objective has been to cut down on patient waiting lists. The board views its role as an inductive agent to: (1) ensure patient

¹⁰³ For a closer look at board models approved for public hospitals, pls. view thesis section 10.5.5.2.1.1 "Structural characteristics of the BDM". Board formation and board functions are legislated in the law on counties and communes, September 25, 1992 ("Lov om kommuner og fylkeskommuner").

¹⁰⁴ This is outlined in NOU 1997: 2, section 10.2.4 "Styrets rolle" (*Role of the board*), p.p. 94-95.

logistics, (2) achieve its operational budget and (3) secure professional administrative leadership within the medical wards. According to the directors, this is what hospital leadership is all about.

"There has to be a change in the quality of leadership, from clinical leadership to a more administrative leadership."

When asked about the significance of *administrative leadership*, the directors all underscored the need for improved ward focus on hospital resources management rather than leadership time spent on clinical issues.

The board-chairman of hospital no. 1 is concerned about safeguarding the hospital's assigned university functions, underscoring a present low level of research activities. Therefore the hospital's strategic perspective is to secure the hospital's continual position as a university based clinic.

At hospital no. 2, the logic of corporate business economics is downplayed. The board chairman makes a distinction between the objective of a private business firm and that of a public hospital. While the former seeks to secure profit maximization for its shareholders the public hospital continuously strives to optimize scarce resources in an effort to benefit patient treatment:

"The hospital's goal is not to earn money so that the owners can stash it away in a bank account. We are not primarily concerned with increasing shareholder value."

The board chairman reiterates the need for hospital management and other supervisory staff to be cognizant of their roles as public servants:

"You have to be concerned with society in general and the role our hospital plays in it."

With the exception of the director at hospital no. 2, the governing board logic is its adherence to the economics of hospital resources deployment. The board mandate is scaled to patient treatment for the deserving DRG-cases and the pursuit of the balanced budget, as paraphrased by the board director at hospital no. 1:

"There is a temptation to seek out those patients and those cases which pay well."

Generally, board directors express little public hospital branch sensitivity outside the needs for effective resources allocation. Little attentiveness is

evident as to the overall perspective of public health in general and the hospital sector's specific role in it.

The governing logic of cost efficiency measures, appear well grounded and explicated in the governing philosophies of the board directors.

10.3.2.1.1.2 Mandate interpretation

The board chairmen all confirm their obligation to represent hospital ownership interests and governing views in hospital operations. As expressed by the board director at hospital no. 1:

"The Board's main concern is with relations upwards, our owners."

It is quite apparent that it is chiefly the hospitals' economic performance that commands the attention of board executives interviewed. From the record of transcribed interviews, it is noted that all board directors are concerned with satisfying hospital ownership's call for balancing budgets and cutting down on treatment waiting lists. The director at hospital no. 1 underscores the board's prioritized objectives of ensuring an effective hospital organization capable of turning out peak production performance.

"We deliver the services we are required to deliver within the framework of a sound economy."

At hospital no. 2, the director confirms the county ownership's tightening of budgetary limits while at the same time calling for improved production. However, the director warns of a potential conflict between the county's demand for cost containment and the call for the hospital to deliver the legislated scope of medical services.

"If we get into such a situation then we will have a national problem which requires a political solution."

In the interview with hospital no. 3 the perceived benefits of a new governance contractual services model is highlighted. Under the provisions of the new model, the new formal hospital owner¹⁰⁵ (Fylkeskommunen) acting as the hospital services procurement initiator (*bestillerrollen*), secures its anticipated needs for medical services from the hospital as the producer of said services (*utførerrolle*). Under this revised governance system the county's political administration, represented by its politically elected county

¹⁰⁵ For details on the ownership change of Case hospital no. 3, pls. view thesis section 10.5.5.4.1 "Structural characteristics".

mayor (Fylkesordfører), requests a set of specified medical services. An annual performance contract is prepared that represents the prescribed performance norm governing a particular period, normally a budget year. The board director expresses great confidence in this new administrative governance prescription and sees it as a measure to improve hospital performance.

10.3.2.1.1.3 Authority assessment

Board directors of both hospitals no. 1 and 3 are expressing confidence in their perceived scope of authority and find it adequate for the implementation of board objectives and actions. Particularly at hospital no. 3, having become an incorporated public organization separated from the county's administrative branch, a confidence in corporate autonomy is noted:

“We don't bother the County Council and the County Council doesn't bother us. We have a free hand.”

Obstacles noted are the dissatisfaction with the hospitals' differentiated staff cultures making targeted changes and improvement transitions particularly difficult:

“The walls between the hospital's different departments are very high. One of our greatest challenges is the will to change.”

While the directors of hospital no. 1 and no. 3 both are comfortable with their perceived scope of authority, this appears not to be the case at hospital no. 2. The board director views the hospital board as an insignificant caretaker without sufficient authority:

“If I am really honest, the Board has little more than a controller function.”

In the opinion of the board director, the system of shared public hospital governance between county administration and the county's political arm has rendered the board without any real executive authority:

“The current situation where a lack of mandate inhibits the Board's influence on operations is not a good situation. One cannot expect Board members to spend time and energy on operational issues if this situation continues.”

The latter statement displays a frustration with what the director finds to be an unresolved structural problem. The director also points out that insufficient budget resources necessitates excessive amount of time spent on cost control with lesser time to pursue core hospital functions:

”The financial problems have taken up so much of our time that we have neither the capacity nor the opportunity to get really involved with the hospital’s inner life and its day-to-day running. ”

One also notes the distress of the director at hospital no. 3 related to external constituents challenging the hospital’s public credibility and thus impeding board authority:

”The media has a lot of influence. If the media writes something negative about some function or other at the hospital, or about a particular patient-case – it doesn’t happen often, but say a few times a year – if there is some scandal or other, the media will be there. Not least if a hospital spokesman has been a little careless in expressing him/herself about what really is quite a trivial matter, then it gets blown out of all proportion.”

Problems in the board’s perception of executive authority are also being attributed to organized employee groups, or employee federations:

”These are organizations with a long tradition in proclaiming complex solutions.”¹⁰⁶.

10.3.2.1.1.4 Impact recognition

Success or failures for the hospital boards are perceived in terms of the their records on resource efficiency. Hospital no.1 looks at it this way:

”No problems can be solved unless we have a financial turnover. After all it is about maintaining operations.”

Board director at hospital no. 3 prides himself in having been able to generate changes and transitions in hospital management. He emphasizes his initiative to establish a hospital strategy plan involving a large number of hospital internal participants. Here again, the board chairman cites the board’s influence in developing the hospital’s strategic focus, having called

¹⁰⁶ Thesis section 10.3.2.2.1.4 “Goal alignment”, discusses the influence of external stakeholder groups.

for plans to be based on the hospital's capacity to remain effective and efficient:

"I don't believe in all these empty promises lying around in strategy documents here and there. The strategy plan has to have a main focus on 4 – 5 areas."

Board director at hospital no. 2 regrets the fact that board is without any direct mandate or control to secure necessary capital investments and investments in hospital maintenance. On this latter point, the directors underscore the board's inability to call on capital resources to replace outdated medical technology equipment.

Related to resources administration, the board chairman points to a common problem of delayed budget approvals making cost control a major problem throughout the year.

"It has taken a long time to reach an agreement on what the budget should be. We have gone well into June and maybe even July. In other words half the year has gone before an agreement is finally reached."

The county and commune governance's traditional inability to ensure proper budgetary procedures is cited as contributing to poor budgetary management within the case hospitals.

10.3.2.1.2 Summary evaluation¹⁰⁷

On branch sensitivity:

Boards express different views and exhibit different positions on branch sensitivity. The board director at the community hospital (hospital no. 2) takes a firm value-based stand on the distinguishing characteristics between a private firm and a public service organization. It becomes apparent that this board director also perceives the public hospital to be an integrated part in the production of society's welfare services. However, no such operationalization of a societal view was offered in the context of the public hospital. Other case hospital directors exhibit a leadership agenda chiefly aimed at resources supervision. Although the hospital director at the university clinic (Case hospital no. 1) is attentive to the financial significance of the national hospital classification, this is not tied to a

¹⁰⁷ Specific reference to case hospital is done either by case number; e.g., Case hospital no., or by its national hospital class, such as "University clinic", "County"- "Community" hospital. See thesis section 9.3.2 "Case hospital selections"; specifically table no. 16 "Selected case hospitals".

strategic perspective. A strategic imperative of costs control at the county hospital (hospital no. 3) aims at transforming the clinical supervision into improved administrative leadership.

Mandate interpretation:

The directors' perception of branch sensitivity generally follows their mandate interpretation. Board mandate is documented in the law on hospitals as well as detailed in local governance prescriptions. However, board focus reflects the present governance prescriptions on the economizing of public resources. A new leaf in institutionalized prescriptions is evidenced through a newly instituted contract administration concept. Contractual hospital services are procured according to specifications in an annual production contract. The board director at the university hospital promulgates economizing resources and maximizing production. Again, the board director at the community hospital abstains. Rather political restitutions are perceived necessary in the event that the hospital is unable to deliver the legislated scope and amount of medical services.

Authority assessment:

Executive management authority as interpreted by the hospital board follows from the preceding analysis. Board directors at both the university hospital and county hospital credit good ownership relations with compatible views on hospital governance. The medical staffs' differing logic is identified as the most serious obstacle to effective hospital management. Other extraneous factors such as media are listed as a disturbing element to hospital autonomy. Again dissenting, is the board director at the community hospital. Several factors are listed as seriously impeding executive management. A complex board-reporting matrix undermines board authority opposite sector governance and internally opposite the hospital administrative director. Also, fiscal and monetary shortages are listed as being so serious that they inhibit operational planning and services production. He lists a disproportionately large amount of time spent on budgetary audit functions completely hindering any other executive function.

Impact recognition:

All board directors agree that allocated resources and their deployment represent the basis for hospital services provided. The community hospital board takes pride in having taken the initiative to develop a strategy that prioritizes resources efficiency measures related to an effective patient treatment program. Common frustration stems from lack of investment capital to replenish equipment and facilities. County hospital board reiterates delayed county budget approval, which reduces opportunities for effective cost supervision.

Executive board management seems to have only marginal focus on the nature, quality and scope of medical services provided. This may explain why none of the hospital boards talk of developing strategies to prioritize medical focus and measures to enhance the quality and costs of services to be provided. Completely lacking is an executive board focus on the development of competence and skills critical to proficient and effective treatment and care.

10.3.2.2 At operations management level

10.3.2.2.1 Analytical approach

In the interview analysis of case hospitals' operations management informants, the focus is on conditions perceived precursory to decision-making behavior. Within the selected interpretative framework four conceptual categories have been identified to help explain top management's goal orientation. Information is drawn from interviews conducted with each of the case hospital directors as well as with administrative staff and management team members. Thus, when referring to operations management one therefore includes both the hospital director and the administrative and staff directors. These are collectively referred to as the respective case hospitals' top management¹⁰⁸.

The following *conceptual categories* have been selected.

¹⁰⁸ This understanding is in line with what is expressed in government white paper NOU 1997: 2; see section 10.3 "Toppledelsesfunksjonen i sykehus", p. 95 and section 10.3.2 "Toppledelsen ansvar og ledelse", p.p. 95-97.

Table No. 22: Conceptual analysis: Organizational dynamics (2)

Conceptual focus	Conceptual category	Property focus
Operations management	Issue perception	Informant's perception of what constitutes important issues for the hospital
	Institutional perspective	Informant's awareness of the hospital institution's strategic implications
	Goal orientation	Informant's goal focus and view on goal realization
	Goal alignment	Informant's view on how the hospital organization works to reach closure with particular emphasis on the relevancy and impact of stakeholder groups

The conceptual categories selected for the analysis of operations management are comparable in nature to the categories applied in the analysis of the board directors. Efforts have been made to account specifically for the operational nature of top-level management. Specific analytical focus is vested on the hospital directors. These are all senior managers with several years of management experience from within the public hospital sector. Two out of the three director informants are medical doctors (hospitals nos. 1 and 2) while the third hospital director (hospital no. 3) is a psychiatric nurse. All three have long employment records attached to the particular case hospital. The other management informants included are senior personnel from within their particular staff professions.

10.3.2.2.1.1 Issue perception

All three directors express poignant views on issues considered relevant to the particular hospital. Their position is marked by the nature of the hospital's national hospital classification¹⁰⁹. At hospital no. 1, one is concerned with implementing the still incomplete State approved university and regional hospital functions:

"The definition of our hospital functions is a priority."

¹⁰⁹ On formal hospital classifications, pls. view thesis section 3.3.1 "Hospital services functions".

The university classification is considered a competitive strength important for its recruiting programs for medical staff and other health professionals. In its recruiting efforts, the hospital seeks to attract candidates with an interest in research and development.

"We attach more weight to these functions than just registering and treating patients. We also have to consider profiling the unit externally. The hospital must make the most of the opportunities for research and development, also professional development".

Hospital no. 3 recognizes its geographical proximity to the larger university based hospitals in and near Oslo and hence its comparably weak competitive position for attracting health professionals. An expressed objective is to develop a scope of general medical services and a patient oriented organizational culture. The director supports the recruitment of a medical staff and health professionals inspired by clinical teamwork:

"I have to build up a staff based on a different situation than that of hospitals such as Rikshospitalet, Ullevål and Radiumhospitalet. We need people who want to work with the patients, do a good, efficient job, work a lot with advising patients and staff. Not necessarily in an environment where research and development is the main focus. There are not many PhD's here".

The hospital's close contact with local clinics and private physicians is another prioritized goal supportive of its objective to better serve primary patient needs:

"The front line of medical services ("Iste-linjetjenesten") is really our main patient recruiting ground. If we want to promote ourselves then we can only do this through the primary health care stations"

This chosen strategy is also representative of the views of the director at hospital no. 2. The latter informant points to a the need for a close cooperation with the community's primary health care system:

"We try to promote ourselves through the local media. We have regular meetings with them to keep them informed of what we are focusing on"

All three hospital directors are concerned with the need to improve leadership. The director at hospital no. 1 stresses the need for being able to develop a whole new generation of leaders in his hospital. This is perceived

to be a challenging task particularly as the medical doctors are apprehensive about such programs. The hospital directors consider this a problem of removing a mental obstacle to management training:

“The first challenge is to free doctors from their own professional biases.”

The director at hospital no. 3 wishes to transform ward *supervisors* into ward *leaders*. In her conception of leadership one needs to take more of an overall strategic view of hospital challenges. Her major conflict with the academically trained doctors is their resentment to teamwork:

“My clinical leaders are relatively alike in that they are all primarily concerned with their profession. They prefer to be on their own than to be part of a team.”

At hospital no. 2, the importance of leadership is linked to an ability to bring about improvements and transformations of established conventions related to people and processes.

“Leadership is critical to whether or not it works”

Hospital directors and their administrative staff express little attentiveness to core functional activities. Administrative leadership precedes issues of clinical nature. The major agenda items within operations management concern resource administration and prescriptions associated with cost supervision.

10.3.2.2.1.2 Institutional perspective

Several government white papers published throughout the 1990's make explicit references to management issues inviting ownership and management attention to the hospitals' strategic leadership. The following excerpt serves to demonstrate governance focus:

“The hospital staff is to develop strategic guidelines to serve as a platform for hospital management and leadership. A clearly defined strategy facilitates the development of the hospital's operational goals and objectives necessary to provide direction and criteria for organizational decision-making”¹¹⁰.

¹¹⁰ ”Ledelse i sykehus” (Leadership in public hospitals), Sosialdepartementet, September 1990, p. 22.

In the above referenced prescriptive note, government white paper reference is made to management's responsibility for strategy development. Ginter's (Ginter, Swayne, and Duncan 1989) views hospital strategy as a behavioral pattern emerging from a stream of decisions, and concern the positioning of the organization within its environment. The distinction is made between strategy as a planning process and strategic management representative of a managerial philosophy. When linking strategic thinking and analysis to organizational action, the act of management planning and leadership thus becomes an integrated executive performance.

It is perhaps in the managerial planning tradition that hospital strategy may be said to have its tradition in Norway. Hospital directors have worked in accordance with a set of management guidelines that helped shape the plans aimed at assuring a maximum consistency in decision-making. New Public Management measures¹¹¹ may be credited with bringing about the competitive aspects in hospital strategy development. Government white paper NOU 1997:2 talks specifically of the emerging competitive elements in public hospitals as follows:

"The over-all quality and services integrated in patient treatment and care, considered critical to patient satisfaction within the hospital, will increasingly become a competitive factor in hospital care"¹¹².

Another strong impetus to hospital strategy development was introduced with government white paper NOU 1999: 15. Here structural models and governance mechanisms present potential new prescriptions on capital management¹¹³. It is reasonable to assume, therefore that the concept and relevancy of public hospital strategy development should have been present and known to all thesis informants at the time of the interviews.

At hospital no. 1, the hospital director is clearly maintaining a strategic management perspective when bringing up the concern for his hospital's university functions

"Strategy today is primarily for cementing the different functions within the hospital. Yet these are still not in line with the white paper

¹¹¹ Pls. vies thesis section 3.4 "The emergence of a corporate logic", p. 48.

¹¹² "Pasienten først"; NOU 1997: 2, January 21st, 1997; section 6.3.5 Ledelse (Leadership), p. 55.

¹¹³ See particularly section 4.2.3 "Det effektive sykehus – rasjonell bruk av kapital og personell", p.p. 27-28.

of 1993. The hospital has made the decision that we are to play in the First Division”

The director further underscores the strategic implications when pointing to the likelihood of public funding spin-offs that may safeguard hospital research programs:

”In addition to general day-to-day operation the university clinic status provides opportunities for research and development.”

A further expected windfall gain from the hospital’s national status, is the likelihood of increased public spending for facilities expansion:

“What we need to do is to ensure that we have the proper framework for further support. In this case we need more space.”

On a mere strategic management level and along Ginter’s (Ginter, Swayne, and Duncan 1989) line of the organization’s behavioral elements, the director narrows the scope down to budgetary constraints:

“The most important objective that I follow up on is the objective which I myself am being followed up on, namely budgets and economic performance.”

The director contrasts his preferred strategy to the governance focus:

”Then I think of patient care; in a professional capacity. These are objectives which my superiors do not follow me up on to the same extent.”

In summarizing the strategic issues, the director recognizes a present hospital leadership that neglects the hospital’s strategic perspective:

“At the end of the day, it is a question of who follows me up and on what. As a Director my performance is judged by my immediate superiors.”

Implicit in this view is the assumption that one is to sacrifice the hospital’s long-term objectives for short-term governance merits earned on cost efficiency measures.

The director of hospital no. 2 views strategy in the perspective of a planning process supportive of local hospital functions. Hence, patient treatment programs are highlighted as being the primary operational objective.

“Our goal is to succeed in patient treatment, providing good quality, effectiveness and efficiency. In other words; short waiting lists and a sound economy. This is our primary focus. We are being evaluated based on economy, economy and economy - which is the exclusive county governance focus”

The director at hospital no. 3 emphasizes a strategic leadership that reaffirms the hospital’s vision of a patient focused institution.

“I need to get all my staff to focus on only one thing; namely satisfied patients. Every hour of the day is to be spent thinking about what one can do to ensure that patients remain satisfied.”

The issue perception, as expressed by the other management representatives, remains equally firm on operational priorities. The rationale is abundance by governance prescriptions on resources efficiency. Strategy as a function of the hospital’s over all objectives vested in its competitive advantage is absent. The scope and time perspective of strategy is related chiefly to patient treatment and its associated costs.

An over all strategic awareness compatible with the law on public hospitals appears absent. Operations management perspective is limited to viewing the public hospital as a production unit. The management challenge of supervising advanced technologies and skills in intensive and integrated processes is not evident. The perspective of operations management is narrowed down to short-term concerns for resources efficiency and effective patient treatment production programs.

10.3.2.2.1.3 Goal orientation

Considering the institutional perspective as evidenced by the previous analysis, the goal orientation is formulated accordingly. The hospital directors’ justification for a priority of administrative prescriptions is referenced to governance expectations. As expressed by the director at hospital no. 2:

“Politicians decide the framework and provide the means. They need to see that this is to the benefit of the general public.”

This recognition of governance preference translates into the following operations management philosophy:

“Every minute a patient spends in the hospital, generates costs. Occupying a bed generates costs. Ensuring an effective patient flow therefore has a high priority. There is still much to be gained by improved hospital logistics”

To attain targeted efficiency, the director makes reference to the goal of working to improve the quality of ward leadership.

“Improving ward leadership is a primary objective.”

At hospital no. 3, the director emphasizes the need to develop an improved production oriented culture within the clinic. The recruiting strategy for medical staff targets candidates who are motivated by patient services and not by academic pursuits:

“I concentrate the most on the production line so to speak, trying to find those who enjoy working with many different types of patients. In this hospital they have to work with every aspect of medicine.”

The emphasis is on satisfying the hospital’s primary functions within the scope of patient treatment and as integrated with the total public health service chain.

“We need to ensure effective logistics within the hospital service chain”

Herein also lies the director’s focus on the need to maintain effective administrative routines facilitating the logistics of the patient medical regimen.

“We need to ensure that we have routines for referring and for discharging patients. This is extremely important. We must understand each other from a professional point of view. We have to speak the same language.”

As with the other case hospitals, the director brings up the priority of working to change old organizational structures and lines of communication.

"I feel that the hospital is so locked into pre-conceived notions and outmoded cultures; old idiosyncrasies and a hierarchical organizational structure. We are working on erasing old myths. "

In particular the director at Case hospital no. 1, emphasizes the need to work with the organization to improve team leadership:

"The major objective is to transform the organization. In particular, high priority is given to developing leadership skills among newly appointed ward supervisors."

The directors' goal orientation as expressed by all three directors, appears uniform in its focus on cost control and seeking to develop leadership traits in support of a managerial orientation. The pattern of the directors' perception of the hospital's institutional perspective transforms into their operationalized goal focus.

10.3.2.2.1.4 Goal alignment

The thesis focus on the informants' alignment of hospital goals is herein analyzed with respect to how management works to secure decision-making closure on a particular matter. At this point, a stakeholder group has succeeded in placing its case on an affirmative decision-making pinnacle. Management needs to align the particular case along with the support of other constituent parties critical to its final endorsement. Such goal alignment may take on different forms from ensuring abidance by formal sector governance to working with critical suppliers to secure a contractual relationship important for hospital operations. The analysis will be presented in a way that profiles how each stakeholder group exerts its position opposite operations management.

In viewing the case hospitals' liaison with external stakeholder groups and their hospital internal counterparts, one subscribes to the stakeholder model as presented in illustration no. 7: "A framework of stakeholder forces".

On sector governance:

The differing nature of county and commune governance regimes is apparent in the informants' views expressing their relationships with hospital owner representatives. As has previously been confirmed by the board director at hospital no. 2, the hospital director confirms a dual reporting line between the hospital board and its county administration. The hospital director's immediate supervisor is said to be the county's commissioner on health ("helse- og sosialdirektør"). However, the hospital director also confirms an active liaison with the county's various political offices.

"I primarily report to the County Committee for Health and Social Affairs, (helse- og sosialutvalget) but also to the County Committee (fylkesutvalget) with the County Council (fylkestinget) as the governing body."

A direct liaison with State-level hospital sector government is also confirmed.

"Then we have a fair bit of contact with the Government, the Ministry, quite a few tasks and discussions there."

The hospital director is actively working with stakeholder representatives at various sector levels. This includes the county's political and administrative regimes up to and including the State sector level ("Sosial- og helsedepartementet"). At the same time he serves a formal working relationship with the board of directors.

The hospital director at hospital no. 1, being a commune or city owned hospital, confirms his discomfort with what he perceives to be unclear formal reporting lines. The director views the board as a mere budget audit group.

"The Board relates to the hospital governors and in terms of mandate is basically on the same level as the Director."

However, the hospital director confirms a perception of the board as being hierarchically slightly above the position of the hospital director.

"The Board answers to the City Council (Byråden) and the City Council is adviser to the County Board Commissioner, (Kommunaldirektøren). This means that the Board is in fact a notch higher than the Director which is a somewhat of an unusual situation."

The hospital director considers the County Board Commissioner ("Kommunaldirektøren") on health and social affairs as his immediate superior, with the board of directors acting in a supplementary capacity as budget audit supervisor.

At Case hospital no. 3, the director's immediate superior is the board of directors with its chairman reporting to the County Mayor (Fylkesordfører).

“I report to the Board who in turn reports to the County Mayor.”

However, the director confirms the need to work closely with the political regime making up the hospital’s county governance system.

“ I need to pay attention to those who wield the power in the hospital in order to be able to implement the strategy.”

The political regime in its totality is considered important in assuring the hospital’s success.

“The Central Committee for Health (Hovedutvalget for helse) and the Congressional County (Fylkesting) are our gatekeepers.”

Operations management informants all confirm the working presence of governance audit units integrated in the hospitals’ formal organizational structures. These are the Work Environment Committee (Arbeidsmiljøutvalget; i.e., AMU) and the Joint Cooperation Committee on Organizational Decision-making (Medbestemmelsesutvalget; i.e., MBU). The former is a committee established to ensure the hospital’s abidance by laws and regulations governing work environments. The latter is established to ensure management information sharing on decision-making issues viable to the hospitals’ mandated functions. Scheduled meetings are conducted and protocols written. The hospital director conducts regular consultation meetings with the AMU and the MBU to have them voice their views and concerns. Work conducted by the AMU and the MBU may in part be overlapped by the hospitals’ office of health, work environment, safety and security (Helse, Miljø og Sikkerhet; i.e., HMS). The HMU organizational placing is within the director’s administrative staff.

Supplanting the hospital internal groups working to ensure employee environment, safety and security is the Norwegian labor inspection authority (NLIA) (Arbeidstilsynet). The NLIA represents the Ministry of labor and government. With its 29 local offices around the country, the public hospitals are subject to all its land-based control activities on the hospitals’ environmental and safety programs.

Furthermore, the hospital directors all recognize the role and presence of the County Doctor General¹¹⁴ representing the State’s Health supervisory board (Statens helsetilsyn). Additionally, the respective county’s Patient Ombudsman (Pasientombudet) governing hospitals nos. 2 and 3, and the equivalent position governing hospital no. 1 (Helse- og sosialombudet) are

¹¹⁴ See thesis section 3.2 “The governance model”.

recognized as being part of the hospital governance audit system. The patient ombudsman office is established to empower patients wishing to have a particular medical treatment matter reviewed. While the County Doctor General is mandated a wide set of governing rights to audit hospital medical performance, the office of the Patient Ombudsman represents a first step in a patient recourse process to lodge a complaint against a particular department.

A summary overview of sector governance may be expressed as follows:

Table No. 23: Stakeholder group characteristics: Sector governance

Stakeholder class	Stakeholder groups	Group objectives	Significance to hospital operations	Group's collaboration with hospital interests
Sector governance	<ol style="list-style-type: none"> 1. Political governance system 2. Sector audit groups 	To ensure fulfilling of political sector objectives	Exercises its influence through legislation, practices prescriptions, resources provisions and decrees on managerial and functional operations	Hospital management is subordinated governance authority as represented and enforced by the respective governance agencies

On Professional affiliations

With respect to the hospital internal employee organizations, the employee federations governing medical doctors and nurses are considered the most important to hospital performance¹¹⁵. Representatives of these two health professions are present both in line management and in supervisory positions within the clinical ward. The majority of doctors and nurses are members of their employee federations.¹¹⁶ Their knowledge and skills go into all patient diagnostic work and the treatment regimen administered by the hospital. Furthermore, from a managerial as well as the medical staff's point of view, the judgment of these two professions are called for when investments are

¹¹⁵ Pls. view these section 2.2.3 "The omnipresence of professions".

¹¹⁶ Of a total of 17.591 medical doctors in Norway, in all 93.9% of these are members of The Norwegian Medical Association (Dnlf) <http://www.legeforeningen.no> (01.12.2002). The Norwegian Association of Nurses (NSF) had a total of 60.197 registered members December 31st, 2000 (Statistisk Årbok 2002; table No. 257, p. 222).

made that require significant and long-term monetary commitments. The historical pattern of conflict-induced resolutions, add credence to any case matter promulgated by the employee federations.

The formal objectives of these respective federations cover both general employee conditions and the principles and scope of remuneration. However, the strategic scope of the medical doctors and nurses' federations go beyond mere general employment conditions.¹¹⁷ The provisions supporting the doctors' specialist education program particularly underline the strong hospital internal position enjoyed by the medical profession¹¹⁸.

The profession of medical doctors has a history of seeking to uphold its autonomy vested in its unique position of skills and legislated special status in the public health system (Christensen 1994). Christensen describes the influence of Dnlf to be particularly prevalent at national health sector level. At the same time, Dnlf is noted for its participation in a multitude of cross-professional organizations, associations, committees and project work groups. Christensen therefore concludes that the influence of Dnlf in national health policy legislation and sector rulings is significant. At the same time Christensen notes Dnlf's heterogeneity in working relationships with other so-called semi-professions. The latter invites a certain amount of uncertainty as to the existence of a possible integrated strategy between the health professions opposite the hospital sector.

The managerial complexities surrounding hospital top-management's working relationship with the medical profession becomes evident during the informant interviews.

"Naturally it is the main employee federations we most relate to, these being the federation of doctors and the federation of nurses."

¹¹⁷ The employee federations of doctors and nurses both have national policy documents promulgating their members' formal position on organization and management. Reference is made to: "Overlegeførenings policydokument om organisasjons og ledelse", dated 2000 and "NSF's formål og prinsippogram, vedtekter m.m. Yrkesetiske retningslinjer for sykepleiere, 2001". The basis of prescriptive policies and programs stem from their respective national statutes and strategic programs; i.e., Dnlf: "Lover for den norske lægeförening", as amended October 1, 2001 (<http://www.legeföreningen.no>); NSF: "NSF's formal, prinsippogram og vedtekter 2001 (<http://www.nosf.no>)..

¹¹⁸ A national board on the education of medical doctors supervises their specialist training as prescribed by regulations governing in-hospital training and the type and the number of staff postings in public hospital.

All case hospital directors refer to the doctors' and nurses' rigid employer - employee agreements. These are said to reflect the director's perception of the employee federations and their presence in the respective hospitals. The director at hospital no. 3 interprets the powerful presence of the Dnlf the following way:

"Firstly I need to pay attention to those who wield the power in the hospital. There are certain groups that have power and it is often those who help guarantee that we have medicine. These are the professional groups on the clinical side. Should one try to bypass these doctors then there is no way one can succeed."

The directors' problems with securing cost-effective solutions for labor-intensive hospital activities, is connected to the medical doctors' collective bargaining power.

"Exclusive agreements for doctors, their special working hours, are a barrier, a major barrier. I am bound by these exclusive agreements."

Also the nurses' association is credited with a strong negotiating position.

"Their union representatives protect their strong professional interests."

The director at hospital no.2 points to a distinguishing character between the medical doctors' association and the nurses' federation.

"Doctors belong to a union with strong professional interests as well as a strong focus on employee rights. Other organizations aim to be purely professional organizations, but it is not clear how much of their focus really is on professional issues."

The informant interviews confirm the medical profession and the nurses' association as representing strong stakeholder positions within the case hospitals. Their institutional position is confirmed at operations management level.

A summary overview of professional employee federations as a constituent actor in the hospital may be expressed as follows:

Table no. 24: Stakeholder group characteristics: Professional employee federations

Stakeholder class	Stakeholder groups	Group objectives	Significance to hospital operations	Group's collaboration with hospital interests
Professional employee federations	<ol style="list-style-type: none"> 1. Dnlf; (Norwegian Medical Association) 2. NSF; (Norwegian Association of Nurses) 	<p>To ensure the best possible terms and conditions governing the member employment, professional standards and professional autonomy in organized medical practice.</p> <p>Generally seeks to uphold autonomous status vested in arbitrated contractual rights and supported by institutional prescriptions.</p>	<p>Critical supplier of medical knowledge and professional skills.</p> <p>Access to and provider of supplier networks and professional affiliations ensuring continuance of core medical functions</p>	<p>Collaborative focus vested on hospital ward and patient treatment and treatment related activities.</p>

On Proxy agents

A dictionary definition of the noun “proxy” is expressed as “the authority to act for another”, or “a person authorized to act for another; agent or substitute”, with its Latin origin being *prôcuratiô*; i.e., *caring for*¹¹⁹. As such one may say that also the governance system audit offices and their staffs focusing specifically on patient rights, as well as those outside the realm of the public health system qualify as *proxy agents*; i.e., that they are acting on behalf of past and/or presently hospitalized patients. The thesis has already outlined recognized proxy agents existing both within and outside the formal structure of the public health sector¹²⁰. Interviews with

¹¹⁹ The American Heritage Dictionary of the English language, 1969, William Morris, Editor.

