So what? The value of reputation in public healthcare organisations.

Author

Kosiol, Jennifer

Published

2021-05-04

Thesis Type

Thesis (PhD Doctorate)

School

Dept Bus Strategy & Innovation

DOI

10.25904/1912/4180

So what? The value of reputation in public healthcare organisations

Jennifer Kosiol
BNurs, LLB, LLM, MBA, BMS (Hons) GCertHServMgt

Department of Business Strategy and Innovation
Griffith Business School

Submitted in fulfilment of the requirements of the degree of
Doctor of Philosophy

Griffith University

January 2021

STATEMENT OF ORIGINAL AUTHORSHIP

The work contained in this thesis has not been previously submitted to meet requirements for an award at this or any other higher education institution. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made.

Signature: _____

Date: 20 January 2021

ABSTRACT

This research investigates the perceptual value of reputation and the underlying relationship between reputation and organisational culture, in a public healthcare organisation in South East Queensland. In doing so, it addresses the following research questions:

In what way is the perceptual value of reputation conceptualised about public healthcare organisations?

In what way is the perceptual value of reputation formed about public healthcare organisations?

How do internal and external stakeholders perceive the value of reputation in public healthcare organisations?

Increasing problems associated with chronic disease and an ageing population are significantly impacting the Australian health system as health organisations struggle to keep up with demand and rising community expectations. Despite these challenges, public healthcare organisations are required to deliver on the healthcare objectives of the government and maintain performance, efficiency, quality care delivery and equity of services. Fulfilling the government mandate and community expectations requires healthcare organisations to focus on strategies that improve performance and provide a competitive advantage to the organisation.

Organisational reputation radiates strong appeal and provides organisations with a competitive advantage over obtaining skilled employees, customer loyalty, improved performance, funding and philanthropic donations. However, the value of reputation within public healthcare organisations has been largely undefined and under researched. Within private organisations, studies have shown reputation to be a valuable intangible resource that has provided organisations with a competitive advantage within their industry and is also likely to be associated with well-performing organisations. This research draws upon existing theory around resource-based view theory to explore the perceptual value of reputation.

Studies that examine reputation tend to focus on measurable outputs. Therefore, empirical research that considers how reputation is conceptualised and formed by key stakeholders is scarce, particularly studies conducted in Australia. In addition, research that focuses on understanding the links between reputation and organisational cultural relationships tend to ignore the value of systems and the quality of the relationships between stakeholders. Therefore, this research draws on existing theory around reputation and organisational culture in order to explore the relationship between these two constructs. Further, this research aims to develop a better understanding of how reputation is defined and formed within public healthcare organisations and provide insights as to how organisations can work towards strategically building and managing their reputations.

This study used an ethnographic, multi-phase, sequential, exploratory research design, and adopted a multilevel (organisational, group, individual), and multiple cultural perspective (integration, differentiation and fragmentation) approach. The study was conducted in two phases: Phase 1 explored internal stakeholder's views of reputation at different hierarchical and professional levels. This included a multi-perspective examination involving diverse hierarchical levels of senior managers and frontline staff. Phase 2 was the external stakeholder group which involved interviews with consumers and potential consumers of healthcare organisations. Findings from the two phases were integrated, compared, and converged, to identify similarities and differences between the two data sets.

Overall, findings indicate that reputation is a multi-dimensional construct based on the perceptions of key stakeholders. Reputation is defined by three dominant conceptualisations namely, *reputation as consciousness; reputation as resource;* and *reputation as appraisement*. By integrating the three conceptual perspectives of reputation, it defines reputation from public stakeholder perspectives. In addition, findings from this research highlight that the value of reputation for public healthcare organisations is identified by three main dimensions namely, *consumer satisfaction; healthcare quality;* and *organisational culture.* Thereby, emphasising that reputation is rooted in stakeholder perceptions of the organisation's actions and behaviours.

This research concludes that the value of reputation in public healthcare organisations is perceived as extremely important by both internal and external stakeholders. Reputation is a multidimensional construct that is stakeholder specific and industry specific. Importantly, the dimensions of reputation identified in this study, provide a basis for measuring reputation within organisations and addresses one of the significant problems identified in the reputation literature, that of an agreed method of reputation measurement. Specifically, reputation measurement should be closely tied to the accepted definition, based on the perceptions of stakeholders, and informed by the dimensions of reputation which are specific to the industry. Therefore, this research supports and extends the literature on reputation and confirms that organisational culture is a dimension of reputation. Hence, reputation management strategies need to be developed in collaboration with all stakeholders to ensure the dimensions of reputation are considered from both internal and external perspectives.

ACKNOWLEDGEMENTS

There are so many feelings of gratitude that arise when I think about the people that I want to acknowledge and thank for their support, kindness, strength and persuasion during this research and development journey.

Firstly, I would like to thank my PhD supervisors: Professor Anneke Fitzgerald (Griffith University) and Dr Katrina Radford (Griffith University). I am greatly appreciative and indebted to each of my supervisors for their support, dedication and commitment to the project. Their dedication, trust, patience, support and intelligent perspective have shaped and guided this thesis throughout. In particular, I am deeply grateful to my primary supervisor Anneke Fitzgerald, whose generosity of time and patience and clarity throughout the process has been resolute, dependable and unwavering. I am always amazed by Anneke's ability to simplify the confusion and highlight the importance of the finest detail. I am also very thankful to Katrina for her contribution, clear thinking and ability to provide perspective during periods of confusion.