¹²⁰ See thesis section 2.4 “The presence of “Corporatism” and other proxy agents”, and thesis section 3.2 “The governance model”.

hospital directors and the hospitals' chief medical officers confirm the existence of hospital policies and formal case processing routines with regard to governance audit agents. The hospital organization's system logic as expressed by the director at Case hospital no.1, is representative of the managerial perception of this "proxy" agent:

"I consider the Patient Ombudsman to be a stakeholder, and we have one in Oslo. The system works as a kind of safety valve for patients who are not recognized by the hospitals normal complaints system or who have turned directly to the Patient Ombudsman for help. The latter is then the spokesperson for the patient vis a vis the hospital and we try to get the patient registered into the normal complaints system. We have experience with conflicting views, but the Patient Ombudsman brings in the professional aspects.¹²¹ The Patient Ombudsman often sees matters from a legal point of view. But as we view patients as stakeholders, the Patient Ombudsman may be considered part of our quality assurance system."

The managerial perspective concerning patient rights is stated by the chief medical officer who has noted an improved system attentiveness to patient rights:

"Patient rights and next-of-kin rights are stronger than before and require more attention. Thus much more of our working time and work force at the hospital is more tied-up than previously in these matters. In that sense our priorities are influenced by public opinion. Just as important as the media is our reputation developed amongst family and friends based on the fact that the patient speaks of the hospital either in positive or negative terms."

Adding this statement to the previously listed feedback from the director at hospital no. 3 makes a powerful case for the hospitals' attentiveness to patient rights:

" I need to get the staff to be clear on the fact that every thing they do must be to the good of the patient. Every hour at work is to be spent

¹²¹ The Patient Ombudsman in the County of Akershus (applicable to Case hospital nos. 1 and 2) is a lawyer in addition to being an educated nurse. Additionally, the office has its own medical advisory board consisting of seven members. A particularly resourceful office when compared with its counterpart at the County of Buskerud (serving Case hospital no. 3) who is without any dedicated support staff.

consciously thinking about what we can do to ensure satisfied patients.”

The hospital director at hospital no. 2 underscores his commitment to patient interests:

“We have input from individual patients and patient representative organizations. We have for example user-groups present in our complaints/injury committee. A strong stakeholder is our Friends of the Patients Association (“Venneforeningen”) through whom we have a lot of contact with users and patients on the issues which they bring forward.”¹²²

The chief medical officer supplants the director’s formal position, adding a note of past system weakness:

“I am afraid that I have seen many examples of colleagues not treating patients well. But this also has something to do with the fact that the patient is becoming more and more demanding and is not willing to accept what one was prepared to tolerate before. An obvious consequence is that we have to change.”

Recent years’ development of patient rights vested in national legislation and public discourse has resulted in revisions in governance prescription, hospital policies, regulations and procedures. The audit functions of the Patient Ombudsman, County Doctor General, and arms of the Health Supervisory Board, provide channels for punitive action when hospital performance proves deviant. Proxy agents external to the institutionalized governance inaugurated patient rights include both smaller and larger organizations. These act as stakeholder pressure groups lobbying their grievances to political offices, media and any other arena suitable for an effective promotion. Largest among these is the Norwegian Federation of Organizations of Disabled People (“Funksjonshemmedes Fellesorganisasjon”; FFO)¹²³. With the increased specialization of medicine, a closer dialogue is established between medical expertise and a particular ailment group. Evidence of the impact of an effective constituent liaison is noted in the interview with the hospital director at hospital no. 3:

¹²² The patient friends organization, a voluntary and independent membership organization working opposite Case hospital no. 2 has nearly 7000 members (from interview with the chair person of Venneforeningen”.

¹²³ See thesis section 2.4 “The presence of “Corporatism” and other proxy agents”.

“When we were short of money we closed down the rheumatology department. In this case the Association of Rheumatism Sufferers (Revma-foreningen) stood up to be counted, for better or worse, on behalf of this hospital. We also have active associations for heart and lung patients who also work very hard for us.”

The chief medical doctor at hospital no. 1 also lends credence to a close cooperation between external proxy groups and the hospital's clinical wards:

“My impression is that we have a good cooperation with many of these groups. We consider them team members. The Association for Diabetics, for example is very much involved here. This Association does in fact finance some of the projects we have and work with us in starting up new projects, financing new ideas.”

Judging from the hospital internal informant feedback, patient proxy groups work closely with their hospital counterparts. A common interest in improving knowledge, methods and procedures contribute towards better patient treatment result.

However, not all patients are diagnosed with ailments automatically bringing them into the safer threshold of a resourceful proxy constituency. In this connection it may be useful to look at the duration of patients' stay in public hospitals. Statistics show that average patient hospital stay is continually reduced. From an average hospital patient stay of 10.6 days in 1981, this had been reduced to 5,8 days in 2001¹²⁴. Behind these numbers may be a host of patient rationale, professional judgment and cultural traits all serving to explain increased regimen expediency. It may be reasonable to assume that a large number of patients admitted and discharged commanding little or no attention from patient proxy groups. As expressed by the Patient Ombudsman at Buskerud County:

“There was more time spent on patients before. Yet today there are more doctors and nurses than before. Then of course, there are more patients too. The admission time is so short nowadays, you almost have to be dead or very lucky to be admitted to the hospital without having to wait for ages. Then you get treated. Then you are discharged”.

¹²⁴ Statistisk Årbok, 2002; Helse og sosiale forhold, table 157, "Utskrevne pasienter fra og liggedager på somatiske sykehus etter kjønn og alder 2001", p. 139.

The Patient Ombudsman at the County of Buskerud serves patients of hospital no. 3. She is a nurse and familiar with the every day life and experiences of many patients. Some of these patients experience their first encounter with the public hospital without the coaching of any patient support group.

”People are not really that demanding. They are concerned with the simple things. For example, that they are met in a proper manner and they want one doctor to relate to. However, 10 doctors may be in attendance in the space of 5 days. Maybe they can relate to 3 of the 10 doctors so that these at least know which patient they are dealing with, and what is wrong with the patient, so that the patient doesn’t have to keep repeating his/her symptoms to different doctors. And that the patient is followed up when he or she leaves here. Failure to do so does not inspire confidence. For some reason or other it appears that many doctors have not been trained in communication skills. That we notify the patient’s General Practitioner (GP) or that the patient himself/herself can inform the GP of the care he/she needs. As you know, it doesn’t function like this today. People don’t hear anything, time passes, and then they don’t dare to go outside their front doors for fear of missing a telephone call asking them to come in to the hospital for a check-up.”

Perhaps noteworthy also is the fact that all patient grievances reported to the office of the Patient Ombudsman are forwarded the particular hospital’s chief medical officer. The latter forwards all such cases to a ward director in charge of the particular clinic to which a patient was admitted. The thesis will not address the grievance handling processes. However, it is important to note that patient grievances are routinely channeled outside the mainstream of managerial decision-making. A further quote from the interview of the Patient Ombudsman confirms this.

“In my experience, the director delegates these issues to the professional part of the organization. There is therefore no point in going to her”.

The analysis of the proxy agents as stakeholders working opposite organizational decision-makers shows a differentiated picture. The strongest proxy group in terms of an ability to influence improved remedial action correlates with patients’ diagnosed ailment. A medically attractive diagnosis will command funds and resources for improved knowledge, stands the best chance of gaining proxy group support. Patients falling outside the

supervised attention of proxy agents may find themselves lesser serviced and thus become more vulnerable to hospital system deficiencies.

A summary overview of proxy agents as representative of a stakeholder group is given in the following table.

Table no. 25: Stakeholder group characteristics: Proxy agents

Stakeholder class	Stakeholder groups	Group objectives	Significance to hospital operations	Group's collaboration with hospital interests
Proxy agents	1. Patient ailment groups representing the chronically ill	To ensure public and professional provisions improving treatment, care and support of the respective patient ailment groups.	Mutual interests in medical research and patient care as basis for cooperation to secure public and private funds to ensure the financing of future research programs.	Patient ailment groups may work to serve interests important both to hospital and proxy group objectives.
	2. Voluntary "Friends of the patients"-groups	To uphold continuous liaison particularly with key medical staff to induce support and action facilitating hospital attention to patients and patient group needs.	Voluntary groups serve to strengthen a hospital's image favorable to the hospital operations.	Voluntary groups work to secure safe and sound patient conditions and thus facilitate hospital – patient communication. Community fund raising programs facilitate auxiliary investments in hospital internal programs aimed at further improving patient conditions.

Critical suppliers:

The modern public hospital is a labor intensive, high-tech, know-how and skills intensive type organization. The continual advances of modern medicine provide still better diagnostic and treatment measures. Therefore there is a societal expectancy to be served by the latest, the best and the safest medical regimen.¹²⁵ As outlined in the contextual analysis, there is a recurring national debate on the perceived shortages of funds allocated the hospital sector.

In viewing the hospitals' critical suppliers as a generic constituent agent, the thesis is here focusing on the suppliers of technology and medicine. The governance concern opposite critical suppliers covers expenditures, product quality and procedural adherence to the distribution of publicly supervised products. Control mechanisms involve regulatory agencies, sector audit groups and hospital internal management processes.

The thesis analysis of critical suppliers seeks to determine how these interact with hospital operations management. External suppliers represent significant operational expenditures. The hospital naturally seeks to curb such capital and cash commitments. A distinction here needs to be made between capital investments and expenditures made on non-capital items. Capital accounts are not presented as part of the public hospitals' budget or accounts¹²⁶. In the empirical period covered (2001), public hospitals exercised little control over capital accounts¹²⁷. Both communes and counties followed the principle of cash accounting. This means that all capital outlays had to be fully accounted for in the year of investment. In this way, the hospital's operational accounts are not evidence of real resources consumption. Also, the law on budgets and accounting in public organizations specify that capital funds shall not be financing operational

¹²⁵ See theses section 2.3 "The influx of societal "medicalization".

¹²⁶ Budgetary procedures governing public organizations are legislated in the law on commune and counties ("Kommuneloven"); September, 25, 1992 (§ 45). Specific prescriptions on budgets and accounting procedures are prescribed by the Department of communes and labor activities ("Kommunal og arbeidsdepartementet").

¹²⁷ NOU 1999:15 "Hvor nært skal det være? Tilknytningsformer for offentlige sykehus"; section 4.2.3 "Det effektive sykehus – rasjonell bruk av kapital og personell", p.p. 27-28.

activities¹²⁸. The justifying argument for this is that a hospital does not engage in activities where no immediate operational funds are available.¹²⁹

While acquisitions of medical technical equipment may be considered as long-term strategic investments, the hospital internal process of planning and financing does not procedurally support it. This makes the hospital vulnerable to poor quality decision-making processes. As is evident from the interview with the chief medical doctor at hospital no. 1, the strategic imperative seems to have dissipated:

“Investments in new equipment are almost force majeure. Equipment stops functioning and the supplier and technical staff say it is not worth repairing. We must buy new equipment now. So as we do not want to cause critical delays for the Laboratory, X-ray, Intensive Care or Respiratory Unit, one just accepts that investments are necessary. It is also the case that once the money is spent, the Director allows the costs to be put through operations accounts. In effect, many millions in equipment investments have been put through general operations accounts.”

Some informants express their concern for expressed investments to represent fictitious needs. The chief medical doctor at hospital no. 1 supervising the investment budget process puts it this way:

*“The strategy may well be that the Clinic or Department presents the needs making them appear greater than they really are. The owners then get the impression that when we are operating with investment needs in the region of 150-200 million kroner, and are actually granted 15 million and finally spend 25 there surely appears to be a situation where matters are exaggerated”.*¹³⁰

¹²⁸ Law on communes and counties (“Kommuneloven”); dated September 25, 1992; chapter 8 “Økonomiplan, årsbudsjett, årsregnskap og rapportering.

¹²⁹ The problem of lacking capital accounting in public hospitals is also discussed in NOU 1999:15 “Hvor nært skal det være? Tilknytningsformer for offentlige sykehus”; specifically in section 4.2.3 “Det effektive sykehus – rasjonell bruk av kapital og personell”, p.p. 27-28.

¹³⁰ Investment budget in plant and medical equipment were in 2001 NOK 17,5 mill. Case hospital operational budget in the same year was approved at NOK 1.2 bill. Building and maintenance’s share of this investment was set at NOK 6 mill. Capital investment at Case hospital no. 2 was in the same period NOK 10 mill. For comparative view on operational budgets at case hospitals, pls. view Table 16 “Selected Case hospitals”.

Different practices seem to exist between case hospitals regarding the handling of acquisitions and purchases of medical technical equipment. All hospitals report new and recent initiatives to professionalize equipment acquisitions. The objective is cost savings to be generated through larger volume purchases, thus creating a stronger negotiating position. Still a problem is defined with respect to the critical dialogue, taking place between ward representatives and equipment suppliers.

“The procurement process has chiefly been a communication between the professionals and the equipment suppliers who have strongly reduced our opportunity for proper negotiations. Discussions have usually gone so far that we are tied up before the matter even reaches the procurement department”

Judged from the informant interviews, there seems to be a constant tug of war between the clinicians and the administrative staff in matters of acquisitions of medical supplies, medicine and medical technical equipment. The chief medical doctor at hospital no. 1 puts it this way:

“A lot of time is spent on this because the medical staff believe that the procurement people do not know enough about the professional requirements and therefore are not properly aware of professional needs. Consequently doctors do not want to be bothered with procurement budgets. In reality the situation now is such that the professionals’ direct communication with the suppliers has gone so far that hands are tied long before matters reach the procurement department.”

Within the medical community at large, technological change is the hallmark of health care (Health Affairs 2001). According to an editorial article in Health Affairs “medical doctors world wide read the same journals and participate in international consortia to encourage best practice through the best available tools and techniques” (Health Affairs 2001). In Norway, there is a great deal of disagreement as to the exact investment needs for medical technical equipment. Hospital internal analysis has confirmed that outdated equipment represents a significant problem for patient safety in hospitals (Vandeskog 2000). Vandeskog makes reference to outdated equipment contributing to resource inefficiency and unacceptable patient quality. Bottom line for the hospital is reduced treatment capacity and the accumulation of patient treatment waiting lists. Prior to coming up with a new national investment support program in medical technical equipment¹³¹,

¹³¹ St prp nr. 61 (1997-98); Innst S nr 226.

the Department of health and social services reported a backlog of NOK 2.5 bill. (milliarder) and with new investment needs placed at NOK 7.3 bill. (Vandeskog 2000). In seeking to document investment needs, a great deal of uncertainty was reported as to the perceived reliability of estimates. Differing and unsystematic routines existed with respect to inventory recording, value assessment and routines for discarding, replacing and projecting new equipment needs (Vandeskog 2000).

The thesis confirms a lack of clear policies, prescriptions and routines with regards to the acquisitions of medical technical equipment. The clinical wards promote the needs to acquire new and improved equipment in order to maintain high quality, safe and efficient treatment programs. The medical profession's preference for supervising the hospital dialogue with critical suppliers curtails management's ability to impact acquisition terms and conditions.

It appears as if suppliers generally enjoy a direct access to hospital internal medical staffs. Based on the informant interviews, the exact consequences are difficult to determine. Programs to pool hospital investments optimize the purchasing process. Case hospital informants confirm that hospitals have benefited from such cooperative arrangements.

Less talked about is the close liaison said to exist between the suppliers of pharmaceutical products and hospital doctors. The control of prescription medicine sold in Norway is supervised by the Norwegian Medicines Agency (Statens legemiddelverk). Total branch sales in 2001 to hospitals and pharmacies amounted to NOK 8.3 bill. (mrd.)¹³². As the public health sector finances a significant share of this, hospital expenditures on prescription drugs become a governance issue.¹³³ The objective of the staff working for pharmaceutical firms in Norway is to uphold a close liaison with the public hospitals.¹³⁴ However, as the chief medical officer at hospital no. 1 notes, the supervision and control of pharmaceutical products appears firm:

¹³² Legemiddelindustriforeningen "Tall og fakta" (Facts and figures), <http://www.lmi.no>.

¹³³ In 2001, public health agencies financed 68.6% of expenditures on prescription drugs (Source: Legemiddelindustriforeningen "Tall og fakta" (Facts and figures), <http://www.lmi.no>).

¹³⁴ In 2001 (31.12.01) 4130 people were employed in the pharmaceutical drug industry in Norway (Source: Legemiddelindustriforeningen "Tall og fakta" (Facts and figures), <http://www.lmi.no>).

“Which medicine the hospital chooses to go for is strongly controlled centrally. There are purchasing committees that select the medicines for our hospital and who negotiate prices for each product type with suppliers. It is possible to go outside this system but there have to be very strong arguments. A special application has to be submitted in order to be able to use medicines other than those that are on the list. And the list is extremely long.”

Some informants make references to their particular hospital being underrepresented in the drugs purchasing committees. The thesis analysis has not looked into this contention. However, informant interviews confirm that pharmaceutical firms do indeed play an important role in clinical operations. As the following informant statement confirms, critical suppliers do influence hospital decision-making on the selection of pharmaceutical products. The chief medical doctor at hospital no. 1 provides the first of such informant statements:

“The pharmaceutical industry supports a number of clinical studies at the hospital. Here between 20 and 25 such studies commence each year. They are financed by the pharmaceutical industry and are often multi-center studies for the Nordic countries, all of Europe, worldwide, or just covering a number of areas in Norway, where there is close cooperation between representatives from the pharmaceutical industry and the clinics. The pharmaceutical industry is interested to know which medicines the leading professionals recommend. Let us just take for example the department for heart disease that treats a large number of patient groups with heart disease in Oslo. Information on treatments administered is transferred through the system when the patient goes to a GP who continues to treat the patient with the same drugs as prescribed by the hospital. Consequently the pharmaceutical industry is very interested in which drugs the hospital prescribes. In this system it is our doctors who decide. But it is the industry that controls the choice of studies they wish to finance. This type of inducement therefore is a topic of discussion because we have to choose how many studies we carry out, also testing of medicines; what proportion of our resources will be tied up relative to independent research and development projects which we also have to carry out. A broad scope of resources is tied up; our doctors and nurses. Things are formally documented. However there is a lot of pressure from the industry.”

The presence of the suppliers of drugs and medical consumables seems in great detail to be associated with the hospitals' medical research programs.

Suppliers introduce new equipment and medicines. At the same time, our staff needs to become updated on new medicines, technology, skills requirement and improved procedures. In this setting, the industry provides opportunities that benefit both management and the medical staff.

The case hospitals show distinguishing traits in their approaches to research programs offered by the industry. As already outlined, hospital no. 1, being a university hospital, confirms its research ambitions. Hospital no. 3, being a relatively large county hospital, has a lesser focus on medical research:

“We raised the problem of the lack of research and development projects with the Director. As a result, a Research and Development Advisory Board was established with 330.000 kroner per year in funds. In my opinion this is a first step in the direction of stimulating research and development. But we also need another type of motivation to stimulate an interest in medical advancement. There are not many people motivated to work on research and development. Here you are all engulfed in practical every day issues and there are no resources, neither in terms of money nor people. When you are running a County Hospital then your task is defined. It is about taking care of a population of a considerable scope. Time does not permit specialization. You have to provide medical services for 225.000 to 235.000 people.”

At the same hospital, the chief medical doctor informs of the hospital's participation in multi-center research programs:

“We have research and development projects related to the pharmaceutical industry. We must not forget that much of what they do is in done in order to get their medicines into the Norwegian market. On our hand, we are dependent upon national surveys to finance some of our own programs. And the medicines have to become known. Therefore there is this type of development projects.”

The scope of research activities is further confirmed in the informant interviews at hospital no. 2, a local hospital. Again, a lack of management-initiated research is confirmed. The chief medical doctor puts it this way:

“Research and development is important, but management has not initiated any such program. It is very much up to the doctors, and each department.”

The hospital director confirms the lack of resources to start up any research program:

“The financing of our hospital does not encompass research projects which we actually are committed to do. We don’t get DRG-points for that. Therefore it is the pharmaceutical industry that finances many of our research projects. This is pretty much up to the initiative of the doctors and the departments.”

The following informant statement made by an informant at hospital no.1 dramatizes the efforts made by suppliers to gain access to the hospital’s medical staff:

“The Director throws us right into the arms of the pharmaceutical industry. I feel that this hospital should live up to its responsibilities and cover a minimum of costs for training courses so as to avoid that certain departments continually attend courses as they have better contacts within the pharmaceutical industry, while other departments who for different reasons don’t have such good contacts, because they don’t use such expensive medication or such expensive equipment, cannot go on courses”.

”We get many offers from the pharmaceutical industry. They bombard us with letters and offers”.

”During recent days I have seen examples whereby one is asked to send out information together with a form where the doctor is to list which medicines he or she prescribes as primary treatment, giving the name of the medicine for the particular condition. Weekly prizes are given to those who submit the required information. This happens to be a company that lives off collecting this type of information and who then sells it to the pharmaceutical companies. In addition they are responsible for printing the general catalogue of medical drugs (Felleskatalogen)¹³⁵.

As outlined in the law on public hospitals, it is the duty of public hospitals to teach and train medical students and graduate staff to maintain their

¹³⁵ Felleskatalogen” (“Felleskatalogen over farmasøytiske spesialpreparater markedsført i Norge”) is a summary listing over all pharmaceutical drugs sold in Norway. The catalogue is intended for medical doctors and other health professionals. The Norwegian Medicines Agency (Statens legemiddelverk) has approved all factual comments made on drugs listed in the catalogue.

proficiency and qualifications. Hospitals do receive financial support to finance medical specialists' education¹³⁶. However, from speaking with members of both management and members of the clinical staffs, the consensus is that funds are inadequate. Thus, it becomes evident that the type of training programs introduced and financed by the suppliers of medical equipment and medical supplies are considered attractive.

“The hospital itself has no budget for training, professional development, courses and conferences. Support for such programs from industry is very important for many, particularly doctors, but also to a certain extent nurses and other professional groups. This creates an intimacy or a bond between professional users here and the drug and equipment suppliers. That I am sure of”.

A summary overview of critical suppliers as representative of a stakeholder group is listed in the following table.

Table no. 26: Stakeholder group characteristics: Critical suppliers

Stakeholder class	Stakeholder groups	Group objectives	Significance to hospital operations	Group's collaboration with hospital interests
Critical suppliers	Producers of tools/ technologies and supplies critical to hospitals' core patient treatment programs	To ensure that the particular hospital continues to request their products and services. The hospitals' continued application of supplier items represents an empirical source for product performance evaluation.	Products are critical to hospital performance. Product costs and services impact operational and economic efficiency. Indirect cost/- performance impact induced through upgrade of hospital know-how, competence and capabilities.	Joint projects on research and development serve both parties with respect to improving supplier products and next improving patient treatment outcome and hospital resources performance.

¹³⁶ Hospitals are each year receiving special allotments to partially cover expenses associated with training and development of health staffs. The governing procedures for this is outlined and explained in the recently issued Government white paper NOU 2003: 1 “Behovsbasert finansiering av spesialisthelsetjenesten”.

10.3.2.2.2 Summary evaluation

Issue perception:

The hospital directors' views of issues critical to hospital operations appear closely aligned with the respective hospital's functional status. The prescribed functional status triggers function focus and overall strategy. The university clinic, values its academic status, as it is believed to support the hospital's national profiling programs. Sector support programs represent financing critical to recruiting, research and development and patient treatment programs. Thus, operations' scope is correspondingly broadened to encompass high quality patient treatment focus, recruiting and training of medical staff and research and development.

The opposite issue perception appears represented at the county hospital explained by its physical proximity to several university clinics in Oslo. Hence, issue perception has triggered a strategy that prioritizes what the director coins as non-academic medicine. Operational focus is an all out effort to integrate hospital patient regimen with community health services clinics. The hospital benefits from improved patient logistics. Recruiting and training programs are scaled accordingly. Medical research and development programs are marginalized reflecting a strategy of treatment production and resources efficiency administration.

As a community hospital, hospital no. 2 has adopted an operations strategy based on an issue perception much like the county hospital. Its even closer proximity to larger scale clinics, regional and university hospitals in Oslo and surrounding communities, makes this appear to be management's chosen operations strategy.

Institutional perspective:

At operations management level at the university hospital, its director and management team all express a strong adherence to a strategic logic triggered by its university status for medicine. The logic may be summarized accordingly: Funds follow status. Funding spin-offs follow in the trail of university based subscriptions. The breach in the logic appears in the hospital director's subscription to the calls of the (Oslo) commune governance administration. A partial strategic write-off is the direct result of a submission to the governing prescriptions of budget austerity. Management subscribes to the commune's shorter-term operational focus.

At the county and community hospitals, the institutional perspectives correspond with their respective issue perception. The director of the county hospital emphasizes the merits of patient attentiveness. It is not clear if this is representative of a genuine patient care philosophy or if it is considered a prerequisite to attract the good will of the community health services and their patients. Pragmatism rules the community hospital, as the director rationalizes the needs to subscribe to county governance prescriptions.

Goal orientation:

The hospital directors' goal orientation depicts how close operations management may identify itself with operational solutions and over which they may exercise a real influence. Here, their perception of issues and perspective on institutional focus bring in their common interest in ward leadership. The corporate logic of governance and operations come together in a common preference for ward leadership development. A differentiated organizational culture is perceived to be an obstacle to operations management programs. The rationale of governance is perceived to be in contrast to the logic of the health professions. Leadership skills at the community and county hospitals are equated with the ability to recognize the merits of patient logistics. The county hospital director comprehends the necessity of communicating a uniform logic to develop and facilitate resources management. At the university clinic, the director works to integrate the differentiated cultures of the health professions into team-based work approaches. This latter challenge is perceived to be greater at the county case hospital. Here the director's objective is to make medical doctors professionally embrace general medicine, as specialists are not welcome in the non-academic environment.

Goal alignment:

The summary analysis of case hospitals' goal alignment centers largely on their capacity to manage the presence and influence of relevant stakeholder groups in hospital decision-making. The hospitals' liaison with stakeholder group representatives is an activity that concerns top management. At operations management level the hospital director and the management team align issue matters relative to stakeholder groups' interests. The subsequent analysis focuses on how operations management relates to such constituent liaison. Stakeholder groups identified in the thesis' contextual analysis will be followed to ascertain stakeholder relations.¹³⁷

On sector governance:

Structural maladies plague the governance of both the county and the community hospital as earlier confirmed by the respective executive board directors. Their hospital directors verify this in their perception of reporting relationships. The director at the university hospital confirms his uncertainty about his true hierarchical position seeking to verify his superior position opposite the hospital board of directors. The community hospital director exhibits a capacity to work effectively with a complex matrix governance

¹³⁷ See thesis section 8.3.2 "Stakeholder selection"; specifically illustration no. 8 "A model of public hospital stakeholders".

system encompassing both county and State sector actor agents. The county hospital director registers her satisfaction with a new governing regime. With the structurally incorporated hospital she perceives a clear and unbroken reporting relationship circumventing the past matrix of political and county administrative actor agents.

Governance instituted audit agencies and the hospital internal system audit control groups are verified as serving their prescriptive functions. However, it becomes clear that issue matters are promulgated only in a consultative format outside the mainstream of hospital management. County and State sector audit offices are not registered as viable constituents within decision-making forums of the case hospitals. Top management does not invite issues associated with the Patient Ombudsman, County doctor general or the State's health supervisory board into the arena for critical operations management decisions.

On professional affiliations:

A uniform recognition exists among the director informants on the presence and significance of the employee federations. The Norwegian medical association (Dnlf) and Norwegian nurses' federation (NSF) are confirmed as wielding significant powers that impact operations management. The directors univocally confirm that both these employee organizations influence operational flexibility and costs management through contractually negotiated employment contracts. Members of organized health professions are said to represent major obstacles to what private industry wish to perceive as managerial prerogatives. Contractual employment conditions impact work scheduling, salary administration, staff recruitment and development and ward organization.

As pointed out in the thesis' contextual analysis, this strong institutional position attained by the medical doctors is attributable to a historical pattern of the power of professionals¹³⁸. The autonomy enjoyed by medical professionals is by Harrison (Harrison and Pollitt 1994) said to be socially oriented towards the perception of illness as an individual pathology rather than one that is socially, politically or economically created. Hospital director informants distinguish between the medical doctors' employee organizations and the nurses' organization. This appears done in a way that perhaps reflects a differentiated view on the health professions and thus their perception of organized medicine. It is particularly evident in the interview with the director for the community hospital who questions the nurses' focus on health professional issues.

¹³⁸ See thesis section 2.2.3 "The omnipresence of professionals".

On proxy agents:

Proxy agents working on behalf of hospitalized patients may be divided into three categories. The *Patient Ombudsman* is the county/commune governance instituted agent working to facilitate a desired patient – hospital dialogue based on an interest in recourse and restitution. The *Friends of patients*-groups are voluntary organizations commonly established around a hospital. A third patient proxy agent is a group organized to aid the chronically ill frequently requiring hospital admission and treatment.

Informant interviews confirm that at operations management, none of these organizations figure in any strategic or day-to-day operational setting. The Patient Ombudsman office works directly with and through the medical ward in their fact-finding processes. “*Friends of the patients*”-groups follow the same logic. Contacts within the clinic provide desired patient regimen insight and represent the arena where the most immediate corrective measures are assumed. Interviews with patient ombudsman representatives convey an impression that only a small portion of patient complaints ever reaches their offices. The great majority of patients do not possess the individual capacity and resources to initiate a formal process to challenge sector authority and judgment. The accomplishments of “*Friends of patients*”-groups are at best considered a non-threatening hospital lobbying group promoting localized patient improvement measures. Limited resources scale action output accordingly.

The informant analysis confirms the pronounced presence in all the hospitals of the chronic ailment/disability patient organizations. Their strongest presence is naturally in the larger hospitals such as the university and county hospital. The analysis shows that the chronic ailment groups and medical wards work in unison to secure project funding for medical research programs. Operations management does not structurally intervene. The situation of active external proxy agent intervention is by the hospital operations management not considered to be of any strategic concern.

The large majority of patients falling outside the supervising shield of the proxy agent groups do not benefit from the support of any other bona fide vested interest group.¹³⁹

¹³⁹ Recent developments within private medical insurance are not taken into account. Effective January 2003, a political decree approved as tax deductible and employee tax exempt employer paid medical insurance. This governance initiative falls outside the empirical time frame of the thesis. It is also too early to determine the impact this measure may have on the hospital sector. Norwegian Patient Accident Registry (“Norsk pasientskaderegister) records a total of 240.000 people waiting on hospital medical treatment. The insurance industry projects a dramatic increase in the number of organizations wishing to insure its employees (Finansavisen, Thursdag 9th January, 2003).

Critical suppliers:

As the analysis has established, all case hospitals struggle with the uniform problem of resource deficiencies. The scarce funds allocated are generally inadequate to uphold a full range of mandated services. Investment funds are utilized to facilitate hospital operations needs and vice versa depending upon how critical a situation may be. Operations management logic as promoted and supplanted by executive authority and sector administration, focuses on resources supervision. While the public hospital is a labor-intensive branch, it is also critically dependent upon medical technical equipment and a continuous stream of medical supplies. Viewed isolated this represents procurement costs. Governance administration staffs largely supervise public hospital investment programs. Financial investment costs do not appear in hospital accounts. This serves partly to keep hospitals' operations management out of the procurement process. The analysis shows that this is far from a professionally sound process. There is a continuous direct dialogue between suppliers and ward users outside the formally established procurement channels. Informants confirm that clinical representatives act to influence supplier choice and equipment preference¹⁴⁰. Providers of equipment and supplies also appear to furnish supplementary services not being part of the governance resources provisions. Industry suppliers supplant governance provisions thus making up critical system deficiencies. Project resolutions between outside suppliers and hospitals-boarder professional, legal and ethical barriers on what is acceptable and what break conventions and codes of ethics. Operations management's lack of involvement permits wards autonomy in medical issues carrying strategic implications. Joint dialogues between external suppliers and ward representatives influence hospitals' directional choices. The hospitals become strategically vested in equipment and supplier choice and locked in the ensuing scope of financial commitments.

Primarily, this is a situation that concerns chiefly the university hospital. The pattern described seems well entrenched. The county hospital passively accepts industry intervention although at a smaller scale. Hospital participation in patient-output testing programs guarantees funding of professional training programs, conferences attendance and insight into relevant empirical research programs. Nurses in charge of purchasing large amounts of hospital medical supplies are equally serviced by the industry and enjoying similar rewards. At the community hospital the practice is as with the two former hospitals but scaled down corresponding to its operational scope.

¹⁴⁰ For a broader analysis of this issue matter, reference is made to The Economist, February 15, 2003: "Pharmaceuticals. Pushing Pills", p. 63.

The issue of industry cooperation is frequently debated in media under the auspices “Morale for sale”¹⁴¹. The interpretative view of hospital informant statements is one where suppliers of equipment and medical drugs and ward staff represent a professional bond. Based on informant interviews, the hospitals’ operations management does not actively intervene in this practice. Issue matters related are resolved in the interaction of ward representatives, sector acquisition program representatives and representatives of critical suppliers. Hospital internal policies and prescriptions confirm formal procedures. However, management does not intervene to resume initiative and control over medical practice and choice relevant to an over-all strategic initiative.

10.3.2.3 Ward management level

10.3.2.3.1 Analytical approach

In all, 15 clinical staff members have been interviewed. These represent medical doctors and nurses, some in supervisory capacities, others working as senior staff within the respective case hospital wards. The interpretative focus is organizational decision-making at ward level. Therefore, the conceptual categories selected for analysis reflect areas of ward interest related to (i) managerial performance, (ii) clinical supervision, (iii) the vested interests of the health professions and (iv) patient orientation.

By hospital ward, reference is made to a larger medical unit or clinic. Drawing on definitions developed by Government white paper NOU 1997:2¹⁴², a ward (*klinisk avdeling*) may be defined as an organizational unit within the hospital. Its assigned responsibilities are to conduct specialized medical sub-functions within the range of the hospital’s total medical responsibility. Ward facilities commonly incorporate bed sections, day-care units, examination rooms and a range of medical support sections organized within and/or outside the particular ward facilitating the clinical activities. The patient is to be examined, given proper medical treatment and provided with necessary facilities and care. Also, the ward staff performs medical research and conduct educational programs for doctors in specialist training¹⁴³. Consequently a number of different professions are assigned to

¹⁴¹ ”Moral til salgs”; title of editorial article in ”Dagens Medisin”, 15th August 2002. The article enters the public discourse on the issue of “mutual dependencies” between the medial industry and medical doctors.

¹⁴² See specifically section 5.6.1 “De medisinske funksjonene”, p. 33, particularly sub section 5.6.1.1 “De kliniske avdelingene”, p.p. 33-34.

¹⁴³ For detailed description of hospital organization, staff employed and services performed, pls. view thesis section 3.3 “Organizing for medical services.

the medical ward to ensure the qualities and qualifications of programs and services executed. The scope of ward activities connected to managerial conduct represents an important part of the thesis' analytical focus. In order to accomplish assigned functions, the ward administers a significant amount of dedicated resources. As such, organizational ward decision-making invites the interests of a wide range of stakeholder groups both inside and outside the hospital.

Hospitals differ in terms of medical specialties offered, range of activities performed, number of staff assigned and the volume of patients admitted. However, as can be seen from Table no. 8: "Selected Case hospitals", all hospitals are equipped to serve both community and county functions. This requires a broad range of medical responsibilities and specialized skills¹⁴⁴. This to evidence the wards' supervisory complexities and the need for well conceived operations management processes and priorities.

The conceptual analysis applies categories that are expected to provide informant feed back indicative of stakeholder interests and influence. These are presented in the following table.

Table No. 27: Conceptual analysis: Operations management (3)

Conceptual focus	Conceptual categories	Property characteristics
Ward supervision	Managerial Attentiveness	Informant's attentiveness to the hospital's over-all managerial needs as perceived relevant to ward operations
	Clinical ward Development	Informant's view of ward development relative to its over-all operational scope of activities
	Subscription to professional field development	Informant's view of how the ward balances the needs of its health professionals opposite operational needs
	Patient Orientation	The informant's view of the clinical staff attentiveness to patient needs

¹⁴⁴ For a detailed classification of public hospital services, their organization and classification, pls. view SAMDATA sykehus 03/01: "Sykehusstruktur i endring. De lange linjer og utvikling siste tiår", p.p. 65-96.

10.3.2.3.1.1 Managerial attentiveness

With respect to the wards' managerial capabilities, the analytical focus is on how the ward balances its over-all objectives opposite its own clinical needs. All ward managers¹⁴⁵ are members of the respective hospitals' top management group. As such, one would expect that the governing concerns and priorities of both executive and operations management is well known to ward managers. However, ward managers express little enthusiasm for having to spend time on what are considered planning processes with little or no relevance to ward operations. The following informant statements verify ward manager disillusionment with managerial exercises at case hospital nos. 1 and 3:

"We have a strategy plan for 2001 – 2004. This was written by the management team. The focus is very much on the economics of the general overall running of the hospital; economic key indicators, i.e. not an operating plan. It is all about the economics. Basically, short-term budgets. In my opinion the Budget Process leaves much to be desired"

"In the strategy plan I was looking for a profiling of what we actually do. But everything was about DRG and income. The focus is only on cutting costs and reductions so that financial and economic goals can be achieved. I feel it is important to follow up the logistics or "patient flow". Actually get to grips with what we do."

"Yes, we have an extensive planning document. The volume is such that we did not manage to decide on any common concrete goals to work towards. At management level we have not had any focus on achieving goals."

"The hospital's strategy plan is characterized by cost cutting and the management have not secured adequate "buy-in" and commitment to the plan. There is not enough focus on the issues at hand and too much focus on money"

"At the beginning of November the Director announces that we have to make up for a deficit of 30 million kroner. At the same time we are to develop a strategy plan. There are a number of department managers who are then presented with these cost-saving tasks. Their

¹⁴⁵ At ward level, the term ward managers and supervisors will be used interchangeably.

reaction is to ask what the point is of a strategy plan when the strategy is down-sizing. Then you don't need a strategy plan! At least not a strategy with a professional clinical/medical focus!"

Ward managers at all hospitals express a commitment to ensure medical services considered to be part of their national hospital status¹⁴⁶. At hospital no. 1, their national classification prescribes a wide range of medical services. Ward management commitment appears firm:

"We have a functional commitment encompassing national and regional assignments towards which I have been particularly observant and loyal to."

As earlier expressed by ward informants at hospital no. 3, the regional hospital classification is evident in the hospital's patient and production oriented strategies. The efficiency-oriented approach to hospital production at hospital no. 2 also is attributable to its community clinic classification. The focus is on serving its local patient constituency in close cooperation with first-line health care institutions.

A common frustration is expressed with respect to administrative prescriptions on production based cost reimbursement programs.¹⁴⁷ Ward criticism encompasses both the logic of DRG and the time required for its administration:

"The problem surrounding the clinical dialogue is that the pressure to be efficient results in "per item" treatment. A patient who is admitted with an intestinal infection is treated for that complaint even if she also has gallstones and is on the waiting list for gallstone treatment. Because of the time pressure the situation is such that a patient who has had an operation for cancer in the large intestine is not subject to more than one check-up here. Then the patient must go elsewhere, outside of the hospital because it is not lucrative for the hospital to carry out the check-up and we have limited resources. The clinical dialogue then evaporates."

"You learn to get round the system. This has to do with main diagnosis and other diagnoses. If you get an epileptic patient, then it is easy to

¹⁴⁶ For the definition of the particular class hospitals and the corresponding medical functions ascribed, pls. view thesis section 3.3.1 "Hospital services functions".

¹⁴⁷ For an explanation of hospital financing systems, pls. view thesis section 3.4 "The emergence of corporate logic".

record the diagnosis as epilepsy. But it is not so easy to record that in fact he also has diabetes, as this is a little irrelevant in this case. However if you do record it, then you get more money.”

Equally compelling is the argument on the time required by medical staff to assign DRG classifications relative to patient diagnosis.

”You can say that 20-30% of my time as a doctor goes to DRG-coding”

State sector initiatives to remedy the problem of hospital treatment waiting lists are not met with ward cooperation, as expressed at hospital no. 3:

”Political direction has been of little consequence to us in our every day work. We have had some friction in the system regarding the matter of sending patients abroad for treatment. This has basically been unsuccessful because the professionals have on the whole considered it to be either wrong or unnecessary.”

Further testimony to the hospital wards’ non-agreeable position on administrative decrees is evident in hospital reorganization programs. Through the Government white paper NOU 1997:2¹⁴⁸ (later promulgated in the proposition of new health laws, Ot prp nr 10 (1989-99)¹⁴⁹ and subsequently made into law July 2nd, 1999¹⁵⁰), prescriptive announcements were made on the introduction of unitary leadership (*enpersonsledelse*)¹⁵¹. However, ward medical staff is still voicing its opposition. The matter of ward supervision also represents a conflict between the medical doctors and nursing employee federations as to what professional background is required for ward leadership. A medical doctor’s view may here be representative of the medical profession’s point of view:

“Unitary leadership or singular leadership is a political prerequisite. It is my belief that this will have very little impact on the day-to-day running, because things will just continue as before.”

The ward’s organizational structure represents the most important and visible element in the medical doctor’s career structure. On a national level,

¹⁴⁸ NOU 1997:2 ”Pasienten først: Ledelse og organisering i sykehus”

¹⁴⁹ Ot prp nr 10 (1998-99) ”Om lov om spesialisthelsetjenesten mm”

¹⁵⁰ ”Lov om spesialisthelsetjenesten m.m.”; Rundskriv I-59/2000

¹⁵¹ For a review of hospitals’ functional organization models, pls., view thesis section 3.3.5 ”Hospital management and the administrative functions”, p. 46.

State sector governance determines the distribution of medical staff geographically, by hospital types and at organizational levels¹⁵². This arrangement is part of a sector prescription to ensure an efficient and just distribution of the nation's medical resources. A ward nurse informant perceives the present-day governance prescription of ward staffing and organization as follows:

"The hospital is run on an old-fashioned patriarchal system with a strong focus on roles and reporting lines, i.e. who the boss is. The doctors reign supreme."

10.3.2.3.1.2 Clinical ward development

Informants all express their professional commitment to and personal interest in the success of the clinic. The clinical ward is the arena for health professionals. Actor credibility is determined on educational background, professional qualifications and professional field associations. Ward planning processes and managerial style are reported to be informal and non-bureaucratic. Administrative management appears to have less governing value:

"Here there are documented goals for each clinic. But in reality we don't take any notice of what is written. Our reality is about giving the best possible service to our community. It is the management's job to ensure that we have the necessary resources to ensure just that, i.e. patient treatment and service."

Management strategy processes are disregarded because of their perceived irrelevance to ward operations.

"The strategy document is in my opinion just paper. Most staff here do not relate to it, neither do they perceive it to be realistic. It is an exercise, which maybe of value, but I think it will take time before it becomes an integrated part of our every day work, if indeed it ever does."

¹⁵² National advisory boards are appointed by the Department of Health to ensure abidance by the legislated rules on medical educational and staffing: (1) "Nationalt råd for prioritering i helsevesenet"; and (2) "Nasjonalt råd for spesialistutdanning av leger".

Ward strategy, although not the result of comprehensive planning processes and not formulated in strategy documents, focuses on securing self-sufficiency and operational autonomy:

"The strategy for my clinic is to ensure optimal medical staffing with doctors and nurses and qualified administrative support."

The medical staffs' perceived self-governing rights to organize its clinical activities, becomes apparent through the interviews. A medical representative expresses the traditional working of a wards' operational infrastructure as follows:

"When it comes to treatment and the extent of it, then there is no doubt in my mind that it is the doctors who set the agenda. Law regulates part of this. However, there is no doubt either that the nurses and their leaders have the greatest influence on such important issues as how the wards are organized, a strong say in the organization of the out-patients function, and resource priorities regarding ward and out-patients. In sum, they define the hospital's capacity to deal with the patients. In the main it is the nursing and auxiliary staff who define the number of out-patients which can be dealt with during a week, the number of operations which can be carried out, the number of X-ray patients we can deal with, and how many we can rehabilitate on the ward."

Other informants also confirm the face value of this functional segmentation to hospital operations. Medical doctors supervise the patient treatment regimen and associated resource application. Staff nurses impact the efficiency of logistical resources' application. Ward nurses largely determine facilities' utilization.

While the wards seem to have an established division of labor between the two major health professions, informants relate their cultural differences. The significance of culture is important as this influences the professions' ability to work along side each other. Medical doctors and nurses perceive this cultural distinction differently. A ward manager looks at it this way:

"Doctors have a kind of anarchy culture which comes from our university background. The nursing culture is one from colleges of higher education, i.e. a "flock culture". They are used to following the leader and being part of the flock. Almost like sheep walking over the edge of a cliff. But it is a very good culture. They take care of each other. If you have a conflict amongst doctors, then you have a

conflict amongst people who basically think alike. If you have a conflict between a doctor and a nurse then you have a kind of double conflict; both a personal and a cultural conflict. The nursing culture requires time, process, caring, and emotions in the process of solving conflicts. It is not a question of problem solving. It is a question about relationships.”

Evidence of the medical profession’s hegemonic stature is present in the following statement:

”Most surgeons think that it is great fun to operate. It is kind of like being in heaven. You are doing something practical, something worthwhile. Something exciting. You have everyone waiting on you. If someone comes and says something to you, then you can just snap back at them, and worst case, apologize afterwards.”

A ward supervisor with a nursing background looks at it this way:

”Nurses are looked upon as a painful necessity so that the doctors can carry out their medical treatment. If only one could see the error in this kind of thinking then things would be managed differently.”

In the hospital internal discussion on unitary management, the issue of professional background is paramount as to who is best qualified to lead the clinical ward. The still unresolved issue concerns how and if ward managers should themselves participate in active clinical work. Medical doctor informants all agree that lack of medical training disqualifies from becoming ward managers. At the same time it is important to ensure that ward managers with medical training can uphold their professional knowledge and skills. According to one medical informant this has a dual aspect:

“You ought to uphold your medical qualifications and thus your credibility as a supervisor of clinical activities. To effectively lead you need to know what goes on in practice and to realize the consequences of your actions. To do this you need to uphold your professional identity. To accomplish this, I believe it is important to ensure 10 to 30% clinical activity while working as a ward manager”

With respect to nurses’ ward managerial qualifications, one medical doctor has the following assessment:

“Medical doctors generally represent basically the best recruitment source for ward manager candidates. Better than nurses and any

other candidates from other health professions. Doctors generally represent the best type human resources ("menneskemateriell") for this type of job. I here speak in terms of intellect and not social status".

10.3.2.3.1.3 Subscription to professional field development

A rapid growth of new technologies improves patient treatment through better medicine, more advanced equipment and safer and more accurate procedures. In the thesis analysis one looks at how the ward acts to secure the continual need for staff's competency development. The informants' views are relevant in assessing stakeholder groups' access to and impact on clinical ward's decision-making.

In a report from SINTEF/UNIMED, one concludes that hospital institutions employing the largest amount of medical field specialties see the greatest growth in resources allocation (Hansen 2001). The report also confirms a high frequency of hospital mergers during the 1990s. As the restructuring creates larger hospital units, these hospitals have been granted a larger scope of medical field specialty functions (Hansen 2001). This permits the particular hospital to develop ward units with a greater scope of medical field activities. The development is confirmed at hospital no. 1:

"We have sorted the medical specialties into separate units. In other words, the general medical fields have been subdivided. We have had to reorganize the ward into a general part and one with specialist units whereby the specialists serve the general sections upon demand"

Ward informants welcome this development. It offers the promise of staying professionally abreast. New staff brings in new knowledge, new procedures and better medicine:

"Technology has played a major role in the development of the Norwegian Health Service. New things are introduced centrally and spread as a result of better training and because the technology becomes cheaper."

The rapid dissemination of technology and specialist staff is made possible partly by a rapid internalization of required knowledge and skills. In this process, the role of other constituent agent groups such as the critical suppliers and proxy agent groups play an important role in facilitating technology, supplies and opportunities for knowledge development. Ward informants confirm their direct interaction with critical suppliers of medical

equipment and supplies. Ties to external suppliers appear organized around the clinics' field specialty groups. However, relationships with suppliers are also connected to individual physicians. Ward managers consider this an unacceptable situation, as supplier contact is lost when the ward contact leaves the hospital. Thus, the practice of stakeholder suppliers appears to be partially outside the supervisory control of ward management.

The speed of technology and medical innovation creates a constant pressure to improve skills. Capital investments lag behind assessed needs (Vandeskog 2000). The acquisition backlog represents a serious challenge as technology depreciation and replacement does not keep up with real time development:

*"In terms of depreciation we say that equipment has a 10-year lifespan. From a professional, medical point of view, the average lifespan for our type of equipment is approximately 3 years."*¹⁵³

This is a critical vantage point for ward management in its balancing between the scope of governance resources provided and the needs for continuous upgrade.

Ward management also recognizes the near-term impact of medical research and development on hospital structures.

"You would have to be naive not to realize that what goes on at molecular level today will have consequences for our infrastructure."

The issue of medical research and its significance to hospital operations and strategic choices appears not to be cohesively acted upon at ward management level. A concluding excerpt from a ward informant serves to dramatize this point.

"A medical-professional strategy is basically non-existent"

10.3.2.3.1.4 Patient orientation

In the ongoing national debates on public health, the role of the patient appears paramount. One issue concerns the hospitals' capacity to deliver services on demand. Treatment waiting lists are used to exemplify system incapacities. New service management principles seek to transform the hospital institutions into a client-oriented sector, attentive to patients' expressed needs. A new law specifically designed to empower hospital

¹⁵³ The issue of capital depreciation is discussed by Myklebust and Selvig in a HMT editorial (HMT No. 6/2000, p.p. 36-37).

patients, requires the medical wards to respond in kind to patient expectancies.¹⁵⁴ In the thesis' analysis of ward patient orientation, the focus is on clinic interactions with patient-related issues.

Patient attentiveness involves ethics, empathy and treatment regimen to cure and to ease pain. Here, each profession argues its uniquely qualified position. The following nurse informant argues against the professed exclusive dialectic position between doctor and patient referred to as the clinical dialogue:

"The doctor-patient relationship is critically important but it also has a tactical agenda tied to the profession of the medical doctor. In the real world, professions other than the doctors have the closest dialogue with the patients. The doctor comes in as a consultant. However, only nurses stay with the patient 24 hours a day. No singular health professional group has the right to claim exclusivity in the dialogue with the patient. The Association of Medical Doctors has upgraded its ethical basis bringing in values such as mercy and care. The Medical doctors' association's Ethical Advisory Board has on their part attacked the nursing profession for professing a monopoly on patient care values. This is, however, is part of upholding the medical professions' own hegemonic position in the hospital"

The national employee federation; i.e., Dnlf's involvement in the issue of doctor-patient dialogue, is by the nurse informant considered not credible:

"The Association of Medical Doctors does not raise critical issues regarding the relationship with the patient. The Dnlf is an employee federation. The specialist associations within the Association of Medical Doctors do from time to time raise issues related to professional merits but rarely raise issues regarding the doctor-patient relationship."

Nurse informants stress the nursing profession's commitment to patient values as representing its core professional objective. Also expressed is the

¹⁵⁴ Passed into law July 2nd., 1999; "Lov nr. 63: Lov om pasientrettigheter. Rundskriv I-60/2000" gives: (1) patients legal rights to receive medical attention from the public health delivery system (§2); (2) patient rights to be properly informed about his/her medical condition and to participate and approve of treatment regimen (§ 3); (3) patient rights to consent to any health treatment (§ 4); (4) patient rights to have access to his/her medical journal (§5).

special nature of working in a hospital environment as being different from a profit-making industrial concern:

"Managing a hospital is particularly demanding because we are dealing with human life. When hospitalized, patients are going through a major crisis in their lives, either because they are acutely ill, or because they are in a situation with the onset of an illness that will seriously affect the rest of their lives. It is particularly challenging to work with people in such situations. Thus I believe that hospital work is based on much deeper rooted values that may not be so prominent in other organizations."

The national focus on the need for patient attentiveness has triggered a range of sector governance financed projects and studies¹⁵⁵. The Public health and social services departments have financed a number of hospital internal projects focusing on patient improvement programs. No descriptive analysis of these programs is available. At hospital no. 1, a "Patient 1st" - project attracted national attention to its professed broad engagement in patient related issues. A hospital nurse informant shares her view on the project viability:

"The whole "Patient First" project was based on a "bottom up" principle. However, securing buy-in or ownership of the project, throughout the organization has been a problem. We have had many projects linked to this central project, but ambitions have not been realized and then the whole thing loses focus. We are still struggling with the basic philosophy of the "Patient First" project. One reason could be the fact that there has not been enough focus at management levels. Personally I think that is the major reason. Also the fact that, given the situation, it was not possible to realize some the issues the project group focused on at clinical level, and in some cases at hospital management level."

¹⁵⁵ A special national public sector advisory forum for hospital organizational development ("Forum for organisasjonsutvikling i sykehus") was established following the publication of government white paper NOU 1997:2 "Pasienten først!" ("Patient 1st!"). While the forum is chiefly concerned with organizational structures and management development, patient attentiveness is one of the prioritized focus areas; "Faglige satsingsområder og forumets arbeidsmåter", February 23, 1998; see section 4.2.1 "Pasientmedvirkning og kommunikasjon med pasienter".

The significance of patient proxy groups on patient issue matters, is by one informant expressed this way:

"It is in any case continual food for thought that the attention and priority a patient receives while in the hospital depends upon the power and influence the patient group has. It is all about priorities. About choosing between resources allocated to transplantation surgery versus the chronically ill or the old."

The significance of medical research in the search for discoveries of new medicines is expressed as a problem of priorities. An ethical dimension is introduced with the competing interests in research aimed at alleviating pain and improving patient care.

"Politically, the focus has been on care of cancer patients, while a large proportion of financing has gone to stem cell research. Little has gone to the relief of the suffering. There has also been much national focus on geriatric care but in reality there is still little being done for old aged patients".

Mention is also made of some particularly resourceful patients calling on their personal network to secure favorable treatment. Again the logic of medicine seems to prevail.

"There are a few resourceful people who force their way through. But all this about resourceful patients is a farce because medical priorities form the basis for decisions. It takes a lot to get around this".

10.3.2.3.2 Summary evaluation

Managerial attentiveness:

The analysis confirms a ward environment that affords little support for operations management prescriptions. Comprehensive hospital planning processes are written off as time consuming administrative exercises insignificant to ward interests. The ward shows a marginal engagement in participating in resolving over-all hospital problems and integrated solutions. Hospital cost reimbursement programs are partially based on clinical cost norms. This necessitates the involvement of medical staff in diagnostic (DRG) coding and in cost reimbursement audits. Ward management is critical of having to spend their professional time on securing correct and timely payment for clinical services. Ward informants also relate how the DRG-coding system serves to erode the patient-doctor dialogue and thus act to negatively influence treatment regimen. Increased ward participation in

the financing regimen surrounding clinical activities breaks with the autonomy afforded medical professionals. Vike (Vike et al. 2002) labels conflicts of this nature as the ambivalence of actor agents in the Welfare state. The ward is caught in the conflicting and unsettled situation established between responsibility, resources and recognition common to public health governance. According to Vike, ambivalence is subject-oriented where dilemmas are resolved through the participant's perceptual orientation. While sector governance is vested in the moral precept of public health, it becomes the duty of the clinical arena to bridge system intentions and clinical capability. Case hospital analysis shows how the medical ward acts and reacts to protect ward autonomy to fulfill clinical obligations related to medical professional merits.

The informants' dismay with managerial initiatives stems largely from the two largest case hospitals, namely the university and the county hospital. Both hospitals have recently participated in hospital-wide strategy processes. Smaller scaled planning processes have been conducted at the community hospital. At the university hospital, ward staffs are particularly critical to the hospital's lack of a research and development focus. The county hospital is concerned about a perceived lack of operational focus as reflected in the strategy planning documents.

At the time of the empirical fieldwork, unitary management was legislated with a uniform implementation deadline governing all public hospitals. Its introduction both at the university and community hospital were delayed. Ward representatives still voice their objections. At the county hospital, however, implementation was already introduced in front of the imposed deadline. The Norwegian Parliament first promulgated the governance logic of unitary management in 1996¹⁵⁶. A comprehensive line of arguments in support for unitary management in public hospitals was formally introduced in government white paper NOU 1997:2. New legislation on hospitals was passed into law July 2nd 1999 containing the same line of argument. The law's prescription on organizing clinical activities was in accordance with the principles of unitary management¹⁵⁷. The fact that the logic of unitary management still remains contested reflects the influence of the medical profession. Ward resentment and its capacity to ignore the legal intent of unitary management evidence the incapacity of the case hospitals' operations management. Vrangbæk (Vrangbæk 1999) views clinical autonomy as

¹⁵⁶ Government white paper Ot prp nr 10 (1998 - 99) "Om lov om spesialisthelsetjenesten m m", section 3.9 "Ledelse i sykehus", p.p. 66-70.

¹⁵⁷ Sosial- og helsedepartementet; Rundskriv I-59/2000: "Lov om spesialisthelsetjenesten m. m.", §3-9 "Ledelse i sykehus", p. 30.

representative of a governing rationale of the medical profession. According to Vranbæk, the medical profession works first and foremost to ensure the ward's professional members' clinical competence development. The profession's ethical rationale is based on the objective of securing the best possible medical regimen afforded the individual patient. A breach with the established hierarchical structure and embedded rationale is by the ward managers perceived as a threat to an autonomy required to safeguard its evolvement as practicing medical doctors.

Ward development:

Clinical autonomy is reemphasized in the informants' view on ward development. Jakobsen (Jakobsen 1999) points to the dangers of internalizing economic efficiency measures and rituals suppressing traditional clinical prescriptions. The implicit dangers, as pointed out by Måseide (Måseide 1983), is represented by the critical problem of implementing governance reforms while at the same time permitting the continuance of the established system of social order. The case hospital analysis points to a situation in which governance administrative prescriptions precede the transition of clinical logic. Ward members resent the rigor of administrative management. Administrative system standards do not serve merits tied to clinical rewards. Thus, ward development progresses on its own cognizance.

Hospital informants confirm a ward regimen built on the preference of the medical members. Doctors set the ward's agenda. Doctors and nurses work professionally in unison, but remain disintegrated in their clinical precepts. The nursing staff ensures the workings of the medical wards' structural interaction thus upholding regimen logistics. Herein lies the power to influence system resources allocation and deployment. Nurses secure the procurement of clinical supplies, its acquisition and consumption. Doctors administer structural means and measures. Ward development thus reflects the cultural disparity between doctors and nurses.

Informants relate how differentiated logics uphold cultural barriers to work integration. Informants confirm shared ward functions based chiefly on professional membership and less on individual qualifications. Both the professions of doctors and nurses rely on the ward's formal structural power. Members of the clinical ward are continuously being socialized into the chambers of this cultural subdivision. Employee federations with their in-house full time union representatives, actively work to uphold group objectives and their structural positioning. The medical doctors' culture of autonomy and elitism is expressed in a practice of non-integration. As such, it serves to uphold the medical hegemony opposite other professions and maintaining a distance to other managerial functions.

University hospital informants express the traditional barriers between professions most poignantly. Still structurally entrenched in the traditional pattern are also the ward members at the county hospitals. With the problems associated with unitary management still untested, the community hospital informants are less adamant in their expressions of professional cultural distinctions.

Subscription to professional field development:

A ward manager is in charge of supervising the professional fields of the assigned scope of clinical duties. Herein lies the responsibility to uphold the expected standard of clinical performance. The clinical ward represents the architecture for collaborative medical practice in a professional field that is said to abhor structure. Within the hospital, a ward's organizational structure affects the interconnections between the health professions. Informants confirm the existence of differentiated cultures vested in their structural positions and by the nature of their respective professions. A commonality between health professions is their need to stay abreast in their knowledge and skills development. This also harmonizes with a ward strategy to attract patients and resources.

Contextual analysis and informant feedback both confirm the active development of field specialization. Wards are continuously reorganized to accommodate development of new medical fields. Hospital informants reveal an organizational strategy to accommodate medical fields' structural requirements. Ward members' professional acumen is the best guarantee for rapid internalization of new technology and field specialty requirements. With scarce resources for investments in new technology, access to external suppliers is critical. Suppliers offer a link with empirical fields and professional networks. Recognizing public hospitals' shortage of funds for education and development, suppliers offer applicable training programs. This is a practice benefiting both doctors and nurses. The extent of it has not been measured within the empirical field being analyzed. Hospitals' operations management does not exhibit a practice of interfering in the practice of wards' supplier group associations. Neither do ward managers exercise any supervision of its staff members' industry associations. It is generally accepted that opportunities avail themselves in a way to improve upon their professional development. On a larger scale, suppliers present opportunities for participating in research and development programs. Such programs are attractive both in terms of the resources provided and in the professional merits awarded. As the ward is organized around the knowledge system it employs, the status of its members is reflected in their involvement with professional networks. The extent of the individual's involvement in recognized knowledge networks, the higher the professional status. The

medical suppliers furnish critical resources that the sector governance does not find itself in a position to provide.

The thesis analysis of informant statements projects an image of clinical wards without a cohesive approach to handling industry advances. Pending initiatives are mentioned at the university hospital to learn the scope of industry arrangements between ward member groups and industry suppliers. Hospital internal initiatives are considered that may seize control over unwanted ward practice. However, ward management itself does not speak of such initiatives to bring about formally approved standards for industry relations. There is no common perspective on shared standards determining supplier selection. Neither hospital board directors nor operations managers bring up any concern for an overall strategy for the hospital's medical field development.

Bourdieu (Bourdieu 1984) speaks of how capital resources may take on different forms. As expressed by Vike, (Vike et al. 2002) resources may be converted for political purposes. This presupposes, however, that monetary funds may be transformed into cultural capital. According to Vike this may be expressed through symbolic representations. In the case of the public hospital, it may serve to facilitate access to the ward's clinical members. In terms of the position of stakeholder groups, industry suppliers wield important influence as the resources presented may be converted to satisfy professional field merits. One may in other words say that industry – ward cooperation represents an exchange network between structural systems. The medium of exchange may be understood in terms of how the nature of value creation may be converted into a differentiated value circulation. In the case of public hospitals, the clinical ward members themselves determined the rate of exchange.

The practice of industry cooperation is seeing its widest practice at the university hospital. These program initiatives stem from ambitious ward members who are motivated by the hospital's academic standing. The practice of industry association is considerably scaled down at the county hospital. This is caused by the hospital's pronounced strategy of non-academic medicine. The issue of supplier association is also present at the community hospital. Here industry cooperation is not presented as a problematic issue. Informant feedback does not confirm a broad scaled practice of industry cooperation. Supplier presence is confirmed, as are the miscellaneous benefits of training and development programs offered clinical ward members.

Patient orientation:

Vike (Vike et al. 2002 p. 209) makes reference to the phrase “welfare positivism” (velferdspositivisme) in explaining the near universal belief that the welfare state’s problem can be solved. While resolutions may vary, problems are believed to stem from a combination of resource shortages and inefficient operations. The common societal expectations remain firm. All citizens have the rights to receive public hospital services irrespective of income, position, age, gender, and location. This universalism in welfare ambition creates a special set of premises for the public hospital. According to Vike, the public sector works on the premises of a continual crisis of resource shortages, growth in welfare services demands and a universal trust in public sector’s capacity to reconcile conflicting interests.

This institutionalized welfare positivism has perhaps been transformed into the national call for an improved patient orientation. Government white paper NOU 1997:2 prescribes a broad set of normative values on patient values considered relevant to the public hospital.¹⁵⁸ The general sentiment is that of reclassifying the receiver of hospital services from having been a patient to becoming a valued client. Parallel legal prescriptions introduced to empower patients, reinforce the need to recognize patients’ rights. The underlying premises of “Patient first” prescriptive codes have been the presumption that a patient lacks the resources necessary to establish a balance in actor-agent relations.

The “Patient 1st.” program, as cited by the university hospital informants, represents a hospital internal project aimed at improving hospital attentiveness to patient rights. Informant perception relates an impression of a project that failed to realize its intended objective. A contributing reason is reported to be a missing ward-management commitment. The project-organizing model did not properly connect with the formal alignment of ward responsibilities. Such informant contentions challenge the popularized norm of patient care as presented in the health professions code of ethics. The two health professions analyzed both make claim to patient-dialogue exclusivity. The professions argue on the merits of patient attentiveness applying the sector’s own prescriptive logic.

Case hospital nurses caution against the power of special patient proxy agents, as they disfavor non-aligned patients. Medical doctors hail the cooperation with proxy agent organizations as they bring in valuable resources to medical field programs. Certain diagnosed ailment groups

¹⁵⁸ NOU 1997:2 identifies ten (10) items that should represent core focus areas for patient satisfaction; these are (1) Services accessibility, (2) Patient attentiveness, (3) Professional knowledge, (4) Field professionalism, (5) Accountability, (6) Punctuality, (7) Openness, (8) Holistic approach, (9) Courteousness, (10) Mutual respect.

attract resources provided that the field medical regimen is aligned with supplier interests. Case hospital nurses are concerned about the direction of medical research as supplier resources favor new medical development in place of a focus on patient relief.

The prevailing ward policy favoring industry cooperation is prevalent at the university hospital. Both operations management and ward informants at the county and community hospital promote patient orientation outside of a strong industry attachment.

A rather social patient codex as outlined in government white paper NOU 1997:2 is not expressed by hospital informants. Rather, the myth of the resourceful patient is strongly contested by some informants. Medical logic and university medicine prevails. Nurses promote non-secularized nursing as the only genuine patient care philosophy¹⁵⁹. Ward management confirms a non-aligned patient care philosophy between the health professions of doctors and nurses.

10.4 Informant interviews: An analysis of actor agent perception

10.4.1 Interpretative framework

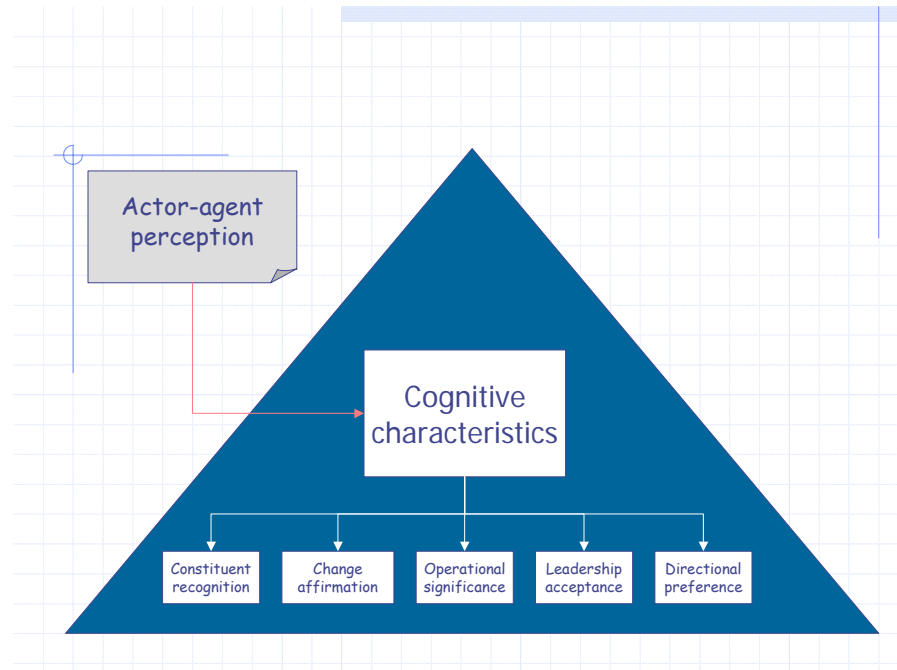
In line with the analytical focus, interview data is presented in this segment of the analysis to provide a comprehension of the nature and dynamics of stakeholder perception. As outlined in table no. 20, “Differentiated analytical framework”, the informant interviews are to facilitate an insight into the actor-agents’ perceptual traits. Such traits are considered determinants of organizational decision-making. Interview data has firstly served to describe the processes surrounding the hospital’s formal decision-making at key organizational levels. Informant feedback furnishes information of a perceptual nature. These perceptual records are next to facilitate the analysis of the informants’ cognitive properties. Based on aggregate informant perceptions, stakeholder groups’ cognitive characteristics are identified. The ultimate research objective is to develop an instrumental basis for how stakeholder group cognition influences organizational decision-making.

In meeting the challenge of informant bias, as described in section 8.3.1 “Informant approach”, the survey respondents selected are representative of specific hospital-internal organizational decision-making levels; i.e., administrative management, medical ward and clinical operations. Informants have been identified who are considered competent to report on dyadic relationships in an organization (Kumar, Stern, and Anderson 1993)

¹⁵⁹ The establishment of the Norwegian nurses association (NDF) in 1912 formally introduced the nursing profession disassociated from practitioners’ religious beliefs.

¹⁶⁰. This also subscribes to the methodological contention of Seidler. Seidler (Seidler 1974) relates the trends in sociological research where one relies on a small number of knowledgeable participants with the capacity to observe and express constituent relationships. Selecting representatives who are key decision-makers and members of the two traditionally strongest health professional groups, follows the previously outlined research rationale on informant methodology¹⁶¹. Accordingly, this consensual approach has been used where cognitive characteristics of multiple informants are mapped relative to their shared stakeholder position. The analytical constructs applied in the analysis of stakeholders' cognitive characteristics, are shown in the following illustration.

Illustration No. 15: Interpretative framework: Actor agent perception



¹⁶⁰ The modern day sociologists Antony Giddens and Pierre Bourdieu both support a methodological contention of the research object as being reflexive and knowledgeable in nature. We all have the capacity to understand what we are doing, to observe what is taking place around us and have the capacity to reflect on our own situation (Jerdal 1998).

¹⁶¹ Pls. view thesis table no. 5 “Informant selection methodology”.

The conceptual foundation of the informant interviews rests on the research model's theoretical prescriptions¹⁶². The intent is to identify the respondents' cognitive characteristics relative to issue matters that reflect decision-making properties. The research strategy partly draws its support from Cyert and March (Cyert and March 1992) in their analysis of organizational goals. Accordingly, the point of entry is the construct variables that affect organizational decision-making. These are reflected in the conceptual categories and their properties selected and shown in the next table. These are to serve as perceptive determinants of the informants' cognitive characteristics.

Table No. 28: Conceptual analysis: stakeholder cognition

Conceptual focus	Conceptual categories	Conceptual category properties
Cognitive characteristics	Constituent recognition	The informants' recognition of constituent interest groups significant to hospital operations
	Change Affirmation	The informants' recognition of sector changes and implicit consequences to hospital operations
	Operational Significance	The informants' acknowledgement of operational performances and factors attributable to hospital output
	Leadership acceptance	The informants' acceptance of the relevancy of leadership in hospital operations
	Directional preference	The informants' preferred hospital decision-making process to successfully meet strategic and operational challenges

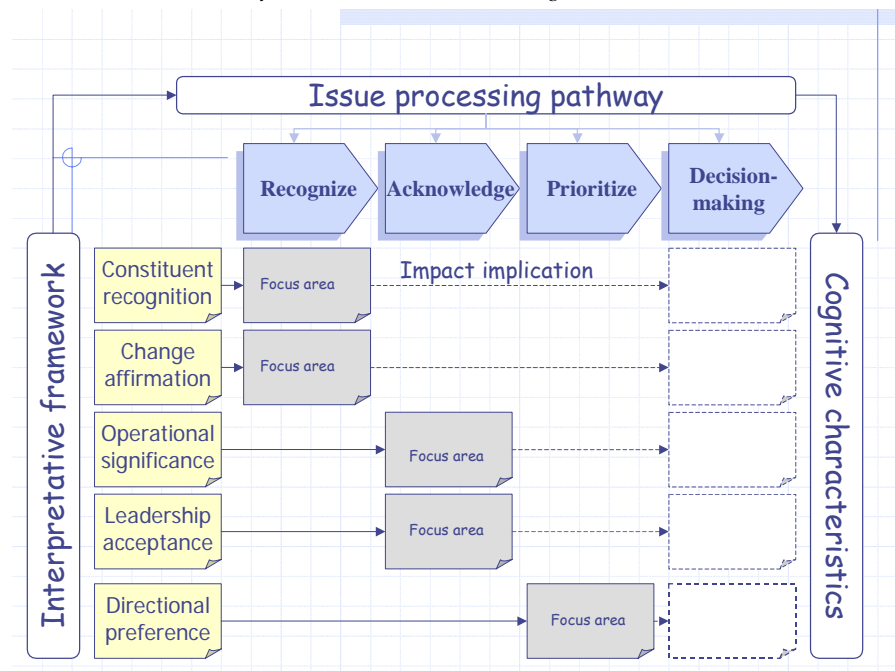
¹⁶² See thesis section 7.2.3 "Thesis research model: Informant interviews" and illustration no. 5.

10.4.2 Analysis and findings

10.4.2.1 Analytical approach

The next illustration represents the analytical model for identifying informant cognition. The model's designated *interpretative framework* is made up of the five conceptual categories inherent in the design school strategizing model¹⁶³. Aggregate perceptual traits recorded in response to decision-making issue matters are considered to be representative of stakeholders' *cognitive characteristics*. The model's *issue-processing pathway* follows the logic of the cognitive pathways as shown in Illustration no. 4: "Processing pathway" around which informant questions are formed (see Illustration no. 12: "Informant interview structure").

Illustration No. 16: Analytical model: Stakeholder cognition



According to Schwartz (Schwartz and Strack 1985), there is a wide agreement on the cognitive processes involved when respondents seek to answer questions optimally. Krosnick (Krosnick and Fabrigar 1998) makes

¹⁶³ See illustration no. 5: "Thesis research model".

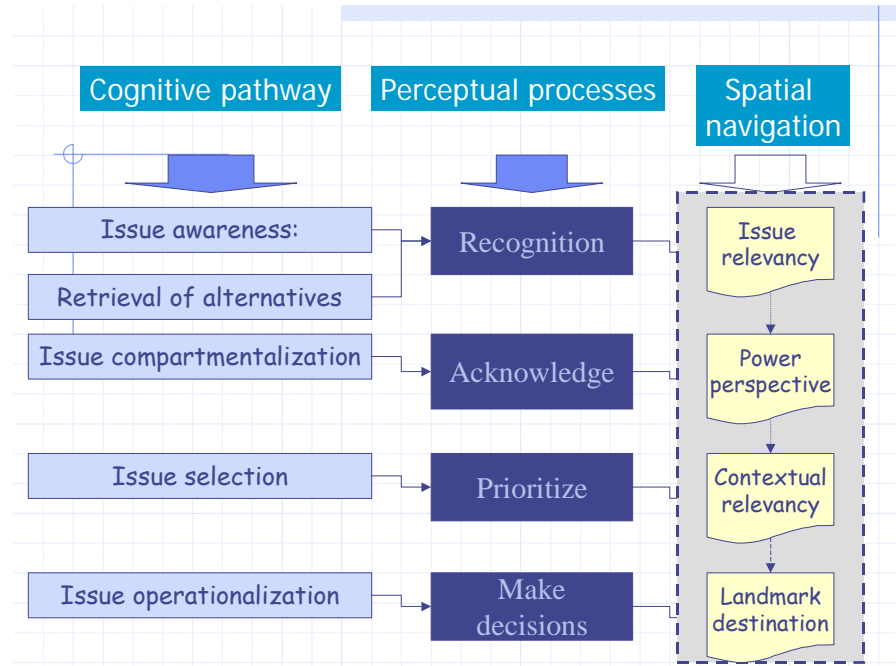
reference to the great amount of cognitive work required to generate an optimal answer to even a single question. Cumulative work required to answer a long series of questions on a wide range of issue matters, represents a substantial effort on behalf of the informant.

According to Golledge (Golledge 1999), “the information processing approach of cognitive psychology is an effort to understand human performance as the consequences of mental operations (cognitive processes) executed on incoming information acquired from perception on stored information (representations)”. Informants’ responses thus involve several stages of information processing. In the interview, these various stages are all established in the interview setting. The selected conceptual categories and their properties are taking the informant through: (1) a *recognition* stage through which the relevancy of issue matter is noted; (2) an *acknowledge* level where the informant analyzes the contextual situation involving the presence of other stakeholder interests; (3) a stage of assessing issue matter *priorities* based on their perceived contextual relevancy; and (4) an ultimate *decision-making* point of departure based on the informant’s “landmark destination”¹⁶⁴. This latter term is applied by Golledge when pointing to an informant’s need to employ a strategic or holistic focus to assist spatial decision-making. The call for an informant’s ultimate decision-making position implying a *directional preference*, may be said to cause “landmark cognition significance”(Golledge 1999). In other words, contextual issues take on salience through the vested nature of stakeholder group interest.

The next illustration traces the informant’s spatial navigation relative to the parallel stages of the informant’s perceptual processes within the framework of cognition.

¹⁶⁴ This concept is introduced in the theses in section 7.2.2 “The logic of spatial decision-making”.

Illustration No. 17: Stages of spatial navigation

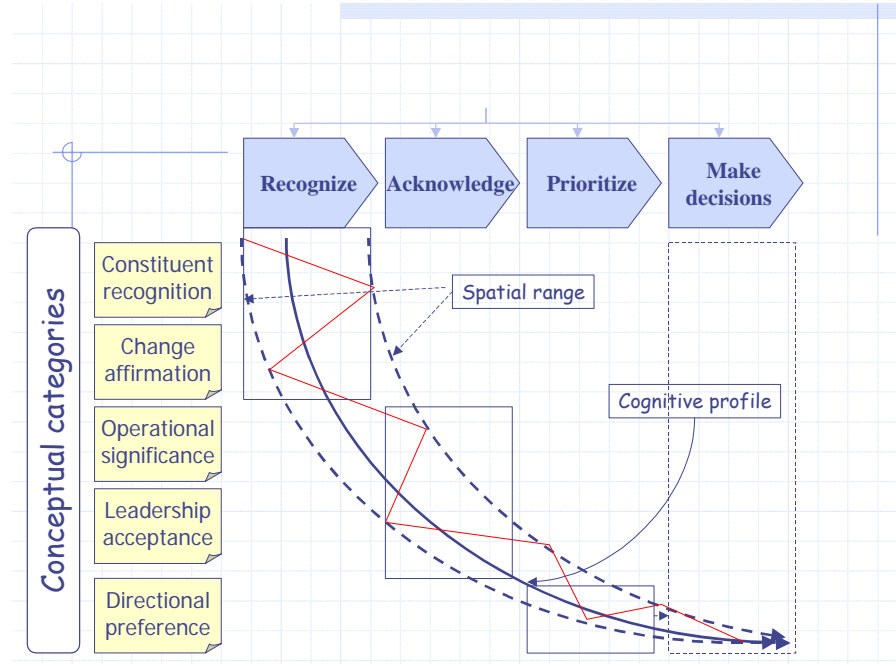


Informant data gathered in the interviews does not provide for a descriptive basis that permits the construction of a cognitive map with any exact geometric properties. Recording the informants' *perceptual processes* facilitates, however, a conceptualization of the cognitive processes. According to Eden, cognitive mapping serves as a proxy of "unseen target phenomena" (Eden and Spender 1998). The interview structure follows the informant's *cognitive pathway*¹⁶⁵. The illustration's *spatial navigation* processes illuminate the stages along which cognition serves its role as a perceptual screening device.

The informant's spatial navigation may be illustrated as follows:

¹⁶⁵ For a review of the theories of cognitive mapping, pls., view thesis section 4.5.3 "Cognitive mapping and decision-making".

Illustration No. 18: Spatial navigation



The thin (red) line symbolizes and traces the informant’s perceptual process in response to informant interview questions. The process is taking place within a spatial range representing the subject’s cognitive boundaries. The solid (blue) line represents the informant’s cognitive profile. The model is purely conceptual, as informant feedback does not permit precise perceptual measures. According to Anderson, cognitive psychology hypothesizes two modes of cognitive processing. “One is automatic, invoked directly by stimulus input. The second requires conscious control, has severe capacity limitation, is possibly serial, and is invoked in response to internal goals” (Anderson 1983 p. 126). Relying on informant feedback linked to a loosely traced cognitive structure is therefore at best an exploratory technique to better explain stakeholder group behavior. Lindsay (Lindsay and Norman 1977) makes a distinction between data-driven and conceptually driven processes. In the case of the informant interviews, responses called for are conceptual in nature, invoking responses that “start at the bottom of the cognitive system” (Anderson 1983).

Stakeholder groups have become institutionalized through their common interests and community action. The research model’s conceptual structure facilitates a type of *community response* analysis on behalf of the informant

groups. According to Ouchi, “the mechanism that transforms narrow self-interests into a balanced state of cooperation among independent individuals is the network of like-minded individuals kept together by common vested interests” (Ouchi 1984 p. 204). Studies of cognitive consensus inquire into the degree to which cultural orientation of groups are congruent (Etzioni 1971). According to Etzioni, organizations differ in the degree of consensus they require in various *consensus-spheres*. “Cognitive consensus encompasses concurrence about shared references and an agreed-upon set of canons for empirical perceptions” (Etzioni 1971 p. 232). Informant feedback is thus expected to render empirical evidence representative of stakeholder group’s cognitive coherence.

The thesis research has assembled a categorization of stakeholder group perception as shown in table nos. 29 through 31. Perceptual traits have been aggregated and grouped into the selected conceptual categories employed in the interpretative framework. As such the table columns and rows are representative of the selected stakeholder groups’ *cognitive consensus* within the conceptual categories analyzed. A subsequent table, no. 32 is a compartmentalization of stakeholder group cognition applicable to each case hospital.

The analysis shows a cognitive profile or consensus, unique to each stakeholder group. Stakeholder responses on issue matters within each selected conceptual category, show the perceptual mobilization along a narrow spatial range. Informant responses on management, medical doctors and nurses all appear grounded in “a logic of appropriateness” (Roberts and Greenwood 1997); that is, a rationale that is to be expected by their particular group.

10.4.2.2 Stakeholder cognition

10.4.2.2.1 Characteristics of management cognition

Management appears cognitively constrained in their perceptual views on all conceptual categories invited. The prevalence of the theorems of New Public Management (NPM) permeates all issue perception. Constituent recognition is framed to fit NPM prescriptions as augmented by the hospital’s executive governance. Stakeholder affirmation of sector changes is narrowed down to their interpretation of reform signals that are verifiable through governance white papers, decrees and prescriptions. Issues of operational significance are perceived of in terms of their relevance to resource efficiency and improved production output. Planning ranges are viewed strictly in a budgetary context void of value creation considerations within a strategic framework. Thus, issues on medical services, research and

associated investments in competence development are awarded little perceptual merit. Issues on hospital leadership reaffirm management's call for resource administration and targeted supervision. The major obstacle to succeed in achieving economically sound operations outcome is believed to be the medical staff's lack of adequate cost management focus. Thus, the directional preference of hospital management is a course chartered through the hospital reform favoring a full range of NPM practices. Management cognition appears to work effectively as a rationalizing force thus representing the stakeholder group's cognitive consensus. By grafting cognitive constraints into organizational goals and decision-making, management appears biased in favor of efficiency frameworks. Management's cognitive characteristics as identified along the research model's perceptual processing pathway, demonstrate how *non-choice behavior* (Roberts and Greenwood 1997) persists through actions of convention, convenience and governance obligation. The analysis thus depicts a taken-for-granted nature of cognition replacing a broader perceptual nature that may have invited rational choice processes.

Management group cognition between case hospitals shows distinguishing characteristics. Both hospitals nos. 2 and 3, display firm commitment to cost austerity, resources efficiency and a production oriented logic. Hospital no. 1 is fixed on the potential gains of its university status. Governance is perceived of as an obstacle to accredited academic function. Strained relationships marked the management's perception of administrative prescription to curb costs and to meet budgetary requirements. Community hospital management perceives its mandate to manage within resources allocated. All other activities are mobilized to serve this end. Governance liaison is viewed as critical to good reporting relationships. Management perceives county reporting lines as critical. The management team members' cognitive sphere appears congruent on governance prescriptions. A management development program serves to internalize management values and a shared logic on hospital administration.

Much of the same precepts of the community hospital are noted among management at the county hospital, although the management team appears less congruent in their cognitive characteristics. The management team of ward directors has newly replaced a previous administrative leadership. Members are cautious towards managing director's grand enthusiasm for the new formal hospital structure (Fylkeskommunalt foretak) removing the country from its line of reporting matrix. Medical ward leaders are uncertain as to how ward issue matters ought to be brought to the attention of hospital management. Management at the county hospital appears to be in a transition stage without uniform cognitive characteristics.

Management decision-making behavior partly attains its legitimacy through a cognitive isomorphism between its members (Fligstein 1991). In Scott's view (Scott et al. 1998), the cognitive characteristics in organizations are grafted through organizational *structuration*. As developed by Giddens, (Giddens 1979) the concept of structuration involves the patterning of activities that constrain and shape action over time. Brint (Brint and Karabel 1991) employs structuration when referring to the extent to which the behavior of organizational constituents patterns shared information.

10.4.2.2 Characteristics of medical staff cognition

From the informant interviews, a cognitive congruence also appears among the medical staff but is vested more in a sociopolitical legitimacy rather than in an institutionalized consensus. Management group action achieves its rewards and legitimacy through utilizing acceptable structures and their associated governance prescription (Pouder 1996). The explanation for organizational isomorphism shared between medical staff is less vested in the logic of structuration. According to Roberts (Roberts and Greenwood 1997); constituent action is grounded in a social context that specifies its reasonableness in terms of social rules and guidelines for behavior.

As is evident from table no. 30, the cognitive consensus perspective of the medical doctors appears congruent on all conceptual accounts analyzed. Medical field issues are shown to take on precedence opposite all other decision-making matters. The concerns of other constituents are considered subservient to those related directly to medical practice. This position governs both the profession's relationship with managerial representatives and its orientation towards representatives of other health staff. While administrative prescriptions are recognized and validated, doctors' involvement in management processes precludes any close integration with the ward and issues of clinical concern.

Their affirmation of sector change processes is equally channeled outside ward venues. The effect perceived relevant to their clinical autonomy is considered marginal. Structural and organizational changes are not believed to change appreciably their formal and informal influence within their wards. The clinical infrastructure is believed to remain intact. This belief in the survival of the clinic and its embedded autonomy, fits Brint's (Brint and Karabel 1991) contention that organizational accomplishment may be less dependent on performance than on the reassuring sense of order it conveys. The medical staff's disinterest in participating in administrative planning processes, thus effectively precludes any efficient organizational diffusion processes of management action. Roberts (Roberts and Greenwood 1997) speaks of reduced operational efficiency caused by diverse and powerful organizational environments exposing "a pre-conscious" constraint. Thus, the field of medical staff in the hospital acts on their cognitive limitations, or

bounded rationality vested in their perception of operational issues. The choice of the medical staff are structured by the socially mediated values and normative frameworks of their constituent group.

Hospital leadership acceptance is low as the administrative leadership is judged as excessively bureaucratized and carrying little significance to ward operations.¹⁶⁶ None of this is surprising when related to a more or less conventional sociology of the medical profession. Evident in the final analysis of directional preference, professional autonomy appears as an organizational imperative of the public hospital. Medical staff's exclusivity is a source of inertia and a summons to justify stakeholder group behavior or practices. According to Selznick, this justification "encourages institutional mimicry or mimesis, which means that the organization is highly sensitive to the cultural environment within which it lives" (Selznick 1996).

The community of medical doctors in the public hospital may be said to represent a consensus sphere kept together by common cultural orientations. Such perceptual commonality is vested in the congruent orientation on their profession. In Etzioni's (Etzioni 1971) analysis of complex organizations, the importance of shared values concerning the rights to exercise power, are stressed. Cultural consensus particularly attached to status groups is critical in forming normative values and determining social integration. Cognition plays an important role in shaping the complexity of organizations. In Selznick's view, cognitive boundaries reinforce group structures that circumvent functional task and employment status. Greenwood (Greenwood and Hinings 1996) stresses the organizational importance of powerful groups such as medical doctors in the public hospitals. The extent to which medical doctors in the hospital access and control key decision-making, is a result of the impregnable exclusivity supported by their group cognition.

Medical staff group cognition shows distinctively different patterns between hospitals. At hospital no. 1, medical staff is uniform in their recognition of the importance of safeguarding their academic obligations. This perception is in contrast particularly to the community hospital. Management at the community hospital has succeeded in establishing acceptance for managerial norms on cost efficiency and effective production. This is contrasted by the medical staff's perception of their own management as spending too much time on management processes serving little or no purpose for their ward objectives. While management and the executive board at the community

¹⁶⁶ Reidun Førde associated with The Norwegian Medical Association's "Senter for medisinsk etikk" at the University of Oslo, argues in favor of professional autonomy in an article appearing in the recently published series on democracy and power, mentioning particularly the burden of excessive bureaucracy ("I dag blir medisinsk praksis i aukande grad overstyr av byråkratiet" (Førde 2003).

hospital claim success with comprehensive business oriented planning processes, the medical staff considers this a wasteful exercise. The county hospital appears to be the only institution in which management has managed to establish a uniform acceptance for NPM-inspired management principles. Here, its managing director and his management team are perceived to be effective in working with governance representatives and in promoting hospital interests. This latter issue perception highlights Bourdieu's emphasis of the significance of communication as a means to power and influence (Engelstad 2003). Engelstad points to the fact that influence is based on power exercised at executive levels, through organizational groups, institutions and through the aggregate of stakeholder interests. Medical staff's perception of management's capacity to effectively mobilize these communication levels reaffirms management credibility. Selznick emphasizes the significance of the organization's interaction with its environment. From this perspective, it seems clear that power may be defined in terms of the capacity to promulgate stakeholder interests (Brint and Karabel 1991). The fact that the very same managing director also is a medical doctor provides perhaps added credence to management's position. Support for this contention may be drawn from Durkheim (Durkheim 1950) who is placing emphasis on the genesis of the institution and the staff's association with core value chain developments. Studies of group consensus support the proposition that congruent cognitive orientation of various individuals and groups stem from common professional affiliations (Etzioni 1971).

10.4.2.2.3 Cognition of nurses

According to Vike (Vike et al. 2002), there is a commonality amongst modern private firms in their clear separation of what is internal and what is to be regarded as external to the organization. The latter receives the services of the former governed by a limited supply of goods in a dynamic interplay between supply and demand. Within the modern welfare services organization this demarcation of internal and external constituents is not that clearly evident. External agents of the public hospital are equally present internally as the internal production is governed by external public prescriptions of universal coverage, irrespective of patients' capacity to pay. One may therefore speak of the public hospital as being without boundary limitations in services scope and access. Political ownership internalizes its governance through administrative prescriptions. Ward medical staff promotes the advances of medical science with the promise to upgrade diagnostic means and to expand cure regimen. At the public hospital's operational level, one faces the diversities and paradoxes between public ambitions and the institution's capacity to perform. Vike here brings in the argument that the hospital internal stakeholders do not possess the capacity

to comprehend the broad and embedded nature of the public hospital's services system. According to Vike (Vike et al. 2002), power or influence in the welfare state is a question resolved by decentralizing or internalizing the dilemmas of political ambition. Internalization of hospital objectives takes place through complex institutionalized processes filtered through the perceptual fields of key stakeholder groups.

The unbroken philosophy of trust between medicine and politics that marked the development of our modern welfare state is today contrasted by an incapacity to govern. Complex budgetary techniques and production incentive systems do not facilitate 1st line hospital actors in their day-to-day routines. Nor is hospital management an integrated leadership function that serves operational processes. The impact of unresolved decentralized problems is most clearly dramatized opposite hospital nurses. Nurses supervise the logistics of patient regimen services. Their operational autonomy testifies to yet another supervisory sedimentation de-coupled from ward and administrative management. Contrasting other stakeholder group cognition, nurse informants uniformly express patient interests as paramount to all hospital operations. Elements of an institutional competitive position are noted particularly opposite the medical doctors. Nurses perceive the doctors' acclaimed hegemonic position related to patients' care regimen as unjustified. The so-called *clinical dialogue* or communication with the patient is claimed to be equally a dialogue entertained by the nurses. Concern is also voiced by the nurses on the continual trend towards specialized medical development. Here, nurses perceive a subsequent need to upgrade their own qualifications to broadened the hospital's patient care regimen.

Hospital NPM-inspired change processes are welcomed, as they are perceived to ultimately alleviate problems caused by resources shortages. Equally well perceived is the legislation on patient empowerment as this is viewed congruent with their professional code of ethics. Nurses are eager to participate in management's planning and control schemes, as these are believed to bring broader attention to the challenges of clinical supervision. The new organizational models emphasizing a participative leadership style, is in line with the nurses' support for process-based work organization and supervision. New legislation introduced that empowers health professionals other than medical doctors is perceived of as improving the position and esteem of hospital nurses.

The profession of nursing is a generalist occupation. While the hospital institution is marked by increased specialization, the nurses' professional identity centers on a broadening range of patient services functions (Vike et al. 2002). This seemingly institutional paradox becomes evident when

analyzing the cognitive characteristics of stakeholder groups between hospitals. Generally, nurses display a uniform cognition profile between hospitals. Patient values are expressed as paramount. Prioritizing a participative leadership style is perceived as benefiting problem identification and improving chances for finding better solutions. Nurses are focused on getting-the-job done; that is, resolving logistical challenges of patient flow across department and wards.

Cognitive characteristics distinguishing nurses between case hospitals are particularly evident between hospital no. 1, the university hospital and the other two hospitals. At the university hospital, nurses express a stronger opposition towards what they perceive as the medical doctors' profiled professional dominance. Nurses project a need for a stronger independent professional identity opposite the medical profession. Some of the values upheld by the nurses at the university hospital, are identical to those promulgated by the medical doctors. An academic perception of nursing is more prevalent at the university hospital than what is expressed by informants at the other two case hospitals. What Pettigrew (Pettigrew 1987) confirms as "dominating beliefs or ideologies" for the medical profession within the hospital, serve as ideational templates also for the nursing profession. Supporting this is DiMaggio's (DiMaggio and Powel 1991) analysis of the need for professions to conform to professionals' constituent expectations. The latter is viewed as paramount to gain legitimacy and to increase their probability of survival as an acclaimed stakeholder group. Templates of isomorphism between medical professions particularly within an academic hospital institution, appears to induce nurses to adopt similar values. This contention is supported by Greenwood in his configurational research. Greenwood (Greenwood and Hinings 1996) suggests that organizational structures and systems provide the underpinnings of ideas and values that serve as interpretative schemes throughout an organization. As nurses and medical doctors work closely within the same structures and organizational schemes, professional mimesis may, however, be considered a response to uncertainty on behalf of the nurses (Selznick 1996).

The presence and influence of the academic institution is not present among the informant nurses at the community and county hospitals. The institutionalized values of the acclaimed "non academic" hospital¹⁶⁷ appear to dominate informant cognition. Management of both hospitals promulgates the importance of resolving problems of resource allocation and administration. This priority meets with the approval of nurse constituents,

¹⁶⁷ See particularly quotes from the informant interview with case hospital managing directors; Thesis section 10.3.2.2 "At operations management level"; view in particular sub-section 10.3.2.2.1.2 "Institutional perspective".

as resources deployment is interpreted to support autonomy in their patient oriented work. According to Vike (Vike et al. 2002), the nurses' perception of their own capacity to work with and resolve challenges, serves to establish a professional identity different from the complexities exposed in higher organizational echelons of the hospital. The cognition of nurses, as a stakeholder group thus seems less constrained by structures, as does hospital and ward management. Nurses also appear less influenced by the presence and conformity pressures of the sociopolitical aspects found valid for the medical doctors. The ideology of nursing appears cognitively on firm ground vested in the ethical philosophies of patient care inherent in the emotional and practical character of patient-nurse relationship¹⁶⁸.

¹⁶⁸ In Vike's (Vike et al. 2002) analysis of power and influence in the welfare state, he discusses particularly recent changes in phenomenology within the profession of nursing; see particularly "Den fenomenologiske vendingen i sjukepleiefaget", p.p. 165-168.

Table No. 29: Stakeholder groups' Cognitive characteristics: Management

Stakeholder groups	Constituent recognition	Change affirmation	Operational significance	Leadership acceptance	Directional preference
Management	<p>Attention particularly addressed to executive and governance stakeholders.</p> <p>Management resources spent largely on aligning itself with constituents representing administrative prescriptions, policies and audit operations.</p> <p>Marginal recognition of external stakeholder groups working directly with hospital internal operations.</p>	<p>Positive perception of New Public Management reforms (NPM). NPM viewed as reinforcing administrative governance.</p> <p>New structural and organizational prescriptions welcomed, as they are perceived to be strengthening medical staff's managerial logic.</p> <p>Patient rights reforms equally welcomed, as new prescriptions are expected to enhance hospital service.</p>	<p>A strong perceptual trait in management's focus on resources planning and follow-up.</p> <p>Administrative prescriptions consume the major focus as hospital operations are interpreted in a resource management context.</p> <p>Long-term planning prescriptions and supportive rationale are absent in management operations and resources administration viewed in a value creation perspective.</p>	<p>Strong belief in the relevancy of structuralized governance. Hospital leadership is perceived connected to the logic of NPM. The hallmark of an outstanding hospital leader is one who masters "the art of" balanced budgets.</p> <p>Instrumental leadership action is tied to measures that ensure subscription to ISF/DRG.</p> <p>Leadership potential is perceived realized only when medical staff accepts the logic of NPM.</p>	<p>Management's rationale for hospital development is vested in the logic of NPM. Measures favoring resources efficiency and productivity, receive chief attention.</p> <p>Management concern for medical services addresses instrumental ramifications tied to cost allocation and consumption.</p> <p>Public health services' structural reforms are welcomed in as much as they create improved governance along with expanded operational autonomy.</p>

Table No. 30: Stakeholder groups' Cognitive characteristics: Medical doctors

Stakeholder groups	Constituent recognition	Change affirmation	Operational significance	Leadership acceptance	Directional preference
Medical doctors	<p>A compartmentalized perception of other hospital stakeholder groups. Medical doctors, as a professional group are considered paramount among all competing constituencies.</p> <p>Medical field issues take precedence to any other stakeholder claim.</p>	<p>NPM reform generally disregarded as just another wave of administrative governance. "The clinic prevails" as the doctors' judgment calls are perceived representative of the hospital's true operational authority.</p> <p>The medical professional's established working pattern of relationships to patients, staff and other external stakeholder groups are expected to remain relatively unchanged irrespective of external events and internal change processes.</p>	<p>Medical staff disinterest in management planning prescriptions as content is considered insignificant to their own interests.</p> <p>Value of participation in strategy processes is perceived a waste, as one does not recognize benefit to clinical operations.</p> <p>Budgetary developments afforded relatively marginal attention as internal deficiencies are believed partly made up for through benefits gained through associations with external networks.</p>	<p>Hospital management leadership is perceived separated from the logic and relevancy of clinical supervision.</p> <p>Ward autonomy is considered paramount to good functioning hospitals.</p> <p>Ward leadership may only be executed by medically trained staff.</p> <p>Professional autonomy for nurses and other health personnel is perceived to be endangering clinical operations.</p>	<p>Expressed concern for what is perceived to be a low level of medical research. Hospital management is perceived to be instrumental in securing governance acceptance for funded programs over and above operations budgets.</p> <p>Ward autonomy is considered critical to the future of medical performance; diagnostics, treatment and cure.</p> <p>Reform measures empowering patients and other health staffs are considered political reforms without significance to health services.</p>

Table No. 31: Stakeholder groups' Cognitive characteristics: nurses

Stakeholder groups	Constituent recognition	Change affirmation	Operational significance	Leadership acceptance	Directional preference
Nurses	<p>Rationalizing all stakeholder claims relative to patient centered activities.</p> <p>Patient care interests expressed as paramount to all competing issues in the hospital.</p> <p>Argues on nurses acclaimed position on the supervision of the "clinical dialogue".</p> <p>Argues on the need for a strengthened autonomy for nursing operations.</p>	<p>NPM's organizational-reform measures welcomed as changes are expected to positively influence patient rights, and thus enhancing the significance of the nursing profession.</p> <p>Affirmative position expressed on nurses' goal to acclaim new management postings in hospitals.</p> <p>Concern expressed over lack of medical research and the nursing profession's low participation in R&D projects</p>	<p>A generally positive attitude towards management planning processes, as nurses share in management's perception of resource shortages to be a major problem to hospital operations.</p> <p>Affirmative views on need to improve patient logistics and care regimen.</p>	<p>Administrative leadership is accepted as nurses are invited to participate in processes impacting their own operations.</p> <p>Nurses are in strong support of participative leadership. Such leadership styles more important than the leader's professional (medical) qualifications.</p> <p>Empowering nurses and other health service staff is perceived important, as this is considered critical to improved patient care.</p>	<p>Empowering more health professions than merely medical doctors are perceived important for the future of patient health treatment and care.</p> <p>Hospital reorganizations and new management philosophies are believed important to create a holistic form of ward leadership and patient regimen.</p> <p>Patient 1st philosophies are perceived of as instrumental to improved public health programs and hence better hospitals.</p>

Table No. 32: Between case hospital analysis

Stakeholder groups	Case hospital no. 1 University hospital	Case hospital no. 2 Local hospital	Case hospital no. 3 County hospital
Management	<p>Focus on hospital's university status as strategy to secure new and expanded resources. Governance emphasis on NPM priorities viewed as threat to strategies supporting medical services development. Frustration with complex governance structure and its complex reporting routines. Management team perceived to be spending excessive leadership resources on cost cutting programs due to growing operational deficit.</p>	<p>Aggressively pursuing NPM-reforms as means to reduce waiting lists and improve production performance. Successful at balancing governance agencies and executive administrative institutions. Pleased with own efforts to promulgate cost austerity programs in the wards. Involves both administrative and ward management in decision-making processes. Prioritizes management development programs for top management team members.</p>	<p>Actively reaffirming vision of a non-academic, production oriented institution "where the patient ranks first!" Reaffirming the hospital's interest in remaining in close contact with community health and social services; the latter considered the "recruiting ground" for new patients. Compatible with new board's priority focus on cost austerity and production management logic. Involving large number of ward staff in developing new hospital "patient oriented" strategies.</p>
Medical doctors	<p>Ward leaders in opposition to hospital management in general, as too little emphasis is believed placed on securing and safeguarding university obligations. Ward staff dismayed with hospital management as too little influence is being spent working to influence executive board and city health administration. Ward is opposed to being involved in too much administrative planning processes believed to have little relevance to clinical operations.</p>	<p>A present situation of management credibility stems from ward's perception of its administrative leadership as commanding good relations with governance agencies. General consensus on hospital management's resources administration focus. Hospital planning processes generally accepted by ward. Little focus on lack of formal hospital programs on medical research.</p>	<p>Hospital top management generally accepted among ward staff as new management team of ward leaders has replaced a team of administrative leaders. General ward acceptance of "working hospital" strategy; i.e., its chosen "non-academic" venue.</p> <p>Non-agreement with use of comprehensive strategy processes as these are viewed as nonessential to ward operations.</p>

...continued

<p>Nurses</p>	<p>Nurses are strongly marking their opposition to medical doctors' professional dominance. A strong need for reaffirming a professional identity of their own.</p> <p>Nurses share in the medical staff's general concern over the hospital's perceived inaction on their university status and obligations</p>	<p>Nurses are in support of management's resource administration. Professionally in opposition to medical staff's claimed hegemony in the "clinical dialogue".</p> <p>Takes pride in the hospital's self proclaimed patient orientation.</p> <p>Generally a strong affirmation of "working hospital" philosophy.</p>	<p>Nurses are focused on "getting the job done" along the lines proclaimed by the managing director.</p> <p>Nurses relate to the "working hospital" culture as part of their patient orientation.</p>
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10.5 Organizational focus: Data obtained from hospital archival records

10.5.1 Interpretative framework

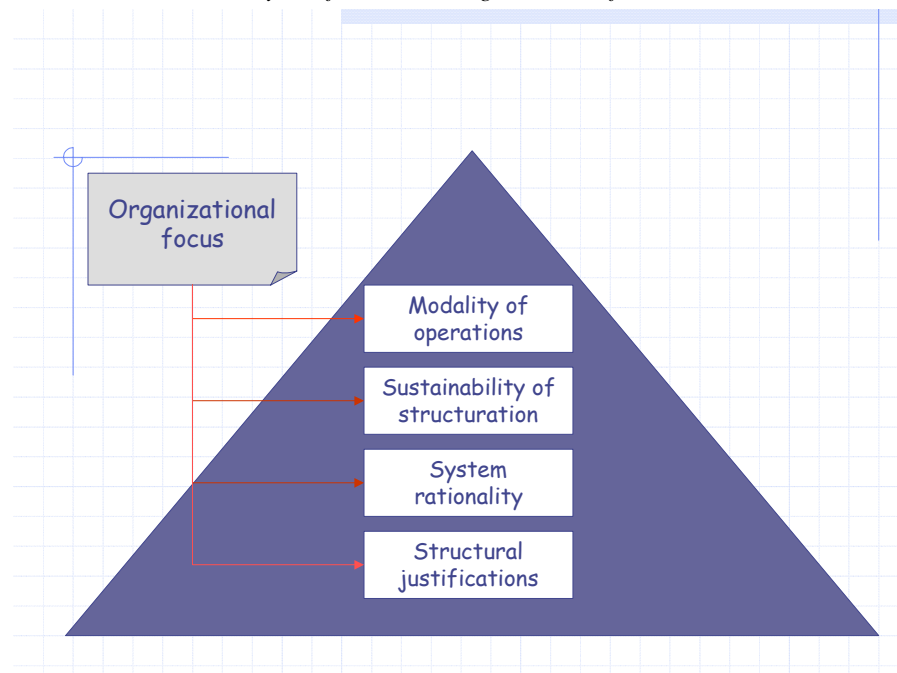
The archival records obtained from the respective case hospitals render important insights relative to how each hospital chooses to fulfill its obligations. As the public hospitals were in a governance transition during 2001¹⁶⁹, one has decided to place particular analytical emphasis on what the new laws on hospitals prescribe as core hospital functional responsibilities¹⁷⁰. The revisions enacted and passed into law January 1, 2001, serve particularly to confirm the hospitals' research and development functions. Medical research is, however, already established as a core hospital function through previous addendum or prescriptions to the original law on public hospitals ("Sykehusloven"). The latest hospital law ("Spesialisthelsetjensteloven") revision (§3-8), also introduces training and education of patients, this to permit the patient to function better once discharged from the hospital. This part of the law is particularly addressing the caring needs of the chronically ill. As the new law underscores that care regimen is not to be regarded as a core hospital activity, patient education and training will be excluded from the thesis' empirical analysis. In the new law's introductory comments, ("Merknader § 1-1", p. 17"), it is emphasized that proper patient care always is integrated in a medical regimen established for hospitalized patients.

¹⁶⁹ See thesis section 3.2 "The governance model".

¹⁷⁰ See thesis section 3.3.1 "Hospital services functions".

In order to learn what type of decisions are prioritized, meeting protocols for 2001 have been analyzed. Decision-making (DM) priorities identified are expected to provide insight into the significance of stakeholder *presence*. An analytical framework, as expressed in the following illustration has been applied.

Illustration No. 19: Analytical framework: Organizational focus



The model renders a sequential structure and an analytical perspective that is expected to catch the nuances of organizational decision-making in the selected case hospital. Thus, the summary analysis of meeting protocols will (1) *identify* issue matters called to the attention of the particular decision-making forum, (2) *classify* these decision-making issue matters as to their affirmative nature, and then (3) seek to *commodify* or identify the nature of each particular issue matter relative to the hospital’s mandated functions¹⁷¹. This latter interpretive approach serves to determine the

¹⁷¹ These are introduced and discussed in detail in thesis section 3.3.1 “Hospital services functions”, and conceptualized in illustration no. 8: “A model of public hospital stakeholder s”.

presence and impact of stakeholder groups. Reference is here made to Morgan's (Morgan 1988) contention on the significance of vested interest parties in pluralistic organization¹⁷². As such, the records obtained carry the potential for having inferences to the research question.

To facilitate a comprehension of data details found in the meeting protocols, the protocol records have been related to other archival sources as outlined in thesis table no. 19 "Archival records 2001". The thesis' analytical procedure viewing each case hospital relative to the interpretative model proposed, will be followed by a summary analysis incorporating all case hospitals.

10.5.2 Hospital no. 1

10.5.2.1 Decision-making meetings as conducted by the board of directors (BDM)

10.5.2.1.1 Structural characteristics of the BDM

The law on public hospitals ("Sykehusloven") specifically calls on hospital owners to establish hospital boards to safeguard governance interests. However, hospital board structure, mandate and membership vary as county hospital owners exhibit different board structure and practices¹⁷³. Some hospital boards draw their membership from its county political electorate. Other hospitals are governed by boards where members are selected from the county administration. Then there are also the so-called professional boards. Here an electorate from outside the county's political and administrative governance constitutes the boards' recruiting ground. Still, other hospitals set up boards made up of members from within the hospital and supervised by the county health sector administration; i.e., so called operational boards (Driftsstyrer).

Hospital board options available to public hospital owners are expressed in the law on county and communes¹⁷⁴.

¹⁷² Pls. view thesis section 2.6 "Organizational decision-making in hospitals".

¹⁷³ This matter is addressed in NOU 1997: 2 "Pasienten først" Ledelse og organisering i sykehus"; section 10.2.4 "Styrets rolle", p.p. 94-95. The new law on hospitals ("Spesialisthelsetjenesteloven") does not call for changes in the county and commune organization governing public hospitals (Rundskriv I-59/2000, "Merknader til § 2-1", p. 18).

¹⁷⁴ "Lov om kommuner og fylkeskommuner av 25. september, 1992" ("Kommuneloven"). Governing implications of this law on county hospital governance is expressed in NOU 1999:15 "Hvor nært skal det være?"; section 5.2.2 "Den fylkeskommunale forvaltningsmodellen", p.p. 36-41.

A professional board of directors governs the university hospital¹⁷⁵. The hospital director has a dual reporting responsibility, answering both to the chairman of the board of directors as well as to the city commissioner in charge of public health administration. The formal line of communication between the commissioner and the hospital director does not constitute a traditional superior - subordinate relationship. The hierarchical organizational line relationship is formally vested in the chairman of the hospital board of directors acting with a mandate to supervise the hospital's governing interests. However, the City commissioner carries full political accountability for hospital performance, and thus assumes full governance rights and mandate to initiate interventions deemed necessary.

10.5.2.1.2 Meeting demographics

The BDM appointed December 10, 2000 consists of seven regular members of whom two are hospital employee representatives. The hospital's managing director has been present at all BDM meetings conducted in 2001. In accordance with various legislative provisions of the *State health services* (Statens helsetilsyn) detailed in the *Law of State Audits* (Tilsynsloven)¹⁷⁶, the *County Doctor General* (Fylkeslegen) has the right to be present at all BDM meetings, representing the auditing function of the State's *Health Supervisory Board*. Having examined the respective BDM protocols for 2001, the County Doctor General is noted as not being present at any one of these meetings. In addition to the regular board meeting members, protocol records document a practice whereby hospital representatives other than the hospital director are invited in on particular issue cases brought before the board. During 2001, in all 30 persons were recorded as having appeared in front of the board on particular agenda issue matters.

Typically, a BDM is scheduled to be completed in 3 hours. In 2001, there were conducted nine such board meetings. Based on the meeting attendance of the regular board membership and the hospital director, an estimate shows that the BDM meetings at hospital no.1 required 189 man-hours during 2001.

Effective August 1st, a newly appointed hospital director replaced the acting hospital director. The acting hospital director had served in a temporary capacity since December 1999. The new hospital director now became the regular hospital representative present at the last two of the BDMs in 2001.

¹⁷⁵ For case hospital details; pls. view thesis section 9.3.2 "Case hospital selections", and particularly Table no. 16 "Selected case hospitals".

¹⁷⁶ "Tilsynsloven" was placed into law March 30th 1984.

A special board meeting was called, December 17 at which time the commune governance board was dismissed. A new executive board was formally instituted, appointed by the new State hospital owner in accordance with the new on hospital governance implemented January 1, 2002¹⁷⁷.

10.5.2.1.3 Issue matter roster

In going through the BDM protocols for 2001, all issues on the meeting roster were examined and catalogued in following the analytical model introduced in Illustration no. 10: “Analytical framework: Stakeholder influence”. Issues falling outside the three main areas of hospital accountability have been specified as *administrative items*. Based on the board’s ruling on each agenda item, each case matter has been entered into the protocol as either an item decided on, or as an item not ruled on; i.e., introduced for the purpose of the board’s orientation or as an item which the board decided not to take an affirmative stand on. All issue items brought before the board are considered to be within the confines of the board’s acting mandate.

The following table shows the board case matter issues arranged as per the distribution key outlined above.

Table No. 33: Process overview: Hospital No. 1 Hospital Board of Directors Meetings in 2001

Agenda issues	Orientation Items	Decision Items	Sum: Issue items
Patient treatment related	5	2	7
Staff education	0	0	0
Research	0	0	0
Administrative items	16	9	25
Sum total agenda issue items	21	11	32

As is evident from the above table, the number of administrative type issues placed on the meeting agenda represents the majority of items acted on by the board. The next table details the type case issue items making up the sum total of the agenda’s *Administrative items*.

¹⁷⁷ (LOV av 15. juni 2001 nr. 93 (Helseforetaksloven) 2001).

Table No. 34: Process overview: Hospital No. 1 Distribution of Administrative type issues attended to by the BDM in 2001

Administrative issues	Orientation Items	Decision Items	Sum: Items
Staffing	0	0	0
Training and development	0	0	0
Salary administration	0	0	0
Personnel administration	2	0	2
Administrative procedures	1	1	2
Strategy development	0	0	0
Budgeting	6	0	6
Accounting and finance	2	5	7
Building and maintenance	1	0	1
Organization	2	3	5
Information technology (IT)	0	0	0
HMS (Health-Work Environment-Safety)	0	0	0
General information	2	0	2
Sum total administrative issue items	16	9	25

10.5.2.1.4 Analysis and findings:

In reviewing the above listed tables on case issue matters making up the hospital BDM agenda, the following findings may be concluded:

1. The board has acted affirmatively on 34% or on 1/3 of the agenda roster for 2001. In all, 66% of the agenda case item total are items recorded as “orientation issues” or items deferred for later board reviews.
2. The case item category of administrative issues represents a total of 78% of the agenda items reviewed by the board. In all 9 out of 25 administrative issue items, or 36% were items that were affirmatively acted upon by the board.
3. In all 7 agenda case items; i.e., 22% of the agenda sum total acted upon by the board of directors, addressed patient related issues. Of these latter cases, 2 issue matters were affirmatively acted upon, representing 6 % of the sum total agenda case items.
4. The board did not invite any research oriented or staff education¹⁷⁸ issue matters as case agenda items during 2001¹⁷⁹.

¹⁷⁸ According to the Law on hospitals, § 8 (Lov av 19. juni 1969, Nr. 57: “Om sykehus m.m.”; as amended July 30th 1992), it is the duty of the hospital institution to facilitate the education of all medical professions employed. A duality exists as to the responsibility to remain professionally qualified. Reference is made to Law on

10.5.2.2 The decision-making processes as conducted by the hospital director and the top management team (TMT)

10.5.2.2.1 Structural characteristics of the TMT

The hospital law in force at the time of the empirical fieldwork (LOV av 19. juni 1969 nr. 57. Om sykehus (Sykehusloven) 1969) did not prescribe any clear-cut model for organizing or conducting hospital leadership. However, hospital management generally, and the leadership role of the hospital director specifically, received much national and sector specific attention throughout the 1990s. This attentiveness to the leadership role and its execution may partly be related to the emergence of the so-called corporate logic taking on a dominating position in public debates on sector governance¹⁸⁰. Also, various government white papers during the 1990's issued prescriptive statements on hospital leadership possibly influencing hospital selection of management models and leadership practice¹⁸¹. Particularly the government white paper: NOU 1997: 2, affirmed a

the profession and practice of medical doctors (Ref.: § 49 in "Lov av 13. juni, 1980 Nr. 42 Om leger"; as amended July 30th 1992) and Law on nursing (Ref.: § 8 ("Lov av 8. januar, 1960 Om godkjenning av sykepleiere) prescribing it a duty for the individual doctor and nurse to remain professionally updated (ref.: § 25).

This duality is further strengthened through national arbitration agreements between the employee federations of doctors (Dnlf) and nurses (NSF) and the owners of the respective hospitals.

Another reference that underscores the importance of hospital supervised education and training may be found in the national advisory boards on medical doctors and nurses (Ref.: "Legeloven" § 49 and "Sykepleierloven", § 12).

¹⁷⁹ Also the first Law on hospitals ("Sykehusloven") prescribes for R&D to be conducted in all public hospitals. As an arena for highly skilled and specialized professions, it is important for hospitals to be associated with new development and advances within medicine and its practice. In government white paper; NOU 1997:2, Section 5.5.3 "Forskning og utvikling" the hospitals' R&D is expressed as an existing responsibility particularly relevant for university hospitals and larger county and community hospitals. However, the law does not preclude any public hospital from the responsibility of R&D as this is considered precursory to maintaining a qualified medical staff. Again, the national associations for medical doctors and nurses respectively both proclaim R&D to be an integral part of their education and development and precursory to fulfill their legal accountability to professional conduct and performance (Ref.: "Lover for Den norske lægeforening; sist revidert oktober 2001" and "NSFs formål, prinsippprogram og vedtekter. Gjeldene fra Landsmøtet 2001").

¹⁸⁰ Pls. view thesis section 3.4 "The emergence of corporate logic".

¹⁸¹ See specifically: "Ledelse I sykehus", Sosialdepartementet, 1990; "Samarbeid og styring. Mål og virkemidler for en bedre helsetjeneste", St.meld.nr. 50, 1993-94; and NOU 1997: 2 "Pasienten først! Ledelse og organisering i sykehus".

governing norm with respect to the role of hospital top management. Specifically in its section 10.3.2.2 “Utøvelse av toppledelsesfunksjonen” (Conducting the top leadership function), emphasis is placed on the hospital director’s responsibility for practising strategic management and the development of a management culture vested in an attentiveness to patient issue matters. Finally, the new law on hospitals, “Spesialisthelsetjenesteloven” places particular emphasis on the importance of the leadership function and the expectancy of the leadership role in the public hospital.

The managing director at hospital no. 1 had adopted a management concept in which the hospital director and the ward directors made up the hospital’s top management team (TMT). At the time of the empirical fieldwork, the hospital ascribed to the shared ward leadership model or “consensus management”¹⁸². However, the consensus management model was only partially in force as three of the hospital’s medical clinics were managed by singular ward directors; i.e., unitary management.

10.5.2.2.2 Meeting demographic:

In 2001 there were a total of 16 regular members of the hospital’s TMT. In all 40 TMT meetings were conducted, each meeting scheduled for 2 ½ hours. As with the BDMs, hospital staff was invited to attend the TMTs on particular case issue items. A total of 143 hospital staff members outside the regular TMT-members were called on case specific issue matters. An estimated total of 1.600 man-hours were spent attending the scheduled TMTs during 2001.

The transition between the newly appointed hospital director and the acting hospital director, took place effective August 1st. The new director assumed supervision of all subsequent TMT meetings in 2001. The new hospital director of hospital no. 1 is, as her predecessor, a medical doctor.

10.5.2.2.3 Issue matter roster

As with the BDMs, all protocolled issue matter items placed on the meeting roster were examined and catalogued according to the analytical model introduced in Illustration no. 10: “Analytical framework: Stakeholder influence”. Issues falling outside of the three main areas of hospital accountability have been specified as “administrative” matters. Each case matter has been entered into the protocol as either an item decided on, or as an item not ruled on; i.e., introduced for the purpose of orientation or as an item where no affirmative stand is taken. All issue items brought before the

¹⁸² Pls. view thesis section 3.3.5 “Hospital management and the administrative functions”.

management team are considered to be within the confines of operations mandate.

A formalized set of hospital goals applicable to 2001, were first issued April 5th, 2001 and later revised June 6th (“Måldokument 2001”). The document lists 10 prioritized hospital objectives. All are due to be accomplished by December 31st, 2001. These are as follows:

1. Implementing the new health governance laws
2. Continue improving on organizational structures
3. Increasing cost efficiency to ensure improved capacity utilization, particularly on day-based surgery activities
4. Implementing new reporting concepts on quality and productivity
5. Implementing management development programs
6. Supporting recruiting programs related to critical functions
7. Working on improved utilization of hospital building facilities
8. Establishing a strategy plan
9. Establishing a decentralized staff specifically supporting ward activities
10. Establishing a budgeting concept for research activities

Additionally, sector and ward/clinic specific plans are recorded in the document amounting in all to 367 prioritized goals for 2001 (June 6th revision).

The hospital also has an official strategy plan governing research and professional field development. (“Strategiplan for forskning og fagutvikling 1998 – 2001”), dated December 16th 1998, formally in force through 2001¹⁸³. The strategy plan lists no specific research projects otherwise connected to the hospital’s operational strategy and associated budgets. Rather the plan may be viewed as a policy document on the importance of conducting hospital research and development projects.

The following table shows the distribution of case matter issues as per the distribution key outlined above.

¹⁸³ ”Strategisk plan for forskning og fagutvikling 1998 – 2001”.

Table No. 35: Process overview: Hospital No. 1 Hospital Top Management Team (TMT)

Agenda issues	Orientation items	Decision Items	Sum: Issue items
Patient treatment related	13	4	17
Staff education	2	1	3
Research	4	0	4
Administrative items	196	30	226
Sum total agenda issue items	215	35	250

As is evident from the above table, the number of administrative type issues placed on the TMT's meeting agenda, represents the majority of items called to the attention of hospital management. The next table details the type case issue items making up the sum total of "Administrative items".

Table No. 36: Process overview: Hospital No. 1 Distribution of Administrative type issues attended to by the TMT

Administrative issues	Orientation Items	Decision Items	Sum: Items
Staffing	0	0	0
Training and development	4	1	5
Salary administration	3	1	4
Personnel administration	26	5	31
Administrative procedures	40	8	48
Strategy development	1	1	2
Budgeting	3	1	4
Accounting and finance	25	4	29
Building and maintenance	1	0	1
Organization	70	6	76
Information technology (IT)	4	2	6
HMS (Health-Work Environment-Safety)	4	1	5
General information	17	0	17
Sum total administrative issue items	198	30	228

10.5.2.2.4 Analysis and findings:

In reviewing the above listed tables on case issue matters making up the TMT agenda, the following may be concluded:

1. In all 86% of the agenda case item total are items recorded as "orientation issues" or items deferred for later management reviews. Thus, the TMT has acted affirmatively on 14% of the agenda roster for 2001.
2. The case item category of administrative issues represents a total of 91% of agenda items reviewed by the TMT. In all 30 out of 228 administrative agenda items were affirmatively acted upon by the

board, representing a total of 13% of the accumulated agenda case items.

3. In all 17 agenda case items; i.e., 7% of the agenda sum total, addressed patient related issues. Of these latter cases, 4 issue matters were affirmatively acted upon, representing 1,6% of the accumulated agenda case items.
4. The number of research case issues handled by the TMT came to 4 singular cases of which none were affirmatively acted upon.
5. Staff education issues reviewed amounted to 3 cases on the agenda, or 1,2% of the total number of case matters listed on the agenda in 2001.
6. The hospital management did not incorporate into its management meetings during 2001 any structured follow-up process to account for either the progress of the over-all hospital goals (“Måldokument 2001”) or the hospital’s strategy plan research and professional field development (“Strategiplan for forskning og fagutvikling”).

10.5.3 Hospital No. 2

10.5.3.1 The decision-making processes as conducted by the board of directors (BDM)

10.5.3.1.1 Structural characteristics

Hospital no. 2 is a county- owned and governed local community hospital (Lokalsykehus). A turbulent county-political period was experienced in 1997 – 1998. This was precipitated by political criticism following hospital cost deficits. It was hence decided by county governance authorities to abort the practice of having hospital-internal boards. The predominant view shared by county political and administrative officials claimed that the operational boards act counterproductive to effective hospital management. Approval for having hospital-institutional boards was legally enacted, September 25, 1992 (Kommuneloven, Chapter no. 2, § 11). A county proposal to implement “professional” hospital boards was approved September 29, 1998¹⁸⁴. Case matter documentation confirms a limited scope of executive authority for the hospital board. County administration, however, retained its executive rights (*instruksjonsmyndighet*) opposite the hospital director. The board of directors was to report directly to the county’s

¹⁸⁴ Reference is made to County governance case file no. 55/98 (Akershus fylkeskommune; “Sak nr. 55/98”).

political governing body¹⁸⁵. The board chairman functionally became accountable to the director in charge of the County commission on health and social affairs (Hovedutvalg for helse og sosialsektoren) a committee membership made up of officials from the County's political arm (Fylkestinget).

10.5.3.1.2 Meeting demographic

The BDM of hospital no.2 appointed September 29th, 1998 consisted of seven regular members of which two are employee representatives. It is noted that in the absence of the hospital director who has the right of attendance at all board meetings, the hospital's head nurse is present. It is also noted from BDM protocols that the *County Doctor General* (Fylkeslegen) did not attend any one of the board meetings during 2001. In addition to the regular board meeting members, protocol records document a practice whereby representatives other than the hospital director, are introduced and present on particular case matter issue brought before the board. During 2001, in all 30 persons were recorded as having appeared on such occasions.

Typically, the BDMs in 2001 were scheduled for 3 hours. Eleven such board meetings were held during 2001. Estimates show that the BDM meetings at Case hospital no.2 required 231 man-hours.

10.5.3.1.3 Issue matter roster

In going through BDM protocols for 2001, all issue matter items placed on the meeting roster at hospital no. 2, were examined and catalogued according to the analytical model introduced in Illustration no. 10: "Analytical framework: Stakeholder influence". Issues falling outside the three main areas of hospital accountability have been specified as "administrative" matters. Each case matter has been entered into the protocol as either an item decided on, or as an item not ruled on; i.e., introduced for the purpose of orientation or as an item where no affirmative stand is taken. All issue items brought before the board are considered to be within the confines of board mandate.

The following table shows agenda case allocation according to the issue matter distribution key outlined above.

¹⁸⁵ Reference is made to a legal opinion expressed by J.F.Bernt as entered into the county case records stating that the hospital board does not have executive authority opposite the particular hospital as the hospital director is confirmed as a section supervisor subordinated the county administration (Jnr./dok.nr./år: 7177/5/98; arkivkode 034H; arb.nr.: a980441).

Table No. 37: Process overview: Hospital No. 2 Hospital Board of Directors Meetings in 2001

Agenda issue	Orientation items	Decision Items	Sum: Issue items
Patient treatment related	9	0	9
Staff education	1	0	1
Research	0	0	0
Administrative items	62	7	69
Sum total agenda issue items	72	7	79

As is evident from the above table, the number of administrative type issues placed on the BDM agenda, represents the majority of items acted on by the board. The next table details the type case issue items making up the sum total of the agenda's "Administrative items".

Table No. 38: Process overview: Hospital No. 2 Distribution of administrative type issues tended to by the BDM in 2001

Administrative issues	Orientation Item	Decision Item	Sum: Items
Staffing	0	0	0
Training and development	0	0	0
Salary administration	2	0	2
Personnel administration	1	0	1
Administrative procedures	1	0	1
Strategy development	0	0	0
Budgeting	1	1	2
Accounting and finance	17	0	17
Building and maintenance	15	3	18
Organization	9	3	12
Information technology (IT)	0	0	0
HMS (Health-Work Environment-Safety)	0	0	0
General information	15	0	15
Sum total administrative issue items	61	7	68

10.5.3.2 Analysis and findings:

In reviewing the above listed tables on case issue matters making up the BDM agenda, the following findings may be concluded:

1. In all, 91% of the total agenda case matters ruled on, are items recorded as "orientation items". Thus, the board has acted affirmatively on 9% of the agenda roster brought before the board in 2001.

2. The case item category of administrative issues represents a total of 87% of the total number of agenda items reviewed by the board. In all seven, or 10% of the administrative agenda case items were affirmatively acted on.
3. In all nine agenda case items, (11%) acted upon by the board of directors addressed patient related issues. Of these latter cases, no issue matters were affirmatively acted upon.
4. With respect to staff education type issues, the board did address one such matter, representing 1,3% of the total BDM-case load for 2001.
5. The board did not invite any research issues as agenda items during 2001.

10.5.3.3 The decision-making processes as conducted by the hospital director and the top management team (TMT)

10.5.3.3.1 Structural characteristics of the TMT(s)

The director at hospital no. 2 has established a managerial model consisting of two management teams. The hospital director supervises both teams. The distinguishing characteristics are based on the respective team's representative make up. The hospital director's "Director's management team" (Ledermøter; i.e., "DMT") includes clinical and administrative managers. The hospital director's "Administrative advisory group" (Administrasjonsrådet; i.e., "AAG") includes only representatives of the administrative staff.

The case hospital has throughout 2001 maintained a "consensus" type organizational structure for nearly all medical wards, with the exceptions of the oncology- and surgery unit. Both the director-supervised teams operate with a fixed meeting structure with formally scheduled meetings and planned agendas. All management meetings have been protocolled. There is no formal mandate distinguishing or otherwise ranking the two forum's respective managerial authority.

10.5.3.3.2 Meeting demographic

The DMT membership in 2001 counted 22 regular participants. There does not seem to have been a practice of inviting special guests to attend on special case matter issues, as only seven such invitees were present in 2001. It is noted however, that the DMT experienced noticeable participant absenteeism. Throughout the period covered, in all 30 participants were recorded as absent.

In 2001 DMT-protocol records confirm 13 meetings, each one scheduled to last 4 hours. Thus an estimated 1144 man-hours were spent attending DMT-meetings.

10.5.3.3.3 Issue matter roster

As with the BDMs, all protocolled issue matter items placed on the DMT meeting roster were examined and catalogued according to the analytical model introduced in Illustration no. 12: “Analytical model of stakeholder influence”. Issues falling outside the three main areas of hospital accountability have been specified as “administrative” matters. Each case matter has been entered into the protocol as either an item decided on, or as an item not ruled on; i.e., introduced for the purpose of orientation or as an item where no affirmative stand is taken. All issue items brought before the management team are considered to be within the confines of operations mandate.

The following table shows the distribution of case matter issues as per the distribution key outlined above.

Table No. 39: Process overview: Hospital No. 2. Hospital Top Management Team (DMT)

Agenda issues	Orientation items	Decision Items	Sum: Items
Patient treatment related	10	0	10
Staff education	0	0	0
Research	0	0	0
Administrative items	65	2	67
Sum total agenda issue items	75	2	77

As is evident from the above table, the number of administrative type issues placed on the DMT agenda, represents the majority of items processed at the meeting. The next table details the type case issue items making up the sum total of “Administrative items”.

Table No. 40: Process overview: Hospital No. 2 Distribution of Administrative type issues attended to by the DMT

Administrative issues	Orientation Items	Decision Items	Sum: Issue items
Staffing	0	0	0
Training and development	0	0	0
Salary administration	2	0	2
Personnel administration	1	0	1
Administrative procedures	10	0	10
Strategy development	0	0	0
Budgeting	0	0	0
Accounting and finance	14	0	14
Building and maintenance	5	0	5
Organization	20	2	22
Information technology (IT)	2	0	2
HMS (Health-Work Environment-Safety)	0	0	0
General information	11	0	11
Sum total administrative issue items	65	2	67

10.5.3.4 Analysis and findings

In reviewing the above listed tables on case issue matters making up the DMT agenda, the following may be concluded:

1. In all, 97% of the total agenda case matters ruled on are items recorded as “orientation items”. Thus, the DMT has acted affirmatively on 3% of the agenda roster for 2001.
2. The case item category of administrative issues represent a total of 87% of agenda items considered by the DMT. In all 2 out of 65 administrative agenda case items were affirmatively acted upon by the DMT, representing a total of 3% of the accumulated agenda case items.
3. In all 10 agenda case items, or 13,0% of the agenda sum total acted upon by the director and his DMT, addressed patient related issues. Of these latter cases, none were affirmatively acted upon.
4. There were no research nor staff education issues raised during the year.

The DMT group has developed a list of prioritized management goals. These are supervised separate from the DMT meeting format. Focus areas in the plan are:

- Division of work assignments between hospital owner and hospital management
- Financing model in a new governance model
- Increase in market share
- Cost management model
- Patient satisfaction analysis
- Patient training center
- Geriatric team
- Cancer treatment program
- Strategy planning process

The goals are detailed on focus area and date planned to have action completed. However, aside from objectives within management development programs, all other goals are stated in general terms; i.e., *Follow-up on.....; Continue development of.....; Prepare plan for.....; Prepare proposal for.....; Establish a pilot project.....; Coordinate plans for.....; Identify regulations governing.....; Continue work on; Evaluate.....; Preliminary evaluation.....*

10.5.3.4.1 Meeting demographic: Administrative advisory group (AAG)

The AAG membership in 2001 counted 5 regular participants. The AAG management team includes the director of each of the hospital's administrative staff; i.e., accounting, personnel, head nurse's office and the office of the chief medical doctor. An AAG-management document was prepared for 2001, listing overall hospital objectives (*Utfordringer*; i.e., Challenges) with the following focus: (1) strategic issues, (2) patient improvement processes, (3) resource efficiency, and (4) staff recruiting and development.

Protocol records confirm 43 AAG meetings in 2001, each one scheduled to last 3 hours. This brings the man-hours spent on attending DAG meetings to 645 man-hours.

10.5.3.4.2 Issue matter roster

As with the BDMs and DMTs, all protocolled issue matter items placed on the AAG meeting roster were examined and catalogued according to the analytical model introduced in Illustration no. 10: "Analytical framework: Stakeholder influence". Issues falling outside the three main areas of hospital accountability have been specified as *administrative issues*. Each case matter has been entered into the protocol as either an item decided on, or as an item not ruled on; i.e., introduced for the purpose of orientation or as an item where no affirmative stand is taken. All issue items brought before the management team are considered to be within the confines of operations mandate.

The following table shows the distribution of case matter issues as per the distribution key outlined above.

Table No. 41: Process overview: Hospital No. 2. Hospital Top Management Team (AAG)

Agenda issues	Orientation items	Decision Items	Sum: Issues
Patient treatment related	24	13	37
Staff education	1	0	1
Research	1	0	1
Administrative items	209	80	289
Sum total agenda issue items	235	93	328

As is evident from the above table, the number of administrative type issues placed on the AAG agenda, represents the majority of items called to the group's attention. The next table details the type case issue items making up the sum total of "Administrative items".

Table No. 42: Process overview: Hospital No. 2. Distribution of Administrative type issues attended to by the AAG

Administrative issues	Orientation Items	Decision Items	Sum: Issues
Staffing	0	0	0
Training and development	0	0	0
Salary administration	7	3	10
Personnel administration	10	4	14
Administrative procedures	57	23	80
Strategy development	0	0	0
Budgeting	4	4	8
Accounting and finance	9	6	15
Building and maintenance	22	5	27
Organization	67	30	97
Information technology (IT)	3	5	8
HMS (Health-Work Environment-Safety)	2	0	2
General information	28	0	28
Sum total administrative issue items	209	80	289

10.5.3.5 Analysis and findings

In reviewing the above listed tables on case issue matters making up the AAG agenda, the following may be concluded:

1. In all, 72% of the agenda case item total are items recorded as “orientation issues”. Thus, the AAG has acted affirmatively on 28% of the agenda roster for 2001.
2. The case item category of administrative issues represent a total of 88% of agenda items reviewed by the AAG. In all 80 out of 289 administrative agenda case items were affirmatively acted upon by the AAG, representing a total of 28% of the accumulated agenda case items.
3. In all, 24 agenda case items, or 7% of the agenda sum total acted upon by the director and his AAG, addressed patient related issues. Of these latter cases, 13 or 35% of sector items or 4% of total agenda cases were affirmatively acted on.
4. There was one research item and one staff education issue raised during the year.

10.5.4 Hospital No. 3

10.5.4.1 The decision-making processes as conducted by the board of directors (BDM)

10.5.4.1.1 Structural characteristics

Hospital no. 3, is a county community hospital (Sentralsykehus)¹⁸⁶. The hospital governance model as applied under this county administration is unique as the concept implemented may be considered a precursory to the new law on hospital governance implemented January 1, 2002 (“Helseforetaksloven”). Prior to the implementation of this latter law, the Norwegian parliament passed new legislation on organizational models applicable to county or community owned business or operational ventures. As an addendum to the Law on counties and communes of 1992/93 (Kommuneloven), based on governmental provision Ot. prop.no. 53, 1998, counties were now permitted to establish “corporations” (“Foretak”) replacing the previous nomenclature of county or community “firms” (“Bedrift”). The political assessment bringing this addendum forth was an expressed interest in finding an organizational structure that permitted an explicit focus on business-oriented management (“Forretningsmessige

¹⁸⁶ See thesis section 9.3.2 “Case hospital selection”; and particularly its Table no. 16: “Selected case hospitals”.

hensyn”). This replaced a practice of administrative supervision to better ensure governance interests (“Forvaltningsinteresser”)¹⁸⁷.

Within this new corporate governance structure, hospital no. 3 has a professional board with its director reporting directly to the county’s political branch. However, unlike the other case hospitals, the hospital board director reports directly to the County mayor (Fylkesordfører) rather than to the politically appointed county offices (as with hospital no. 2) or city (as with hospital no. 1) commissioner on public health. This new provision was established to avoid any governing conflicts stemming from the previously confirmed dual reporting prescription.

10.5.4.1.2 Meetings’ demographic:

The BDM at Hospital no. 3 consisted of seven regular members, two of whom were employee representatives. The hospital director is noted as having been present at all BDM meetings conducted during 2001. Having examined the protocols of all BDM meetings in 2001, it is also noted that the County Doctor General has not been present at any one of these meetings. In addition to the regular board meeting members, protocol records document a practice of hospital representatives being present and introduced on particular agenda case matter issues brought before the board. During 2001, in all 17 persons were recorded as present and available on particular case matter issues brought before the board.

Typically, the BDMs in 2001 were scheduled for 3 ½ hours. In 2001, nine such board meetings were held. This brings the estimate of the BDM meeting attendance at hospital no.1 to 220 man-hours.

Responding to the new hospital law enacted July 2nd, 1999, a new hospital board was elected December 12, 2001.

10.5.4.1.3 Issue matter roster

In going through the BDM protocols for 2001, all issue matter items placed on the meeting roster were examined and catalogued according to the analytical model introduced in Illustration no. 10: “Analytical framework: Stakeholder influence”. Issues falling outside the three main areas of hospital accountability have been specified as “administrative” matters. Each case matter has been entered into the protocol as either an item decided on, or as an item not ruled on; i.e., introduced for the purpose of orientation

¹⁸⁷ This interpretation is based on NOU 1999:15 “Hvor nært skal det være”, chapter 6 “Kommunalt foretak og forvaltningsbedrift”, section 6.1.1 “Bakgrunn for nye tilknytningsformer”, p. 53.

or as an item where no affirmative stand is taken. All issue items brought before the board are considered to be within the confines of its mandate.

The following table shows the distribution of case matter issues as per the distribution key outlined above.

Table No. 43: Process overview: hospital no. 3. Hospital Board of Directors Meetings in 2001

Agenda issues	Orientation Items	Decision Items	Sum: Agenda items
Patient treatment related	0	2	2
Staff education	0	0	0
Research	0	0	0
Administrative items	22	16	38
Sum total agenda issue items	22	18	40

As is evident from the above table, the number of administrative type issues placed on the meeting agenda, represents the majority of items acted on by the board. The next table details the type of case issue items making up the sum total of the agenda's "Administrative items".

Table No. 44: Process overview: hospital no. 3. Distribution of Administrative type issues attended to by the BDM in 2001

Administrative issues	Orientation Items	Decision Items	Sum: Issues
Staffing	0	0	0
Training and development	0	0	0
Salary administration	0	0	0
Personnel administration	0	0	0
Administrative procedures	5	3	8
Strategy development	0	1	1
Budgeting	0	3	3
Accounting and finance	12	4	16
Building and maintenance	0	2	2
Organization	1	2	3
Information technology (IT)	0	0	0
HMS (Health-Work Environment-Safety)	0	0	0
General information	4	1	5
Sum total administrative case items	22	16	38

10.5.4.2 Analysis and findings

In reviewing the above listed tables on case issue matters making up the BDM agenda, the following findings may be concluded:

1. In all, 55% of the agenda case item total is items recorded as “orientation issues” or items deferred for later board reviews. Thus, the board has acted affirmatively on 45% or of the agenda roster for 2001.
2. The case item category of administrative issues represent a total of 95% of the agenda items reviewed by the board. In all, 16 of a total 38 administrative agenda case items (42%) were affirmatively acted upon by the board.
3. In all 2 agenda case items, or 5% of the agenda sum total acted upon by the board of directors, addressed patient related issues. Both of these case issues were affirmatively acted upon.
4. The board did not invite any research oriented or medical staff education issue matters as case agenda items during 2001.

10.5.4.3 The decision-making processes as conducted by the hospital director and the top management team (TMT)

10.5.4.3.1 Structural characteristics

In conjunction with the aforementioned change in the hospital’s formal reporting structure, the hospital director introduced a new membership structure for the top management team. From having a team consisting of staff administrative leaders, the director now established a new team made up of the hospital’s clinical ward managers. As outlined in NOU 1997: 2, Norwegian public hospitals vary with respect to the make up of the director’s management staff¹⁸⁸. According to a survey completed in conjunction with the NOU 1997: 2, common to most director teams is the inclusion of the chief medical doctor, head nurse, personnel director and the chief accountant.

In addition to the hospital director, the management team consisted of seven medical ward supervisors and the director in charge of technical support (Driftssjef), all reporting directly to the hospital director. Ward supervisors were all internally recruited following a selection process in which management interests and qualifications were emphasized as required candidate qualifications.

¹⁸⁸ See NOU 1997: 2 “Pasienten først: Ledelse og organisering I sykehus”, section 5.6.3.1 “Direktøren og direktørens stab”, p. 37.

10.5.4.3.2 Meeting demographic

The concept of *consensus management* was aborted early 2001 in conjunction with establishing unitary management. Subsequently, there were now a total of 9 regular members of the hospital TMT. In all 16 TMT meetings were conducted in 2001, each meeting commonly scheduled to be completed in 3 hours. Thus an estimated 432 man-hours were spent attending the scheduled TMTs during 2001. There seems to have been no practice of inviting other hospital staff members to be present on particular issue matter cases, as TMT protocols has no record of such guests

10.5.4.3.3 Issue matter roster

As with the BDMs, all protocolled issue matter items placed on the meeting roster were examined and catalogued according to the analytical model introduced in Illustration no. 10: “Analytical framework: Stakeholder influence”. Issues falling outside the three main areas of hospital accountability have been specified as “administrative” matters. Each case matter has been entered into the protocol as either an item decided on, or as an item not ruled on; i.e., introduced for the purpose of orientation or as an item where no affirmative stand is taken. All issue items brought before the management team are considered to be within the confines of its mandate.

Based on a board initiative in the second half of 2000, the hospital management supervised a strategy planning process resulting in the hospital’s first formal strategy plan covering the period 2001 through 2004¹⁸⁹. The strategy plan was approved by the board, January 17, 2001 and had the following action program:

1. Improved patient flow
 - a. Increased production
 - b. Expanded treatment capacity
 - c. Improved technical support
 - d. Improved system coordination
 - e. Inaugurate new medical wing to cut down on waiting list patients
2. Improved flow and continuity in patient treatment
 - a. Remove discontinuity items and improve treatment efficiency
3. Improve joint actions with primary health care lines
 - a. Efficient completion of patient journals
 - b. Application of technology based patient reference services
4. Improved patient- and public information services

¹⁸⁹ ”BSS Strategiplan 2001 – 2004”.

- a. Develop and subscribe to communication and media strategy
 - b. Reduce/remove number of complaints on poor communication
 - c. Cut down on time consuming administrative procedures
 - d. Improve patient satisfaction
5. Improved application of professional skills and knowledge
- a. Reduce number of vacant nursing positions
 - b. Reduce staff turnover
 - c. Improve change-management skills
 - d. Induce research and development programs

The plan announces management’s intentions of a supervised follow-up on development action plans throughout 2001, while the overall strategy plan is to be revised on an annual basis.

The following table shows the distribution of case matter issues as per the distribution key outlined above.

Table No. 45: Process overview: hospital no. 3. Hospital Top Management Team (TMT)

Agenda issues	Orientation items	Decision Items	Sum: Agenda items
Patient treatment related	24	20	44
Staff education	2	2	4
Research	0	0	0
Administrative items	94	22	116
Sum total agenda issue items	120	44	164

As is evident from the above table, the number of administrative type issues placed on the meeting agenda, represent the majority of items called to the attention of the TMT. The next table details the type case issue items making up the sum total of “Administrative items”.

Table No. 46: Process overview: hospital no. 3. Distribution of Administrative type issues attended to by the TMT

Administrative issues	Orientation Items	Decision Items	Sum: Issues
Staffing	4	4	8
Training and development	1	0	1
Salary administration	0	1	1
Personnel administration	6	0	6
Administrative procedures	26	6	32
Strategy development	0	1	1
Budgeting	0	0	0
Accounting and finance	22	2	24
Building and maintenance	0	1	1
Organization	4	7	11
Information technology (IT)	0	0	0
HMS (Health-Work Environment-Safety)	0	0	9
General information	31	0	31
Sum total administrative case items	94	22	116

10.5.4.4 Analysis and findings

In reviewing the above listed tables on case issue matters making up the TMT agenda, the following may be concluded:

1. In all, 73% of the agenda case item total are items recorded as “orientation issues”. Thus, the TMT has acted affirmatively on 27% of the agenda roster for 2001.
2. The case item category of administrative issues represent a total of 71% of agenda items reviewed by the TMT. In all 19% or 22 out of 116, of the administrative agenda items were affirmatively acted upon by the hospital director and its management team, representing a total of 13,4% of the accumulated agenda case items.
3. In all 44 (27%) agenda case items acted upon by the TMT, addressed patient related issues. Of these latter cases, 20 issue matters, or 46% were acted upon affirmatively.
4. There were no research cases issues attended to by the TMT during 2001.
5. In all 4 staff education case issues were addressed by the TMT, representing 2% of the total number of cases handled by the TMT during 2001. Half of these, or 2 were affirmatively acted upon.

10.5.5 Summary findings: Analysis of archival records

10.5.5.1 Analytical approach

Viewing the case hospitals' archival records serves two purposes. Firstly, meeting protocols and other supportive documentation confirm a decision-making agenda and ultimate decision-making choices. This is important data as it serves to verify which constituent cases succeed in reaching important hospital decision-making forums and which cases are decided upon. Secondly, archival records in general, and meeting protocols in particular, are important pieces of collaborative evidence when viewed opposite informant interviews. As such, the sum analysis of case hospitals' organizational preferences and its organizational dynamics bring the thesis closer to having answered the research question.

10.5.5.2 The significance of structure

In Giddens (Giddens 1984) view, structure represents governing rules and resources. It may therefore be relevant to speak of the hospital board in terms of the legitimacy it represents by the origin of its constituency. The board models applied by county and commune governance vary in their systemic justification. The governing structures of the university hospital and the community hospital are established within a parliamentary framework. However, as has been determined in the analysis of the structural ramifications, the parliamentary scheme has been discounted to fit its call for a reporting duality. Herein are the requirements for the directors to report to a matrix of county office representatives. In addition, these two directors are also obliged to maintain a formal hierarchical dialogue with their respective boards. The distinguishing structural characteristics of the county hospital make the hospital director exclusively accountable only to the board. The straight line of command is further extended with the board itself reporting directly to the county's political branch represented by its county mayor.

This structural differentiation may in part be attributable to the latter board's superior merits relative to its record of affirmative decision-making. Viewing the board from the perspective of agenda cases processed, the community hospital is clearly the superior performer. However, the relatively high number of information case matters introduced may partially explain the output imbalance. Discounting further for the same hospital's relatively large number of case items connected to facility expansion projects, all three case hospitals turn over a relatively equal volume of agenda cases. The county hospital acting outside the system realm of a matrix reporting relationships displays the most assertive decision-making.

The absence of complex interceptive communication contributes to its affirmative actions.

10.5.5.3 The sustainability of structuration and the rationality of systems¹⁹⁰

Subscribing to Durkheim's (Durkheim 1962) rationale of social structures, structural legitimacy is represented by an asymmetric set of powers. Such systemic powers are represented by their enabling and constraining measures and serve to open up certain possibilities of action. Some measures may be of a restrictive nature. The constraining power of the board is represented by responses to remain uncommitted on operational issues. Giddens (Giddens 1984) refers to these as negative sanctions. However, by the very nature of its structural power, the board may also represent capabilities to bring about intended outcomes of action benefiting yet other stakeholder preferences. The case hospitals show a clear preference for reviewing administrative case items. Their major focus is directed towards budgets and resources allocation. As such, board priorities reflect the focus of their governing constituencies. This functionalistic interpretation of agenda priorities demonstrates what Giddens (Giddens 1984) labels system morphology, said to persist between matrix actors of common political structures.

Giddens post-structuralistic interpretation recognizes actor agents' relational codes existing below surface manifestations. Such manifestations here refer to the prescribed board mandate. The board directors are all tenured politicians experienced in county and commune politics having been part of their embedded structural properties. This serves to secure the reproduction of relations and the endurance of system logic. In Giddens' view, the practices of actor agent interaction within the totalities of its governance system, serve to institutionalize governance. Thus the contextual logic of hospital boards is embedded in the case matter preference of its superior governance actors.

The analysis shows that the case hospital boards do not address contextual matters rooted in hospital value creation processes. Along the lines of Habermas (Habermas 1991), one may argue that the boards' lack of contextual insight precludes it ever to profess any sector expertise and thus permits agendas void of value creation issues. Habermas' makes reference to the mounting bureaucratization of the administration in State and society. His claim is that it is inherent in the nature of the case that the know-how of highly specialized experts would necessarily be removed from supervision

¹⁹⁰ Giddens (Giddens 1984) refers to structuration theory as conceptually representing structure, system and duality of structure.

by rational debating bodies. Habermas' concludes that the control of the state's political bureaucracy is possible only by means of society's political bureaucracy. Consequently, the public hospital is subject only to the control within the framework of its own governance. In as much as this is a structural matter within one and the same governance body, it is not possible to arrive at an appropriate relationship between governance decrees and board deliberations.

The decision-making pattern as exhibited by all the respective case hospital boards confirms a preference for economic and financial issue matters¹⁹¹. With its attention generally detached from patient treatment issues, research and development and staff education, the boards do not fulfill a role as promulgated by sector governance. However, it must be stated that county and commune prescriptions are not uniformly clear in their detailing of hospital mandate. Board instructions for hospital no. 1 are the clearest in their specification of governance prescriptions and on the diversity of mandated functions. The formal board mandate states unequivocally that it is the board's duty to plan and coordinate hospital activities regarding treatment, research and staff education¹⁹². At hospital no. 2, the county authorities are less detailed on the formal mandate. Board instructions emphasize that it is the board's duty to ensure that the hospital is managed so as to secure long-term and over-all hospital needs in line with county strategy. This makes the board responsible for establishing a hospital strategy and programs for its supervision and control¹⁹³. The mandate established for the board at hospital no. 3, the instructions are stated in terms where one cannot read into it any prescriptions validating neither the law on hospital nor later governance prescriptions detailing staff education and medical research¹⁹⁴.

¹⁹¹ According to Mørkved (Mørkved 2001), the national focus on maximizing the efficiency of public governance saw its most significant initiative with governmental provision: St.meld. nr. 4 (1987-88) "Perspektiver og reformer i den økonomiske politikken". A so-called "New State ("Den nye staten") was to be noted for its improvement in effective and efficient resources administration. A governmental white paper in 1991; NOU 1991: 28 "Mot bedre vitende", was also considered an important follow-up, further outlining government reform intentions based on the logic of New Public Management (Mørkved 2001).

¹⁹² "Instruks for styret ved Oslo kommunale sykehus"; § 6 "Styret skal planlegge og koordinere etatens virksomhet og utbygging på feltene praktisk medisin, forskning og undervisning; jfr. § 1" (1989)

¹⁹³ "Felles vedtekter for styrene ved SIA/Stensby, Bærum og Ski sykehus etter Fylkestingets behandling. Vedtak i Fylkestinget 20.02.01".

¹⁹⁴ Buskerud fylkeskommune: Saksframlegg 18.11.99; referanse 99/01520-1: "Etablering av fylkeskommunale sykehusforetak fra 1 januar 2000".

The boards' uniform record of non-compliance may thus be considered indicative of a system reproduction of ignorance opposite the complex contextual properties making up the public hospital.

10.5.5.4 The modality of operations

Applying the logic of Giddens (Giddens 1984), the conditions governing the continuity of structural intentions, determine how an organization is facilitated in its operational processes. Thus, the manner in which the board executes its mandate, confirms its legitimacy through the domination exerted on the hospital agenda.

In analyzing the case hospitals' decision-making record, the pattern of case matter issues processed resembles that of the respective boards. Between 80 and 90% of all agenda cases are of an administrative nature, dominated largely by organization, accounting and salary administration issue matters. Excluding for the moment the AAG management team of the community hospital, all case hospitals' operations management teams include ward managers. What makes this observation particularly revelatory is the fact ward representatives do not use the top management forum to promulgate ward issues. The lack of agenda attentiveness to medical, research and staff education confirms this latter contention.

The hospital operations management's lack of interaction with value creation issues, confirms a scope of influence confined to administrative matters. A stakeholder group ceases to be a viable force when it does not apply its influential power. Such a link between power and action presupposes the capacity to deploy a range of causal measures. As the top management teams uniformly fail to position themselves on operational issues, their insignificance to the respective hospital's value creation processes is confirmed.

The pattern of management focus resembles that of their respective board of directors. The county hospital shows a superior affirmative decision-making track. A higher attention devoted patient related matters, shows a managerial focus levelled more at operational issues than that which is observed in other case hospitals. A strategy plan initiated by its board of directors, further reaffirms a goal-oriented management. However, the nature of strategic objectives is still resource efficiency and a production achievement orientation.

The community hospital with its practice of two management teams shows no particular distinctive traits in agenda focus. Both the DMT and the AAG prioritise administrative issues. Judged by the frequency of meetings,

caseloads processed and the higher rate of affirmative decision-making, it appears quite clear, however, that the director's AAG management group is representative of the hospital's top management team.

Thesis findings from the informant interviews are supported by the analysis of archival records. Structural conditions shape both the nature and efficiency of communication as it also influence decision-making focus. Board informants verify both the structure complexity and partly an ambivalence associated with the governing agenda. County and commune governance focus is on measurable entities instrumental in impacting resources deployment. This permeates the hospital boards' agenda priorities and executive attention. Hospital informants verify a decisional sedimentation culture within the case hospitals. The archival records analysis also supports a view of hegemonic ward operations. Ward properties are by medical staff choice, not brought forward to be included in the agenda of hospital management.

Giddens (Giddens 1984) labels properties implicated in the reproduction of contextual totalities, as structural principles. Subsequent practices evolving over time within such totalities make up embedded institutions. As such one may confirm case hospital management as institutionalized administrative regimes where its powers are exerted in the process of sanctioning administrative system prescriptions. The modes of management conduct reflected in the case matter agenda, reaffirms an executive and management function vested outside the hospital's value creation processes. As such, stakeholder group informants manifest the existence of governance morphology.

11 Summary and conclusions






11.1 Empirical significance and population conformity: Findings generalization

The thesis objective has been to arrive at an explanation of how hospital organizational decision-making is influenced by stakeholder groups. In the context of constituent representation, stakeholder groups are conceptualised as they converge on organizational decision-making. The thesis model developed, has established a conceptual construct abstraction of the interaction between constituent interests.¹⁹⁵ To arrive at research closure, the thesis has identified relevant hospital stakeholder groups and their vested interests in hospital operations. Empirical findings show constituent perception and preference on issue matters tied to public hospitals. Thesis analysis shows how stakeholder groups work to influence decision-making at various levels of the public hospital organization. The following table depicts hospital stakeholder groups and their matrix interaction. The conceptual foundation is based on the thesis' stakeholder model as shown in Illustration no. 8: "A model of public hospital stakeholders". Stakeholder convergence has been (colour-) coded to indicate the nature of group interrelationships.

¹⁹⁵ See thesis section 8.3.2.1 "Methodological approach".

Table No. 47: Stakeholder group interaction in public hospitals

External Stakeholder Groups / Internal Stakeholder Groups	Sector Governance	Professional Affiliations	Proxy Agents	Critical Suppliers
Hospital top management	Hierarchical relationship governed by mandates, rules and regulations 1	Relationship governed by negotiated agreements on employment terms and conditions 2	Diagnostic groups for the chronically ill working with hospital management to ensure patient rights 3	Administrative staff engaged in contract administration to ensure abidance by the hospital's contractual terms and conditions 4
Work-Force Representation groups	Contractual relationship delegated Hospital Management 5	Close contact maintained to ensure over-all affiliate strategies 6	No formal relationship nor matrix cooperation identified 7	No formal relationship nor matrix cooperation identified 8
Patients	Special audit offices and/or audit policies and procedures established to safeguard patient interests 9	No formal relationship nor matrix cooperation identified 10	Relationship dependent on patient initiative and/or patient diagnosis qualifying for special proxy interests 11	Matrix relationship supervised by hospital medical staff 12
Clinical Supervisors	Supervisory relationship vested in Hospital's formal organization 13	Contact maintained through employee federation organization 14	Contact established when following up on patient rights violations 15	Relationship maintained on research projects, product evaluation and networking 16

-  Formal hierarchical stakeholder relations (1,2,5,9,13)
-  Employee federation based interaction (6,14)
-  Contractually governed stakeholder relations (3,4)
-  Services exchange relationships (11,12,15,16)
-  No known stakeholder interaction (7,8,10)

The empirical field covered is limited to three case hospitals. Case hospital no. 1 represents the university hospital and/or county hospitals assigned regional and university-clinic functions. Case hospital no. 2 is representative of the four-functioned somatic structure of community or local hospitals. Case hospital no. 3 is representative of the county hospital, also assigned various community hospital functions.¹⁹⁶

¹⁹⁶ This combination of functional assignments across standard hospital classifications is a common governance practice. Detailed documentation on public hospitals' classified status and additional functional assignments is available in

The population of case hospitals satisfies sampling property requirements that qualify for contextual richness and case category representation.¹⁹⁷ The thesis research strategy has established a conceptual and methodological venue relevant for generalizing the thesis' empirical findings. Case sample validity testing as shown in table no. 15: "Validity assurance control", supports within and across comparisons for different classes of case hospitals. Thesis research validity is strengthened through the use of the uniform nature of constructs selected. External validity is present, as descriptive patterns have been identified across case hospitals. Thesis replication logic is supported by the sampling conformity test as shown in table no. 14: "Sampling conformity test". With the exception of regional class hospitals, county and community case hospitals fit the sampling conformity test relevant for public hospitals. Uniform empirical characteristics have been identified through the research methods conformity tests. In summary, it is the thesis position that the findings herein may be generalized to fit the national population of county and community hospitals. It is therefore important to recognize that also the case hospital referenced in the thesis as a university hospital, fits the category of county hospitals. Larger county hospitals are commonly assigned regional and university/country functions. These two classes of public hospitals represent 92 % of the total population of Norwegian public somatic hospitals¹⁹⁸. Certain structural nuances exist within the sample case hospital population. These are identified as significant sampling factors making them important either as a "political case", "typical case" and/or an "opportunistic case".¹⁹⁹ The distinctiveness of the commune governance model applicable to Case hospital no. 1 makes it both a unique *political case* as well as an *opportunistic case*²⁰⁰. Case hospital no 2, as a *typical* local hospital case, attracts empirical attention due to its structural commonalities with all local hospital institutions. The incorporatization of Case hospital no. 3 (Fylkeskommunalt foretak) makes for a *opportunistic* governance case²⁰¹. Equally, the latter hospital may be considered representative of a *typical case*, due to its county hospital status shared with all other county hospital institutions. The descriptive analysis of case hospitals is important when interpreting the significance of governance structure.

SINTEF/UNIMED's SAMDATA publications. On 2001; see SAMDATA sykehus Tabeller; 2/02; particularly chapter 8 "Aktiviteter og kostnader"; p.p. 129-155.

¹⁹⁷ See thesis section 8.3.5 "Case sampling properties".

¹⁹⁸ See thesis section 9.1 "The national population of public hospitals".

¹⁹⁹ See thesis table no. 14: "Sampling conformity test".

²⁰⁰ See thesis table no. 16: "Selected case hospitals".

²⁰¹ Ibid.

To ascertain the true significance of thesis findings, efforts have been made to relate relevant organizational and sociological theories. Hospital culture, values and habitats interact with governance choice processes. Stakeholder groups continuously evolve around the hospital organizations' decision-making processes. Actor-agents' relational influence on organizational decision-making is confronted with the structural powers of hospital internal actor agents. The subsequent summary and conclusions are a stylistic rendering of the thesis findings that denotes the internalization of decisional power within the public hospital.

11.2 Methodological justifications

In the opinion of Grimen (Grimen 2000), the quality of qualitative empirical data is measured by its sociological representation of the empirical field. Such a sociological representation is achieved when the analysis provides an over-all picture of the social activity of a group, an organization or a society. The thesis research's ontological assumptions has been followed (Morgan and Smircich 1980). Morgan's position emphasizes the importance of understanding the empirical context in a holistic fashion²⁰². Ontologically, the thesis rests on its principle presumption as to what constitutes a social phenomenon and in what way it is manifesting itself. In the thesis' contextual analysis one has identified stakeholder groups interacting with hospital organizational decision-making. Actor agents have been analyzed as to their interaction and influence on decision processes and priorities. Stakeholders' cognitive properties have been determined through an interpretation of informants' perception of relevant hospital contextual issues. As such, the thesis' descriptive analysis is representative of stakeholder group behavior as it is manifested in hospital decision-making. The thesis' position on what constitutes social phenomenon, merges methodological individualism and methodological collectivism²⁰³. Methodological individualism calls for the social phenomenon to be explained exclusively by the characteristics that govern individual behavior. Methodological collectivism, calls for social phenomenon to be explained by laws governing holistic events and by explanations of individual behavior related to the positions served within the societal system. With respect to the analysis of hospital stakeholder groups, one is looking at societal actions representative of constituent group interests. Stakeholder group constituents

²⁰² See thesis section 5. "Research question".

²⁰³ Harald Grimen discusses in his book "Samfunnsvitenskapelige tenkemåter" the theoretical precepts for merging methodological individualism and collectivism vested in the philosophies of George C. Homans and J.W.N. Watkins. See particularly chapter 8, p.p. 218-240.

act based upon their common positions, feelings and values relative to the nature of the hospital organization. The thesis is therefore looking at the perceptions and actions of individual constituents behaving in unison to induce social phenomenon represented by hospital decision-making.

In analysing and explaining social phenomenon, the methods chosen reflect the prescribed ontological position. Selected construct variables measure individual action and serve to explain relational properties. The thesis' epistemological stand rests on its ability to collect data representative of both collective and individualistic social phenomenon. Through data acquired from the case hospitals' decision-making processes, one has solicited what may be referred to as social events. Such events are representative of the institution's structural contingencies. Empirical data provide the accounts of social phenomenon. These are representative of individual actions linked together to constitute aggregate pictures of stakeholder characteristics and actions. Thus, through respondent perception, the aggregate accounts of cognitive logic are representative of the group responses to social phenomenon. It is therefore the thesis position that the empirical/descriptive accounts are representative of research merits rooted in scientific ontological and epistemological considerations.

11.3 The reification of leadership

The thesis research question has addressed the issue of organizational decision-making. As has been documented in the analysis of research data, decision-making processes in the public hospital subscribe to formal prescriptions along complex structural webs of governing authorities. The sociologist Max Weber (Jones 2002) and his purported views of (Occidental) rationalism claim that bureaucratization leads to *reification* or an abstraction of formal relationships. Leadership abstraction serves to stifle motivational incentives to rational conduct of performance. To the extent that the public hospital is part of a larger sector governance structure, thesis contentions on leadership reification take on a revelatory position. Organizational decision-making in public hospitals is representative of an extensive interplay of constituent actor-agents or stakeholder groups. Affirmative actions made at the various organizational decision-making levels project a rationale embedded in their respective structural positions. While executive and operations management are shown to merge largely in a common symbolic and a myopic substance of supervision, the clinical ward acts in a detached fashion supported by an embedded position of clinical autonomy. This largely detached form of hospital decision-making processes supports a contention of leadership reification.

This section summarizes thesis contentions that imply a status of leadership reification in public hospitals.

11.3.1 Implicating governance structure

To enable a final conclusion on the empirical findings and to consider its implications, it is necessary to integrate in the analysis the philosophies and principles of hospital governance. These have partly been brought forward in the thesis' contextual and archival records' analysis. It is here important to look at the nature of hospital services as a welfare state benefit viewed opposite the logic of open market transactions. The issue of welfare state principles carries important implications for the governance structure.

Marshall (Marshall 1950) quotes *social citizenship* as representative of the core idea of the welfare state. According to Espin-Andersen (Espin-Andersen 2000), if social rights are (i) granted legal and practical status of property rights, (ii) if they are inviolable, and (iii) granted on the basis of citizenship rather than performance, they will entail a de-commodification status for individuals vis a vis the market. De-commodification occurs when a service is rendered as a matter of right, and when a person can maintain services access without reliance on the market. Thus it is important to view the welfare state not only in terms of the rights it grants, but also take into account how Government activities are interlocked with the role of the market. "The mere presence of social assistance may not bring about such a de-commodification unless they also emancipate the individuals from market dependence" (Espin-Andersen 2000). Thus, the concept of social citizenship also involves social stratification. The welfare state's objective is to maintain a structure of equality in its own right. If workers are market dependent, obviously they are difficult to mobilize for solidaristic action. Thus, the welfare state becomes an active force in the ordering of social relations. In European welfare state development, the issue of de-commodification has been contested. The Scandinavian welfare states tend to be the most de-commodifying. By guaranteeing benefits tailored to modest expectations, a synthesis of universalism in coverage has so far blocked off the market. Notably Norway and Sweden have succeeded in retaining universalism. However, a certain degree of political consensus is required to preserve a political support for the high taxes that such a welfare model require (Espin-Andersen 2000).

In the thesis conclusion, it becomes necessary to understand the State's capacity to uphold its governance model. The model needs to be capable of maintaining a necessary degree of social stratification while upholding the status of de-commodification. The implication rests with system governance structure and the impact carried on organizational decision-making.

In Dingstad's contention (Dingstad 1998), the Scandinavian welfare state is erected within a governance structure based on a philosophy of close supervision²⁰⁴. The Corporative state as developed following Second World War, bears a close resemblance to what Sejersted (Sejersted 2001) refers to as the merging of ideology and special interest groups. According to Sejersted, the ideological guideline has been to harmonize a collective of vested interests. The function of ideology in the Scandinavian welfare system has been to merge constituent and societal interests into a credible alliance.

The basis for this development is rooted in a structuralist form of power dissemination found in Norwegian constitutionalism in the late 19th Century. The latter is generally known as the principle of legality (Sejersted 2001). All public initiatives should be vested in approved legislation. The duty of public governance was to operationalize the legal prescriptions entailed in such initiatives. This constructivist principle in the infallible nature of public governance was vested in a new and optimistic faith in the capacity to supervise national developments. The inclination to increasingly legislate the practices of society represented a philosophy that viewed legislation as an instrumental force to implement national strategies. According to Sejersted, this utilitarianism was rooted in moralistic perceptions tied to the distribution of welfare goods.

The furtherance of the social democratic reforms following 1950 depicts a pattern reminiscent of the early constructivist development. The liberalistic state of the preceding century was based on a program to diminish the State's power through legislation. Governance should ensure instrumental developments in the sense that future events should be predictable and manageable. Now, a new state governance principle emerged. The previous principle of legality presupposed the laws of court to precede the judgements of governance. The new governing practice developed through localized empowerment prescriptions (Fullmaktslover)²⁰⁵. Here governance actors were expected to take the initiatives in place of market-based solutions. The principles of legal facilitation had thus become replaced by a principle of governance process supervision. The new principle of process governance ensured a liberalization of centralized government. This philosophy entailed a democratisation of governance through a wider societal participation.

²⁰⁴ See thesis section 3.1.2 "From pre modern- to late modern hospitals".

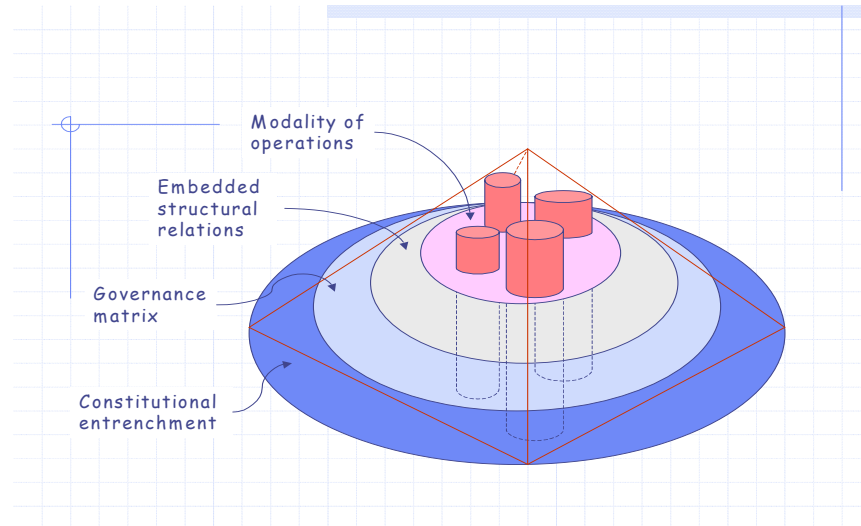
²⁰⁵ These prescriptions ("Fullmaktslover") were originally viewed as controversial measures of governance as they entailed a principle of having the executive branch of the Government ("Regjeringen") independently prescribe the mandate, rights and scope of authority vested in each particular area of application.

Legislation introduced in Norway between 1960 and 2000 demonstrates the operationalization of the new principle of *process governance*²⁰⁶. The thesis demonstrates how this new governing rationale became embedded in the hospital governance structure. Parallel to the introduction of process governance, came a structural resolution. The latter developed as a consequence of conflicts with vested interest parties that did not succeed in accessing the parliamentary processes. The constitutional issues centred around how to legislate democratic participation that served special interest groups critical to the general welfare of citizens. The issue of governance was one of institutionalising a parliamentary form of democracy that ensured localized democratic processes for constituent interest groups. Corporate pluralism²⁰⁷ became the outcome of a constitutional wave of reforms that follow the inception of the principle of localized process governance. Corporate pluralism opened up for conflicts to be resolved between organized special interest groups. A modern and complex society with a growing demand for public regulations, required a framework for cooperation between those who regulate and the regulated (Sejersted 2001). The national arbitrations between hospital governance representatives and employee federations represent the institutionalised processes established to resolve differences between constituent actors. In the next illustration, a model is developed to show the structurally based foundation upon which the public hospital rests.

²⁰⁶ See particularly thesis sections: 3.1.2 “From pre modern- to late modern hospitals”, and 3.2 “The governance model”.

²⁰⁷ Term originally coined by Stein Rokkan (Sejersted 2001).

Illustration No. 20: The sustainability of hospital structuration²⁰⁸



The illustration is a conceptual abstraction of the structurally vested sector system of public hospitals. The illustration's *constitutional entrenchment* refers to the constitutional basis of the county and commune hospital governance. Its legislative history confirms the entrenched nature of its institutional grounds.

The model's reference to *governance matrix* addresses the formal ownership system of county and commune governance. Political and administrative actor agents make up the structure of governance. Influence is facilitated through the legality of structure and the prescriptive nature of formal interaction with hospital management.

The *embedded structural relations* depict the integrated nature of public hospital governance. In addition to the presence of formal governance sector representatives, formalized contractual actor-agents are recognized stakeholders. The principles and practices of corporate pluralism need to be considered.

The hospital's *modality of operations* implies the totalities making up the organizational decision-making scene in public hospitals. Here, all stakeholder groups convene in their efforts to influence decision-making. The model's cylinders symbolize hospital internal stakeholder groups with their organizational roots legitimized in the hospital's structural strata. They

²⁰⁸ In thesis section 10.5.5.3 "The sustainability of structuration and the rationality of systems", it is shown how Giddens (Giddens 1984) conceptualizes his structuration theory representing structure, system and the duality of structures.

represent the complexities of merging diversified stakeholder interests into integrated hospital goals and programs.

The illustration label of “*sustainability of hospital structuration*”, points to the managerial complexities of governance system totalities.

11.3.2 The significance of decision-making homogeneity

Structurally, the thesis’ analysis provides an insight into the significance of system contingencies governing stakeholder interaction in public hospitals. Within this decisional framework, the focus has been on executive, operational and ward management levels. Hveem (Hveem 1996) makes reference to a conceptualization of power that presumes the existence of a conflict acted out between two parties. However, Hveem also points out that influential power may not only be exercised through affirmative decision-making. Reference needs also to be made to a conceptualization of power that includes the ability to defer decision-making or to prevent certain parties and processes from interacting (Lukes 1974). When interpreting the nature of influence, a pattern of issue matter distinctiveness is present. In the thesis, this manifests itself in a preferred constituent role-play attached to the respective organizational levels. Stakeholders seek to safeguard their influential power through upholding their decision-making homogeneity. The latter makes reference to the decision-making preference for organizational matters that are unique to the particular constituent’s organizational level.

The thesis analysis of hospital decision-making has provided an account of organizational priorities and decision-making rationale. The analysis shows that the various organizational decision-making levels work in patterned ways to manifest their relative importance. The major focus of both executive and operations management is on constraining actions attached to resources deployment. The inductive norms are based on subscriptions to cost-effectiveness.

The national pattern of hospital sector governance resembles that of the British National Health Services program outlined in the Government white paper: “Working for Patients” (1989) (Johnson 1993). According to Johnson, the reorganization of the British National Health Service (NSH) was a product of neo-classical economics; i.e., a return to the primacy of market forces and a commitment to competition and effectiveness and consumer choice (Johnson 1993). New Public Management, evolved approximately twenty years ago from Anglo-American and OECD-related prescriptions (Vanebo et al. 2001). The public hospital sector reforms have largely

incorporated the NHS logic and operational rationale of the NPM governing philosophy²⁰⁹.

Executive board directors and hospital operations management express a unison support for cost contingency philosophies. The constituent agents' cognitive rationale verifies the vested nature of the managerial missions of cost austerity. However, these findings are representative of a rational choice paradox. The paradox demonstrates a perceptual conflict between what constitutes prioritized operational choices and what formally is mandated as hospital objectives. In public hospital management, operational means have replaced core functional output as the hospital's ultimate end.

One possible explanation of this sociological phenomenon is Habermas' (Habermas 1991) contention on actors' lack of contextual insight. Another societal theory is proposed by Bourdieu (Bourdieu and Wacquant 1992) who makes reference to Aristoteles' concept of the *endoxa*. An *endoxa* represents the society's common stance on an issue matter. It enjoys the general public's recognition, as it represents a prevailing political position. Statements representative of such a public stance generally receive popular support, as they are perceived to be in line with acceptable political thinking. In the analysis of the respondents' perceptual views on hospital related issue matters, hospital governance constituents are supportive of sector prescriptions. The existence of an *endoxa of cost austerity* in public hospitals appears well rooted among executive- and operations management. This sector *endoxa* has thus become the common sense stand or the general picture of hospital management reality (Solli 1998).

The thesis' confirms sector governance with a singular instrumental pursuit for public hospitals. Administrative measures preclude an equally affirmative pursuit of clinical performance. An explanation for this skewed governance focus may be explained by Foucault's concept of governmentality²¹⁰. According to Johnson, *governmentality* rejects the notion of the State as a coherent, calculating subject whose political power grows in concert with its intervention into the civil society. This is contrary to the constitutional development in Norway, which culminated in the present form of process governance (Sejersted 2001). However, another interpretation of governmentality, as introduced by Johnson, is the institutionalisation of

²⁰⁹ See thesis section: 3.4 "The emergence of corporate logic".

²¹⁰ According to Foucault (Johnson 1993); "The form of government which came to have populations as its object of rule, and political economy as its principle form of knowledge, was an ensemble of institutions, procedures, analysis, calculations, reflections and tactics that in sum constitute *governmentality*; i.e., a very complex form of government". See also thesis section 3.1 "A historical review of the hospital organization".

expertise in the form of professions. Foucault was concerned with the professional expertise as it empowered radical extensions of the capacity to govern. The face value of his propositions may be said to be a State's recognized jurisdiction of medicine as a strategic measure to govern. Modern institutionalised medicine thus becomes part of the apparatus of *governmentality*. The implications of Foucault's theory of the State and the medical profession in it, confirms institutionalised medicine to be part of a governmental ploy. In the latter interpretation, the autonomy and hegemony of the wards and their professional members may be viewed as a master pattern of social control (Johnson 1993).

Ward autonomy provides for a hegemonic decision-making position. It is Freidson's (Freidson 1970) contention that once a profession is established in its protected position of autonomy, it is likely to have a dynamism of its own. It develops new ideas or activities that may only vaguely reflect or even contradict those of the dominant elite. Thesis analysis of empirical accounts supports the picture of a hegemonic position relative to the web of stakeholder groups addressing ward issues. The thesis has not sought to assemble empirical support for a governance sector strategy. However, Foucault's philosophical angle brings into contention Christensen's (Christensen 1994) assessment of the public health's institutional governance. According to Christensen, the representation of members of the medical profession permeates all levels of public health governance²¹¹.

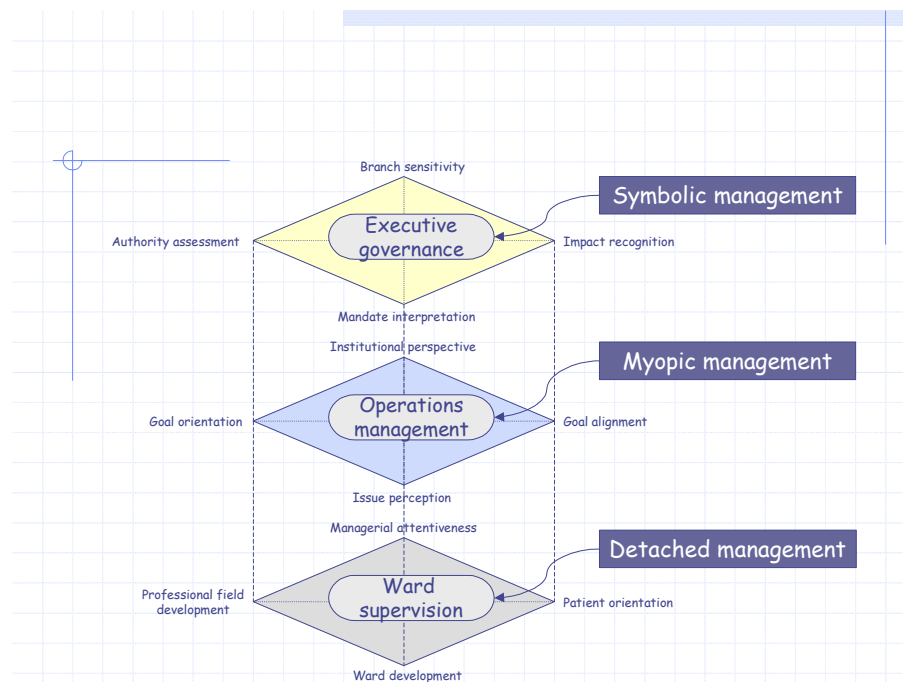
11.3.3 Decision-making sedimentation

The thesis has interpreted stakeholder group power in a hermeneutical focus. Stakeholder intentions have been viewed in terms of their vested interests evident in the outcome patterns of hospitals' decision-making. In the following illustration, focus is on hospital decision-making at the three analysed organizational levels²¹². Thesis' conceptual categories applied in the empirical analysis are shown as they have been employed in the informant interviews. A conceptualization of management performance has been attached to each organizational level. The diagnostic terms applied are indicative of the thesis view of stakeholder group influence.

²¹¹ See thesis section 6.2 "A pathway to a new paradigm on public hospital governance".

²¹² For the analysis of individual decision-making levels of executive, operations and ward management; pls. view illustration no. 9 "Hospital decision-making sectioning".

Illustration No. 21: Decisional sedimentation



The conceptualization of hospital management dramatizes the divergent perceptions inherent at the various organizational levels. In Vike's (Vike et al. 2002) analysis, the contention is that the power of governance actors is determined by their capability to decentralize sector dilemmas. According to Vike, this is not consequential to a planned strategy. It evolves out of complex institutional processes where actor agents lack insight into core operations and the ecology of decision-making processes. The thesis findings partly subscribe to Vike's proposition. The empirical data represents a perceptual focus of executive, administrative and ward management levels. Decision-making commonalities are verified in their joint subscriptions to administrative governance. However, this managerial equilibrium replaces a differentiated perception of organizational priorities. The metaphorical *decisional sedimentation* conceptualizes a segregation of decision-making objectives. Hospital boards' lack of marginal sensitivity to mandated objectives, serves to distance itself from core hospital issues. This is contrary to sector intent as expressed through legislature on hospital board role and executive scope of authority²¹³. Governance prescriptions are

²¹³ See "Lov av 25. september 1992 nr. 107 "Om kommuner og fylkeskommuner"; § 67 "Styrets myndighet".

prefaced in legislation governing public service organizations. In particular, the discussional introduction of legislative intent on public organizations, details the role of boards in public organizations²¹⁴.

As outlined in the thesis' analysis, the board's narrow scope of influential authority creates a governance distance from hospital value creation processes. It is the thesis' contention that boards act largely in a symbolic venue. *Symbolic management* is representative of communicative efforts and relational activities serving a role of an executive figurehead. Consequently, lack of board involvement in organizational decision-making, precludes executive management from influencing hospital strategy and operational position. Its messages of operational austerity and effective production performance is promulgated but without being linked to instrumental action.

The importance of hospital operations management has been the focus of attention in all governance reform prescriptions over the last thirty years. Ever since the passing of the first law on hospitals in 1970, sector governance has sought to establish a modern leadership role. The recruitment, selection and development of hospital leaders have had top political priority. Particularly, with the introduction of the latest hospital law ("Spesialisthelsetjensteloven")²¹⁵, one seeks to ensure an organizational form that facilitates a professional form of leadership. Thesis findings show a managerial practice operationally detached from wards' value creation processes. Management's goal orientation is scaled to fit administrative services. An active interaction with sector governance and hospital internal system audit groups, takes precedence. Planning processes are confined to administrative subscription as introduced by governance representatives. Such facilitative measures carry little significance to strategic direction and prioritized actions. Nor is operations management critical to the wards' interaction with outside stakeholder groups. As with the board of directors, this narrow scope of operations management involvement is contrary to legislated and prescribed governance intent. Governance prescriptions on hospital leadership authenticate management involvement in the total scope of hospital activities.

Drawing on marketing literature, and particularly Theodore Levitt's criticism of John Kenneth Galbraith's (1968) view of advertising as an artificial want creation (Grant 1999), the term *myopic management* is applied. The term "*myopic*" is defined to mean "shortsightedness or lack of discernment in

²¹⁴ Ot prp nr. 53 (1997-98) "Om lov om interkommunale selskap og lov om endringer i kommuneloven mm (Kommunalt og fylkeskommunalt foretak); see specifically section 2.2.3 "Styets kompetanse", p.p. 23-24.

²¹⁵ See specifically § 3-9 "Ledelse i sykehus".

thinking or planning”²¹⁶. The thesis analysis of hospitals’ operations management establishes a picture of shortsighted organizational focus. The institutional perspective calling for over all strategic thinking and corresponding action, is lacking. Missing too is the operational interaction with the clinical wards, normally assuring for contextual comprehension.

The thesis analysis of stakeholders’ perceptual characteristics at ward level, confirms a regression within the health staff. As the ward is organized around the knowledge system it applies, it explains the close integration existing between stakeholder groups. The health professional groups’ influential power is largely vested in the cultural basis of their own work. Managerial prescriptions are without merit for the medical profession. Ward’s health professional groups produce a tangent set of actor agents, with separate cultures and augmented logics. The thesis’ analysis depicts low ward attentiveness to management issues. Focus on clinical development is marked by goal alignment along the logic of professions. Clinical staffs work together but in their separate ways. Differentiated professional logics warrant separate solutions to professional development and institutional orientation. This lack of integrated team-based operations makes common purposes harder to reach agreement on. Parallel but incompatible cultures within the ward units make clinical work fragmented and difficult to supervise. Ward management works detached from other managerial levels within the hospital. Within the ward, the respective stakeholder group work under differentiated perceptions of medical merits, patient care orientation and resources effectiveness.

The contentions of ward professionals’ desire for autonomy may in part be a myth. According to Harrison (Harrison and Pollitt 1994), the autonomy presumably enjoyed by professionals, is partly illusionary. The medical profession is heavily influenced by the socialization established with its external network. The thesis confirms a close stakeholder liaison with critical suppliers. A critical issue becomes one of determining and recognizing the stakeholder balance of power between ward actors and critical suppliers.

The issue of hospital controversies generally concerns the access and availability of resources. This is the focal point of management-ward interaction. The empirically confirmed gap between operations management and ward supervision is a void of critical significance. In so far as this managerial breach may be regarded as an absence of leadership, it makes room for staged and manipulative stakeholder behavior (Habermas 1991). It is important therefore to recognize the purposive nature of decision-making by agent participants.

²¹⁶ The American Heritage Dictionary of The English Language.

11.4 A third dimension of stakeholder group influence

11.4.1 Welfare state empowerment

The thesis introductory quote from Jan Grund (Grund 1995), expresses a certain distress with what he perceives to be the “game” governing the exchange processes within the public hospital system²¹⁷. Vike (Vike et al. 2002) confirms that this analogy is commonly applied to describe a relational dimension pattern of behavior between constituent actors in structural processes. According to Vike, actor-agents at managerial levels, naturally keep an emotional distance to issue matters that are handled. Structural processes represent a second dimension of formalized or contractualized relationships. Vike accepts the likelihood also of a third dimension, a moral dimension of such exchange processes. However, any clear-cut boarder line between stakeholder “games” and value-based exchanges has not been empirically determined. The thesis does not distinguish between good or bad stakeholder group exchanges. Nor have any value-based issues been identified as opposed to clear-cut contractually vested accounts. However, the nature of welfare services developed does introduce the potential for a cultural dimension entailed in the moral dimension of exchange relationships. As such, it is important to account for how any value-laden residue from a cultural dimension impacts the level of influence as exerted by a stakeholder group.

A common conceptualization of the public hospital is one whereby services are produced outside the intervention of the market forces of supply and demand (Vike et al. 2002). Resource allocation processes vested in a predefined public health policy, governs its distribution. Ogden’s (Ogden and Watson 1999) optimum stakeholder “fit” is attained when the expectations of stakeholder groups’ are balanced. Throughout the thesis’ contextual analysis, one has focused on the structural dissemination of power. Decision-making authorities have been identified commensurate with constituents’ mandated position and the correspondingly vested scopes of authority. Stakeholder groups’ interaction establishes a web of constituent actors where vested interests are addressed and acted upon. The emerging pattern of influence may easily be interpreted as a continuum of stakeholder confrontations where hierarchical position and resource capacity are the only critical variables.

Part of the thesis’ epistemological challenge has been to ascertain how the very nature of the welfare product itself may be representative of a source of power. Vike (Vike et al. 2002) argues the relevancy of a product’s

²¹⁷ See thesis section: 1.1 “Intent of the study”.

symbolic value (*tegnverdi*)²¹⁸. This symbolic value associated with sector services entails a social codex grounded in the hospital's value creation processes. According to Bourdieu (Bourdieu and Wacquant 1992; Bourdieu 1984), the product codex functions as a "passionate force" rather than as an objective structural representation of the social phenomenon. It is Vike's argument that this codex or symbolic value is a cultural phenomenon serving to enhance constituent identity. As such, it also serves to permeate the actor agents' cohesive actions. This contention may here be considered an extension of the relational dimension of stakeholder power. A support for such a third dimension of power is also provided by Lukes (Lukes 1974) who purports that an issue matter's ideological scope represents an influential force.

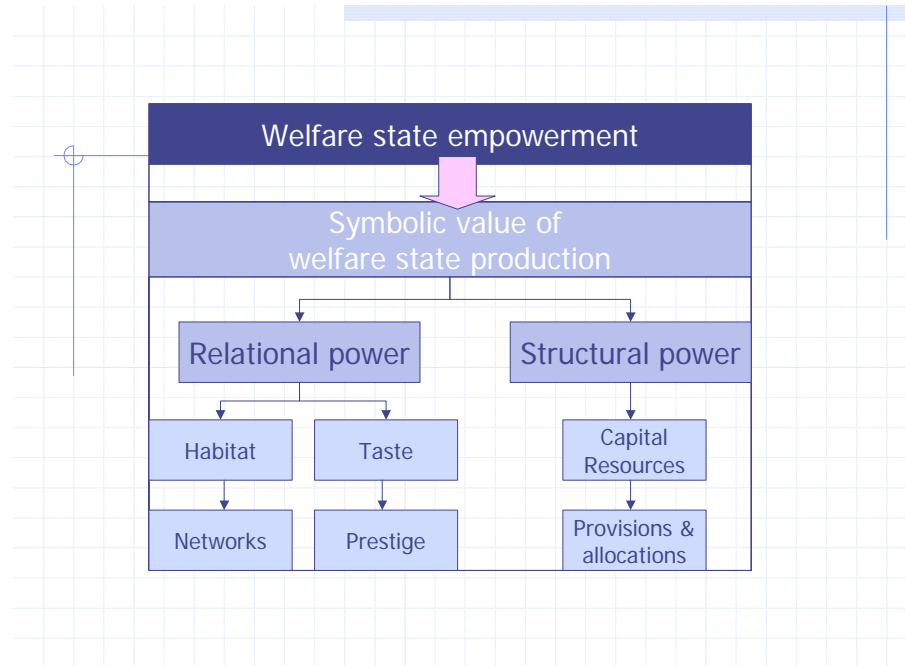
Vike labels Bourdieu's *symbolic value* as a driving force in an institution's value creation system. Thus, the actor agent's proximity to an organization's symbolic value creation enhances the stakeholders' structural mandate and relation position. It is Bourdieu's (Bourdieu 1984) contention that the control of the cultural capital, provides the constituent agent with a capacity to exercise influence by means of a manifested superior cultural position. The value creation and exchange processes in complex organizations thus become associated with a power differentiation in stakeholder exchange processes²¹⁹.

The thesis' visualization of the welfare state's structural and relational empowerment, as embedded in the cultural dimension of hospital stakeholder power, is presented in the following illustration:

²¹⁸ Vike's contention is drawn from Bourdieu in his "The Political Economy of the Sign" (1998).

²¹⁹ This contention follows Michael Kearny (1996) and the latter's analysis of Baudrillard's and Bourdieu's perception of power as a medium of exchange.

Illustration No. 22: Welfare state empowerment²²⁰



Evident from the illustration is the transfer of the symbolic value of welfare state production, or the cultural contingencies attached to hospital health services. Secondly, the structural and relational capital sources of power are displayed through the actor-agents' influence. Such influence has been established through their professional networks and prestigious positions. Friedson (Friedson 2001) uses the term "ideology" when referring to the institutions of professionalism. As shown in the analysis, doctors and nurses project claims, values and ideas that provide the rationale for their acclaimed views. As such these ideologies permeate their vested positions on constituent issue matters.

11.4.2 Relational influence on organizational decision-making

The following table is developed based upon an analysis of the significance of stakeholders' relational powers as applied to hospital organizational decision-making.

²²⁰ The conceptual categories "Habitat" and "Taste" is taken from Vike's (Vike et al. 2002) outline of Baudrillard's contention on the symbolic value of product items ("The Political Economy of the Sign", 1998).

Table No. 48: Relational power

Organizational decision-making level			
Sources of inductive power	Executive governance	Operations management	Ward supervision
Professional membership	Weak decision-making influence	Weak decision-making influence	Strong decision-making influence
Professional field association	Weak decision-making influence	Weak decision-making influence	Strong decision-making influence
Empirical access	Weak decision-making influence	Marginal decision-making influence	Strong decision-making influence
Professional network	Weak decision-making influence	Weak decision-making influence	Strong decision-making influence

	Strong decision-making influence
	Marginal decision-making influence
	Weak decision-making influence

With respect to managements' interaction with external stakeholder groups, issue matter outcome is contingent upon the value based or ideological position. As such, professional membership is significant as constituent power. The thesis has also found that membership in, or a professional association with a medical speciality, is equated with professional prestige. Such membership is assumed to ensure of proximity to professional networks and possibly access targeted resources²²¹.

It is equally a source of relational power, that constituents are able to provide credible evidence of access to patients as part of a larger empirical field consideration. Finally, represented by the medical profession, hospital institutions and industrial representatives, make up a formidable stakeholder grid based on common constituent interests. The synergistic forces of such a

²²¹ This conclusion on the importance of networks reveals a close parallel with the distribution of power within privately owned firms, or corporations. In Engelstad (Engelstad 1999) recently published work on the significance of societal power ("Mot en ny maktutredningen"), he emphasizes the significance of information flow and the organization of network alliances as significant sources of firms' inductive power.

*pharmaceutical/industrial - hospital complex*²²² carries significant implications for ward planning and operational direction.

As shown in table no. 48, decision-making levels are reviewed applying sources of inductive power, as analytical agents. A strong affirmative picture emerges with respect to the ward stakeholder groups' influence; i.e., doctors and nurses, with a capacity to influence decision-making based on their relational powers. As is shown in the table, both executive governance and operations management representatives are considered to carry only marginal influence based on the same analytical merits.

11.4.3 Structural influence on organizational decision-making

A similar comparative analysis has been developed on the hospitals' structural power agents. Strange's (Strange 1988) analysis of political power systems, contends that structural power generally is more important than relational power. The former commonly includes financial, production and knowledge systems' power agents. As the thesis has attached skills and professional knowledge to what is termed relational power, one is here left with the two agents governing resources allocation and deployment. Structural power as related to the public hospital sector is relevant to assigning and employing capital provision for hospital operations. The following table evaluates hospital stakeholders' decision-making capacity related to their structural position.

This distribution of inductive power as herein analysed, is reflected in the following table comparing the relative power of management agents.

²²² Arnold S. Relman, editor of *The New England Journal of Medicine*, alerted his readers in 1980 to a rise of a "new medical-industrial complex" as the most important health-care development of the day. Relman wanted to distinguish the growing business that sold health services to patients for a profit, such as walk-in clinics, health chain hospitals, dialysis centers and home care companies from the "old" complex of firms that sold drugs, equipment and insurance (Starr 1982 p. 429).

Table No. 49: Structural power

Sources of inductive power	Organizational decision-making level		
	Executive governance	Operations management	Ward supervision
Structural integration	Strong decision-making influence	Marginal decision-making influence	Weak decision-making influence
Sector network	Strong decision-making influence	Marginal decision-making influence	Weak decision-making influence
Production control	Weak decision-making influence	Marginal decision-making influence	Strong decision-making influence
Employee federations	Marginal decision-making influence	Marginal decision-making influence	Strong decision-making influence

Strong decision-making influence
 Marginal decision-making influence
 Weak decision-making influence

The executive management's proximity to the political and administrative governance agents confirms its access to sector governance. The hierarchical distance between sector governance and core clinical activity naturally precludes the ward's immediate access to structural power regimes. As concluded through both the informant analysis and the study of archival records, the dissemination of structural power is served by complex matrix solutions. This is evident in a differentiated access to governance agents. However, as a general picture, the table depicts a linear communication structure. Here, managerial proximity to sector governance provides a correspondingly stronger negotiating position.

A distinction is made in the table analysis between structural integration and sector network. This implies that due consideration is given the complex web of hospital sector governance. As has been discussed in the thesis' contextual analysis, a range of sector audit offices partake in the supervision of hospital activities. To balance its operation and priority for clinical activities, it becomes a managerial prerequisite to incorporate the concerns of these audit groups. Again, the thesis applies the same contextual logic of equating hierarchical distance with stakeholders' inductive power. While the analysis of informant interviews confirms a somewhat differentiated picture between the hospitals, the general conclusion stays firm.

In her analysis of structural power in national and international politics, Strange (Strange 1988) emphasizes the significance of production control. Within the modern public hospital, resource allocation receives prominent focus as the public hospital sector is allocated a significant share of the nation's resources²²³. Divergent views reflect both differentiated philosophies on the welfare state as well as mirroring dispersed perceptions of governing logics. However, as stated by Østenrud (Østerud 1999), the precondition for the welfare state is the adequacies of resources capable to ensure its growth. The proponents of New Public Management place their trust in the efficient allocation of resources. Such a strategy carries consequences for the production of welfare goods and the national economic well being in general²²⁴. With the ward's direct resources supervision, its impact on priorities and its efficient use is paramount. While executive and operations management clearly influence the budgetary processes, ward management is representative of a supremacy position. Ward staff members demonstrate their capability to impede and defer management measures addressing capital-intensive clinical activities. As proposed by Williamson (Williamson 1996), many dependency issues may be addressed in efficiency terms, whereupon power considerations largely vanish. However, ward autonomy, combined with the health professions' exclusive skills position, implies a significant control of resources deployment. Thus, the ward's influential power vested in its structurally based position provides for an immense stakeholder position.

The significance of employee federations in organizational decision-making issue matters is not uniformly confirmed. Managerial informants point to the federations' in-house presence as being obtrusive to efficient resource administration. Rigid, collectively arbitrated agreements on employment terms and conditions are said to impede flexible staffing solutions. Judged by the contextual analysis and informant interview data, employee federations represent a strong stakeholder group position. Hospital internal employee federations' integrated promulgation of their vested issues may carry a significant consolidated weight opposite hospital management. Christensen (Christensen 1994) traces this latter contention to the initial

²²³ An analysis published by Health Affairs (Anderson and Hussey 2001), ranks Norway fifth among OECD-countries on health care spending; i.e., 8.9% of GDP (Gross Domestic Product); behind the US (13.6%), Germany (10.6%), Switzerland (10.4%) and France (9.6%).

²²⁴ Details on the Government's public change program governing resources efficiency is published in government white paper NOU 1991:28 "Mot bedre viten. Effektiviseringsmuligheter i offentlig sektor", and "Stortingsmelding nr. 4, 1987-88, "Perspektiver og reformer i den økonomiske politikken".

presence of the medical profession in governance agencies. According to Christensen, the medical profession is in a unique position to promulgate its position on what is to become the legalized practices of medicine. Other associated prescriptions secure the placement of staff and their skills progression programs. Committees staffed by members of the medical profession induce national policies governing patient grievances procedures. The Norwegian medical association (Dnlf) promulgates national strategies on the structure, organization, staffing and supervision of public hospitals. Nationally arbitrated agreements on employment terms and conditions represent the localized negotiation framework within the respective hospitals. The remedial action subsequent to a local hospital labor conflict empowers the employee federations to deploy measures carrying significant impacts on the hospital's resource position.

Since its national inception following the Second World War, the principle of *collective pluralism* has established an organizational form of democracy. The purpose of this has been to secure rights and privileges commensurate with the ideals of the welfare state. One argument is that negotiated employment conditions ensure organizational stability and a good working climate. In sum, this enhances productivity (Østerud 1999). While the thesis does not take a stand on the issue of hospital efficiency, it finds empirical support for the influential position of employee federations. Their strong stakeholder position is established in part by the comprehensive organizational framework of interconnectedness.

11.5 Precursors to new organizational leadership paradigms

11.5.1 Governance paradigm developments

The major issues surrounding governance of the public health programs following World War II has centered around balancing between continual cost efficiency reforms on one side, with the politics of welfare on the other. The continual conflict of political vs administrative governance causes persistent tension. Also, the governance model in operation at any one time influences the interplay between public hospital stakeholder groups. In order to assess the relevancy of public hospital decision-making, one needs to better understand past and present governance paradigms.

Table no. 50 "Governance paradigms in Norwegian public hospitals" summarizes key development trends in public hospitals governance since 1980. Each decade identified, highlights the utilitarian governance that has permeated public health reform thinking. Each paradigm is given a conceptual label characteristic for the period's prevailing governance logic and management rationale.

The governance prescriptions introduced in the 1980's prioritized improved decision-making procedures subscribing to detailed planning processes. As pointed out in the thesis' contextual analysis, the prescriptive governance measures of the 1980's came in response to preceding decades of capacity expansion. Calls for expanded internal control regimes made for a rigid and inflexible governance system. The Norwegian adoption for what in the 1990's became known as New Public Management, combined the planning and audit prescriptions of the 80's with what may be called a neo-classical industrial logic that sought to optimize cost-efficiency and effective production systems. The prevailing over-all political challenge has been one of determining how far one would be willing to go to facilitate operational autonomy independent of political control (Christensen and Læg Reid 2001). It is Christensen's contention that the NPM-programs to improve resource efficiency actually are compatible with established public management traditions. The next decade of the new millennium (00's) is so far recognized by an institutional logic supportive of contractual management. System changes have created a governance modality that lessens the broader scope of political supervision. The overriding principle has been one of avoiding service units embedded in overlapping organizational structures. New and structurally divested entities are believed to improve value creation processes based on specialization. In this new paradigm public hospitals distinguish between owner (*eier*), audit regulator (*regulator*), procurement agent (*bestiller*) and provider (*utfører*). (Christensen and Læg Reid 2001). Consequently, the interactions between stakeholder actor-agents appear more pronounced. The NPM-dimension of contracting management incorporates exposing public services to open market competitive bids and privatization of non-core public services. The overriding logic is to have market mechanisms replace centralized governance and performance audits. The instrumental objective is improved cost efficiency of public services. An immediate problem thus becomes one of coping with differentiated services levels that introduce the potential for inequality, discrimination and social disintegration (Blomquist and Rothstein 2000).

The accelerating rate of public service reforms, dramatizes the need for a continuous reassessment of the role of public governance. Paradigm anomalies may be identified both in terms of the context of discovery and in the justification of content (Kuhn 1962). Following March and Olsen (March and Olsen 1984); "what we observe in the world is inconsistent with the ways in which contemporary theories ask us to talk". Present-day stakeholder theory is based largely on normative/philosophical theorems on the intrinsic value of all constituent interests. Considerations afforded constituents are grounded in our societal norms and values. From championing a State representing a "collective moralism" through a

“governing state”, Christensen perceives of “the State as a supermarket” (Christensen, Lægneid, and Zuna 2002). Christensen perceives this scenario as an extension of to-days NPM governance prescriptions. The State as a supermarket emphasizes service user participation. Cost efficiency is achieved through open competitive solutions between actor-agents. Public governance excels through innovation and continuous improvement processes. Under such governance regimes, organizational forms and management logic will increasingly emulate the private sector. This supports the paradigm anomalies as pointed out by Christensen. The next paradigm of public hospital governance may therefore be marked by a compliance logic toward competing stakeholder groups. Decentralized governing structures and liberalized market operations will necessitate strategic management logic. A consequence of this, public hospitals thus need to integrate management programs that promote a value creation logic rather than the present day cost supervision rationale. Continued patient empowerment may introduce the opportunities for strengthening patient proxies. The emerging hospital insurance programs may empower patients to seek treatment solutions established through national and/or international medical services networks. Theoretical implications tied to this new public hospital governance paradigm will be introduced in the subsequent section. Public hospital paradigm characteristics are detailed in the next table.

Table No. 50: Governance paradigms in Norwegian public hospitals

80's Administrative logic	90' Industrial logic	00's Institutional logic	10's Compliance logic
Prescriptive Management	New Public Management	Contractual Management	Strategic Management
Expansion curtailment Administrative systems control Planning and achievement orientation Governance actors' resolve participation	Functional supervision Balanced budgets Production incentive systems Cost based accounting and reimbursements	State ownership Structural realignments Reframing hospital organizations Market liberalization Management systems	Value creation logic Integrated solutions Multiple source financing Market harmonization Patient empowerment Dissolving professional hegemony International health services networks

11.5.2 Paradigm relevancy to public hospital leadership

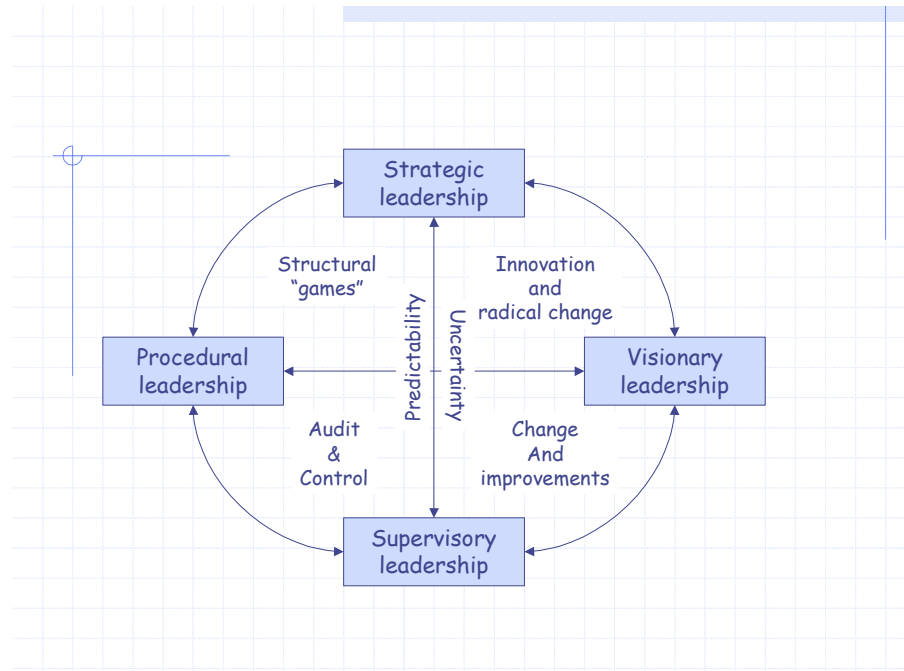
11.5.2.1 Decision-making positions

Hospital leadership is considered critical to fulfilling sector obligations²²⁵. The concept of leadership is in itself a term that contains many facets and invites many definitions. Relevant definitions commonly distinguish between leadership that either is focused on: (i) prescription of procedures (ii) supervision of common goals (iii) subscription to over-all organizational strategies, or is focused on (iv) transformation type leadership that pursues visionary goals. Entailed in all four leadership modalities is the need to make affirmative decisions. Within the context of public hospital organizations, leadership that secures organizational decision-making is

²²⁵ Reference is made to newspaper article in DN (Dagens Næringsliv), dated 12.02.03 in which plans for a national leadership program is announced for leaders in public hospitals. Excerpt quote: "We have assumed a State role for the national governance of public hospitals. Now we will pursue a common national program for the development leaders. We have many leaders in the public health sector, but too little leadership".

critical to stakeholder influence at executive, operations and ward management levels. Decision-making may also be considered a source of conflict as to what can be done and how it may be done (Freidson 1986). As such, organizational leadership requires managerial attentiveness to both structural and process-type operations. According to Hemphill and Coons (Andersen 1995), “leadership is the behavior of an individual when he is directing the activities of a group toward a shared goal”. Roach and Behling contend that leadership is “the process of influencing the activities of an organized group toward goal achievement” (Andersen 1995). Erik Johnsen combines the attentiveness to leadership function and leadership action. His sum leadership conception becomes one of goal-setting, problem-solving and communicative interaction between people (Busch and Vanebo 1996). The thesis has placed the conceptual extremities of decision-making processes within a coherent framework governed by decision-making style. The result is a conceptual illustration of the process requirements generated by leadership style.

Illustration No. 23: Decision-making processes and leadership styles



In order to identify the hospitals’ decision-making position, the properties of the various conceptual paradigm positions need to be defined. These are introduced in the next table.

Table No. 51: Decision-making processes

Decision-making processes	Process characteristics
Innovation and radical change	Organization processes are marked by innovations and radical changes.
Change and improvements	Organizations are marked by capacity to adapt to changing demands and improvement needs.
Structural “games”	Organization processes are marked by prescriptive governance that is vested in contractual relationships.
Audit & control	Organization processes are marked by detailed governance supervision of operations management.

11.5.2.2 The distinctiveness of the hospitals analyzed

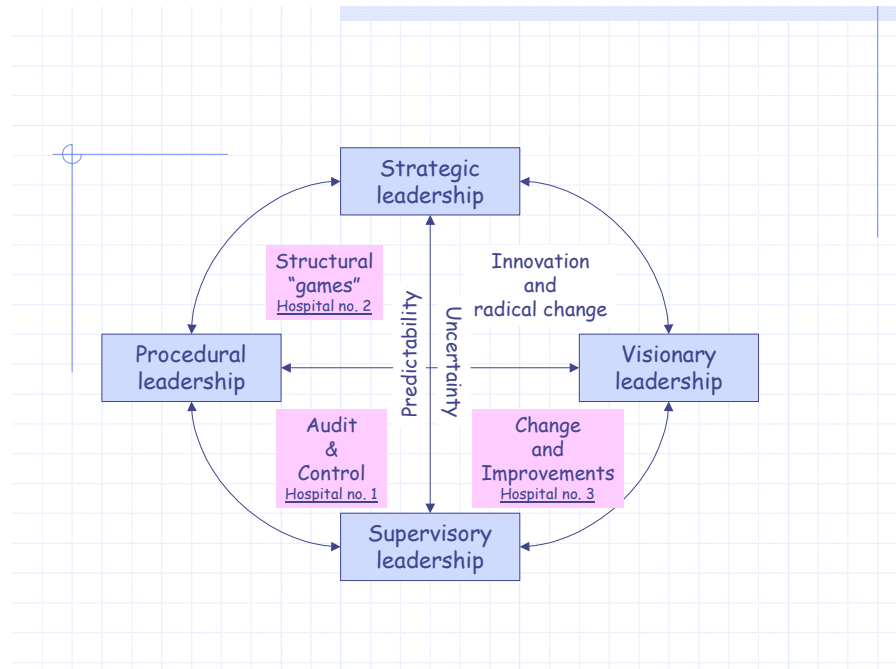
In an analysis of the hospitals’ operational characteristics relative to decision-making processes evident in the thesis empirical research, the conceptual distinctiveness of class hospitals becomes evident. This knowledge is important as it serves to solidify class hospital generalizations. All three hospitals analyzed are uniform in the sedimentary character of decision-making. Executive and operations management’s resource based planning and control schemes clearly places particularly hospital no. 1 in the “audit & control” position (see illustration no. 24). The hospital’s strained reporting relationship with both its board and its city health planning agency has so far precluded any operational autonomy progressing along the lines of newer paradigms of governance. Hospital internal hegemonic decision-making at ward levels serves to deteriorate management’s leverage position opposite its executive superiors. Hospital no. 1 is still governed by the paradigm of prescriptive management reflected in strict administrative supervision and control.

At hospital no. 2, management acts within the confines of a governance paradigm of New Public Management and its industrial logic. Governance rapport is good as hospital management conforms to calls from above for resource efficiency and budgetary prescriptions. Subscribing to DiMaggio’s contention (DiMaggio and Powel 1983), abidance by governance prescriptions may not be for reasons of perceived operational efficiency, but to increase their legitimacy, resources and survival capabilities. Thus, the thesis places hospital no. 2 in the leadership decision-making process sector of “structural games”. Informants testify to management’s capacity to “play” governance actors in order to optimize sector norms and conditions.

Within its new incorporated ownership structure (Fylkeskommunalt selskap), hospital no. 3 is in transition from a New Public Management paradigm to the present logic of contractual management. Complex matrix relationships with executive board, political and county administrative governance agencies are part of the past. Hospital management and its executive board are reframing a reporting relationship based on contractual properties. While the hospital is still marked by sedimentary decision-making, management is actively taking steps towards structured change processes. While the informant feedback testifies to only marginal success, it nevertheless marks a concerted effort on behalf of management to integrate planning and controlling processes. The position of the thesis is therefore to place hospital no. 3 in the category of “change and improvements” decision-making processes. A continued practice along this type of decision-making requires attentiveness to a broad range of hospital stakeholder groups to alleviate risks associated with constituent compliance.

The pattern of organizational decision-making processes confirms class hospital positions as shown in the following illustration.

Illustration No. 24: Decision-making paradigm positioning



11.5.3 Theoretical contributions

11.5.3.1 The nature of decision-making instrumentality

The research question is believed to represent a significant societal concern. The thesis has set out to produce a plausible and empirically defensible explanation of the phenomenon of stakeholder influence. The true task of the research has been to gain an insight into what one may call the empirical reality. The preceding summary and conclusion, represents the thesis' descriptive analysis of relationships between hospital stakeholder groups. It purports social relations based on construct relationships identified through empirical observations. Stakeholder relationships have been shown as to the influence exerted on decision-making outcome. Contentions on stakeholder groups' influential powers are based on ontological assumptions and an epistemological position on the realism of having captured targeted events. To guide this empirical process, the thesis has employed theoretical-conceptual models that address contextual field phenomenon.

The following propositions reflect thesis explanations of how stakeholder groups influence decision-making. In Troye's (Troye 1994) view, it is important that theoretical propositions reflect factual empirical accounts. Bourdieu (Bourdieu and Wacquant 1992) points to a need for the researcher to practice reflexivity. This points to the need to consider both the empirical *evidence* and the reflections of the researcher. According to Troye, the most important outcome of theoretical reflections is an awareness of the interpretative venues and how these influence the realizations of a contextual reality.

Drawing on Troye's (Troye 1994) conception of four critical domains for relevant research contingencies, one has tabulated the following research audit reference scheme.

Table No. 52: Audit: Four domains of research

Substantial domain	Decisional domain	Theoretical domain	Methodological domain
<ul style="list-style-type: none"> • Stakeholder presence • Stakeholder behavior • Stakeholder power • Stakeholder achievements 	<ul style="list-style-type: none"> • Through Governance decrees and prescriptions • Through governance actions and interactions • Organizational decision-making • Stakeholder relations • Stakeholder interactions 	<ul style="list-style-type: none"> • Stakeholder theory 	<ul style="list-style-type: none"> • Informant interviews • Archival records

The thesis' perceptual accounts appear uniform along horizontal organizational strata. However, viewed in a hierarchical context, the stakeholder groups' cognitive profiles are non-congruent within the conceptual categories analyzed. The empirical field's substantial domains show a clear presence of viable stakeholder groups. Empirical data presents evidence of stakeholder interaction differentiated by environmental origin and vested interests. Stakeholder power is shown to be disseminated in a detached fashion, where the stakeholders exert their influence along plateaus of hegemonic group reigns.

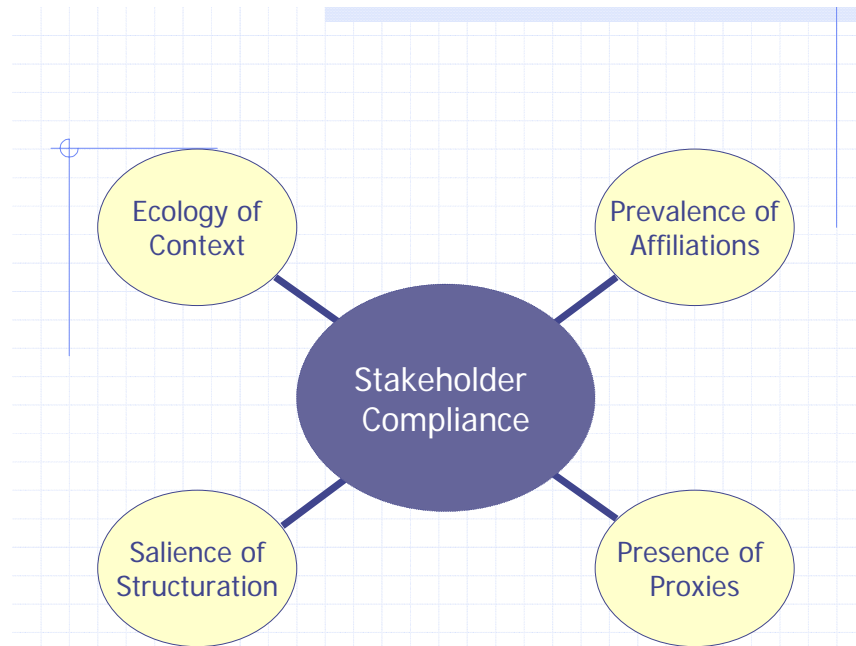
Stakeholder theory seeks an instrumental position on how constituent interests may be balanced in decision-making situations. The traditional stakeholder "fit" (Ogden and Watson 1999) represents an ideal balancing point between the dynamic forces of supply and demand. In the case of the public hospital, the governance of regulations, hegemonic positions, and societal norms replace the dynamism of open market operations. Public service users, suppliers and proxy agents work in integrated patterns with hospital internal representatives to resolve system needs and constituent expectations. According to Etzioni (Etzioni 1971), compliance theory reflects a basic thesis that organizations differ along the suggested dimensions in the means of control they apply. This situation effects organizational actors' nature of involvement with lower participants. Compliance represents a major element of a relationship between those who wield influence and exert power over those on whom they exercise it (Etzioni 1971)²²⁶. Complex organizations such as public hospitals require compliance in the multifaceted exchange relationships between constituent groups. The empirical analysis of the public hospitals shows a decision-making sedimentation structure that differs in its compliance rationale. Each decision-making level is shown to have cognitive spheres unique to its contextual position. The analysis of stakeholder informants shows how cognitive orientations differ between constituent groups relative to their organizational level.

A stakeholder consensus model built on the presumptions of cognitive congruence, acknowledges the practice of differentiated influential means and their applications. The following illustration is a conceptualization of

²²⁶ Compliance refers here to both a relation in which an actor behaves in accordance with a directive supported by another actor's power, and to the orientation of the subordinated actor to the power applied. By supported, Etzioni relates this term to "those who have the power manipulate means by which they command in such a manner that certain other actors find following the directive rewarding, while not following it incurs deprivation. In this sense, compliance relations are asymmetric (or vertical)" (Etzioni 1971).

organizational decision-making addressing the multiplicity of the public hospital's stakeholder groups. The model's instrumentality is vested in the universal relevancy of differentiated applications of influential means. This is determined by organizational levels and by the nature of constituent issue matters. As such, instrumentality here connotes the predictability of differentiate influential means employed when faced with a diversity of stakeholder group interests.

Illustration No. 25: The axiomatic characteristics of decision-making



The salience of structuration, as identified in the empirical analysis, empowers formal governance through mandated tasks and authorized scopes of responsibility. Structural and systemic power normally incorporate remunerative measures. In *the ecology of the organizational context*, normative power mobilizes both structural and relational means of influence to attain desired objectives. Etzioni (Etzioni 1971) defines normative influence as resting on organizational manipulation of symbolic character.²²⁷

²²⁷ One may say that the interaction of hospital internal stakeholder groups are marked by what Greenwood labels "environmental determinism" (Greenwood and Hinings 1996). Such determinism is, according to Greenwood, based on "the political dynamics of intra-organizational behavior".

The model's *prevalence of affiliations and the presence of proxies*, connote the hospital's relationships with external stakeholder groups. The presence of external stakeholder constituents and their exchange relationships with internal stakeholder groups, invites the exercise of *coercive power*. According to Etzioni (Etzioni 1971), coercive power rests on the application of sanctions and restrictions to control the exchange outcome through strong influential application. These various forms of decision-making powers have all been identified in the thesis' empirical analysis, as have been also the descriptive accounts of constituent interchange.

11.5.3.2 A descriptive/empirical stakeholder theory

The thesis' empirical account of the hospital context disqualifies present normative paradigms on stakeholder management. Their theoretical content, rooted in classical and post-modern normative prescriptions, is not reflected in the thesis' empirical reality. As hereby expressed in the thesis' proposed "stakeholder theory of detachment", stakeholder management is projected to work counteractive to the balancing of otherwise bona fide stakeholder interests. Empirical accounts show how public hospital governance promotes instrumental management action that suppresses an organizational focus based on the multiplicity of constituent interests.

The following table outlines the proposed theoretical descriptive/empirical proposition as rooted in the thesis' empirical reality and as vested in the reflexive consciousness of the researcher.

Table No. 53: Propositions on descriptive/empirical stakeholder theory

Theoretical proposition on the "Balance of stakeholder management"	Descriptive nature of theoretical propositions	Thesis summary reference to supportive empirical contentions
"Stakeholder balance of detachment"	Implies that stakeholder management in public hospitals balances stakeholder interests relative to an operational agenda within their own organizational confines.	11.3.2 Decision-making homogeneity <ul style="list-style-type: none"> ○ The significance of decision-making homogeneity 11.3.3 Decision-making sedimentation <ul style="list-style-type: none"> ○ The segregation of organizational decision-making

It is believed that this theoretical proposition is consistent with the thesis' descriptive summary, coherent in the structure and comprehensible as it

serves to reaffirm the answer to the research question. The table provides specific reference to the thesis' analytical summary. As such, it permits future research to confirm methods and procedures when research replication is sought. Finally, the propositions' theoretical position is vested in the venues of existing stakeholder theory. The proposition introduced is focused on stakeholder group behavior as it explicates management of stakeholder group interests.

Normative stakeholder theory emphasizes the present-day paradigm of connecting social values with social relations in stakeholder management. The thesis provides a descriptive account of how such relations purport to exist within a contextual environment. Thus, the theoretical proposition is consistent with past and existing stakeholder theory in the sense that it focuses on stakeholder management vested in decision-making behavior.

11.5.4 Implications of the present paradigm on organizational decision-making

According to Haukaas (Haukaas 1997), whenever public organizations are established, positions of power are considered. Thus, the hospital sector authorities are continuously faced with the classical issue of politics: Either to conduct the politics of creativity (*la politique politisante*) or the politics of routines (*la politique politisè*)²²⁸. According to Sejersted (Sejersted 2001), the art of public governance is aimed at accomplishing a proper balance between these two forms of politics. A logical presumption is one where the political considerations are viewed *a priori*; i.e., where the degree of governance leaves the substance of specific action to an autonomous operation (Sejersted 2001). The welfare state in Norway rests on a philosophy that works to preserve a de-commodified public health service system in a fully stratified society (Espin-Andersen 2000). This presupposes a governance of "*la politique politisante*". This entails that the welfare state rejects a transfer of the creative and specific action to market-based solutions. Thus, public health governance has been exempt from the philosophy of the liberal State and its programs of process supervision. Prior to Januar 1, 2002, public hospitals were governed through a regionalized system vested in counties and communes. The sector favored instrumental measures that assured effective resource application. The recent introduction of a state-based ownership and governance model, presupposes the continuance of a centralized hospital governance system

²²⁸ The concepts are from Jon Elster's "Contradiction" (Sejersted 2001 p. 26).

(Helseforetaksloven)²²⁹. This is evidenced in the governance white paper, published in 1997²³⁰, in which the need for a broader application of legal and economic measures associated with the new reforms, is reiterated. It may therefore be perceived to be a contradiction, when the latter initiative is announced as a measure for modernizing the public health sector.

Starr (Starr 1982) makes reference to some critical observations associated with governments' continued search for control over hospital expenditures. His contention is that the State's continued striving for instrumental control over public expenditure, enforces a developmental trend towards turning public organizations into corporate enterprises. According to Starr, such a development will have a profound impact on the ethos and politics of both medical care and hospital institutions. The prognosis, as envisioned by Starr, is not simply the weakening of the sovereignty of the health professionals, but also the introduction of organizational disunity, services inequality and conflicts throughout the entire health care system.

The thesis' analysis depicts a situation in public hospitals reminiscent of Starr's contentions. The public hospital sector acts supremely in its instrumental preference for curbing cost developments. The thesis also shows accounts of organizational decision-making where executive and operations management act oblivious to the nature and needs of the hospital's value creation process. The practice of detached organizational decision-making, precludes integrated management solutions.

Through the new law on hospital ownership, the State assumes the formal responsibility for all public hospitals. Reorganization measures enacted into the new law on hospitals (Spesialisthelsetjenesteloven), challenge the autonomy of the medical profession. Corporatization of hospitals and the implementation of unitary management, are intended to bring about a holistic approach to health services management²³¹. In the government white paper which previews the intent of the law, a broadened management mandate is perceived to be precursory to improved hospital governance. The latter dramatizes the call for improved hospital leadership.

The research project's empirical findings support the contention of hospital leadership reification. The contention of reification rests on the empirical findings vested in the thesis' theoretical propositions. A disjointed approach

²²⁹ See particularly the promulgation preceding its legal introduction; Ot.prp. nr. 66 "Om lov om helseforetak mm.", 2000-2001; section 2.1.3 "Politisk styring", p.p.11-12.

²³⁰ St.meld. nr. 24 (1996-97), „Tilgjengelighet og faglighet. Om sykehus og annen spesialisthelsetjeneste"; See particularly: 1.1 "Meldings formål og bakgrunn", p. 5.

²³¹ See chapter 1 (Helsesforetaksloven) "Sammendrag", p. 7.

to a complex value creation process invites Williamson's concern for subgoal pursuits (Williamson 1996). Williamson warns of selective exposure to problems, goal distortions, bargaining and coalition formation. The empirical analysis shows the public hospital with a hybrid form of organizational decision-making. The formalized hierarchical structure is operationally subdivided into decision-making enclaves. Here, organizational preferences are enacted by virtue of their stakeholder position.

Any transactional cost assessments are outside the thesis venue. However, the lack of integrated activity planning and goal orientation implies a presence of significant resource inefficiencies. This contention is supported by analysis completed by SINTEF/UNIMED. According to their reports, the average technical hospital efficiency has only marginally improved during the 1990s (SAMDATA 2000)²³². In the same period, cost effectiveness declined. Based upon projections made by SINTEF/UNIMED, there is an unrealized efficiency potential of approximately NOK 2,5 billion (mrd.)²³³.

Another implication related to the thesis contentions on leadership reification, centers on hospital strategizing. Mintzberg recognizes the challenging nature of articulating and developing cohesive hospital objectives. Citing Lindblom (Lindblom 1977), a tenured researcher on government policy-making, Mintzberg contends that no-one has yet to employ a rational-deductive system for welfare services analysis. It is precisely within such complex power systems that planning has experienced its most dramatic failures.

Present-day hegemonic and short-term planning documented in the thesis research, serve to impede cost efficiency and austerity objectives. In addition, narrow planning concepts are also steering strategies away from potentially rich and integrated perceptions of what an organization may be able to accomplish (Mintzberg 1994). According to Rumelt (Rumelt, Schendel, and Teece 1995), strategy links environmental circumstances and organizational behavior to market outcomes. Adjusted for the nature of hospitals' institutionalized legitimacy, profitability may be converted into a concept of societal costs. The sustainability of the public hospital is dependent on its relative position as a viable service producing unit. Value creation activities are part of an interdependent system in which the costs or effectiveness of one activity can be affected by the way others are performing (Rumelt, Schendel, and Teece 1994). To the public hospital, this involves the capacity and capabilities of a large number of health professional staff, choice of technologies and election of medical field

²³² See section 9.5 "Trender for sykehusenes effektivitet", p. 125.

²³³ Ibid., p. 126.

specialties. Detached and hegemonic decision-making precludes strategic choices from engaging the broadest range of stakeholder interests. The lack of strategic focus on ward priorities leaves the hospital vulnerable to operational dysfunctions and disruptions. Operational discontinuities may erupt due to lacking strategies for the recruitment of professional staff. A dysfunctional staff recruitment strategy serves to incapacitate hospital-internal training and development programs. Lack of a cohesive medical professional strategy precludes the proper scaling of operational goals and investment programs. The hospital medical research program may be viewed as an integral part of professional staff development and therefore improve medicine and treatment regimens. Thus, a hospital strategy pre-empted by overall clinical considerations and associated value creations processes, serves no directional purpose for viable long-term operations.

Sector governance authorities themselves recognize some dramatic shortcomings in the nation's public hospital system. The education system established to secure the supply of health professionals, is suffering from serious flaws²³⁴. Sector audits, document a lack of funds and an unsatisfactory allocation of the same. Poor quality of post-graduate medical training and development receive much criticism in all government white papers over the last decade and a half. Insufficient R&D funding has equally been criticized. Medical R&D in public hospitals in Norway is financed through special allocations. While such provisions have increased sharply over the last three years, the grants are still relatively small²³⁵. The most dramatic acknowledgement by the public hospital sector, however, is that no-one can account for how- or how much medical research is being conducted in Norwegian public hospitals. The Department of public health is able to confirm its monetary contributions earmarked for education, special projects and medical research. However, there is no cohesive project auditing, neither regarding projects financed nor research project outcome.

In government white papers, concern is expressed at the lack of research quality supervision and control. In an OECD analysis on medical R&D articles published in the period between 1996 and 2000, Norway comes out behind all the other Nordic countries in terms of articles produced and also

²³⁴ See particularly: St meld nr 24: Tilgjengelighet og faglighet. Om sykehus og annen spesialisttjeneste”.

²³⁵ The so-called functional allowances (funksjonstilskudd) are provided generally to hospitals with county, regional and university clinic functions. Sum transferred as functional allowances was in 2000 NOK 1.9 bill. (mrd) (SAMDATA 2/01). Medical research projects are also financed by Norwegian research Institute (Norsk forskningsråd; NFR). In 2001, the NFR provided NOK 251 mill. for medical research projects.

based on comparisons of article citations²³⁶. The annual report on Norwegian Research and innovation (NIFU 2001) points to the fact that Norwegian medical research has not followed the international research trends. The pattern based on research publications, confirms clinical medicine and biomedical fields such as neuroscience, biotechnology and molecular biology to be directions pursued.

The time-tested taxonomy of separating management from the medical professions is inherent in the present logic of all hospital internal stakeholder groups. However, the stakeholder groups represented by the two major health professions proclaim recognition of the need for organizational changes. Change needs perceived by the informants point in the direction of change management and/or innovation style decision-making processes. However, the cognitive logic representative of executive and operations management does not show an equally strong recognition of the need to challenge the singular focus on an administrative and neo-classical industrial logic of the present form of governance. A present governance rationale of “institutional logic”²³⁷ precedes a possible transition to a paradigm of “compliance logic”²³⁸. Whether one will see a paradigmatic change towards “strategic management”²³⁹ and a leadership of “innovation and radical change”²⁴⁰, depends largely on the discourse on welfare state prescriptions. As expressed by March and Olsen “Meaningful political equality cannot be viewed simply as a problem of aggregating interests but requires attention to the shaping of citizen preferences” (March and Olsen 1989 p. 143). In the continued development of a formula for a welfare state regime, one best heeds the call of Starr: “The dream was that reason would liberate humanity from scarcity and the caprices of nature, ignorance and superstition, tyranny, and not least of all, the diseases of body and spirit. But the dream of reason did not take power into account” (Starr 1982 p. 3).

The governance model of reaching societal agreements through the politics of consensus and stabilization, has rested on a public sector capable of securing common resources, rights and duties (Guldbrandsen et al. 2002). In his analysis of powerful societal elites, Guldbrandsen points to the flaws inherent in national governance consensus models. Within the national principles of pluralism are conflicts of vested interests that remain unexposed. It is believed that the thesis project has served to expose some of these conflicts and their implications.

²³⁶ NIFU, “Det norske forsknings- og innovasjonssystemet – statistikk og indikatorer 2001”, section 4.1.2 “Siteringshyppighet”, p.p. 162-163; figure 4.1.2., and figure 4.1.3, p.p. 162-163.

²³⁷ See table no. 50: “Governance paradigms in Norwegian public hospitals”.

²³⁸ Ibid.

²³⁹ See illustration no. 23: “Decision-making processes and leadership styles”.

²⁴⁰ Ibid.

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