This study would not have been possible without the generous assistance of the Health Service under study. A special thank you to Ms Linda Fraser, Nurse Unit Manager, who was generous with her time, knowledge and understanding. Linda went above and beyond to assist with this research and to provide information about the health service and key stakeholders. I am very grateful to all of the voluntary participants who offered very valuable insights and meaning to the value of reputation.

I was fortunate and grateful to receive a Commonwealth-funded Research Training Program (domestic) scholarship offered through Griffith University. I am very thankful to many colleagues, peers and friends at Griffith University. While it is not feasible to name them all, I am especially thankful to Dr Jose Medina Noel, who provided a steady stream of positivity, guidance and support, to Griffith University Library Gold Coast, and in particular Research Librarian Maria Connor for her expertise with research and Endnote.

To my dear friends who have listened to me, encouraged me and provided unwavering support, I am truly grateful to you all. A special thank you to my daughter Mandy who dedicated hours to become my expert with Endnote, and for giving us the best gift of all, our granddaughter Amelia Harper, born September 2020. A special thank you to my son James for being my study partner and helping me stay focused. And finally, to my wonderful, supportive, generous and loving husband Mark, you are my strength when I needed, you are my biggest fan and my best friend by my side always. I owe it all to you.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF ABBREVIATIONS

AHHA	AUSTRALIAN HEALTHCARE AND HOSPITALS ASSOCIATION
AHPRA	AUSTRALIAN HEALTH PRACTITIONERS REGISTRATION AUTHORITY
AMA	AUSTRALIAN MEDICAL ASSOCIATION
ANCC	AMERICAN NURSES CREDENTIALING CENTRE
CEO	CHIEF EXECUTIVE OFFICER
EMT	EXECUTIVE MANAGEMENT TEAM
ECMO	EXTRA-CORPOREAL MEMBRANE OXYGENATION
FRMAC	FORTUNE MOST ADMIRED COMPANIES
IHPA	INDEPENDENT HOSPITAL PRICING AUTHORITY
HHS	HOSPITAL AND HEALTH SERVICE
NPM	NEW PUBLIC MANAGEMENT
NCP	NATIONAL COMPETITION POLICY
NHHRC	NATIONAL HEALTH AND HOSPITALS REFORM COMMISSION
NCoA	NATIONAL COMMISSION OF AUDIT
PBS	PHARMACEUTICAL BENEFITS SCHEME
PC	PRODUCTIVITY COMMISSION
RQ	REPUTATION QUOTIENT
RBV	RESOURCE-BASED VIEW (OF THE FIRM)
SCRGSP	STEERING COMMITTEE FOR THE REVIEW OF GOVERNMENT SERVICE PROVISION
WHO	WORLD HEALTH ORGANISATION

Chapter 1: Introduction

Late in the afternoon at the Executive Management Team (EMT) meeting in a large tertiary public hospital, a discussion was being held around the service improvement strategies recently implemented in the healthcare organisation. The discussion was about a high-tech solution that saved the life of a patient. Clinicians decided to use the high-tech solution as a complete treatment, whilst the high-tech solution was only approved as a temporary measure until the patient could be transferred elsewhere; the clinicians decided not to transfer the patient. "Those doctors are cowboys", was the comment made by a senior executive about the way in which this service improvement decision was being implemented.

The decision, made by the EMT, was to implement an Extra-Corporeal Membrane Oxygenation (ECMO) service at the hospital. The service was designed as transitional, whereby, patients would stay for 24-48 hours and then move on to a referral hospital with a larger ECMO service. To be able to say the healthcare organisation had an ECMO service would be a significant boost to the reputation of the organisation as a whole. However, the clinicians implementing the service were concerned about the risks to these incredibly unwell patients by transferring them within a 24-48-hour period, and to their own professional reputation by not managing the service at a full and complete level. What eventuated was a complete service from admission to discharge, without the EMT being informed. When the EMT became aware of the full service being implemented it sparked the negative comments which eventually reached the ECMO clinicians. What resulted was frustration, anger and offence between the EMT and the clinicians. This was because of the significant risk to the reputation of the service and the organisation as a whole due to the threats to reduce the service to a transitional delivery mode.

Remarkably in the meantime, the hospital had become known as a successful ECMO service provider, which had boosted the reputation of the healthcare organisation and the professional reputations of the clinicians delivering the service. The reputation of the ECMO service within the organisation had grown significantly and was becoming well known both state-wide and internationally. This provided the healthcare organisation with a significant competitive advantage, with research groups and professional training programs seeking to become involved and invest in the service. However, the reputational value from the change in the progression of the service from transitional to full service was not fully realised by the executive or the clinicians. What was apparent were the competing, and issue-specific, reputations from the service improvement strategy at both professional and organisational levels, and the clear disconnect between the senior manager decision-making level to the frontline operational-execution level, in the understanding of the value of reputation.

1.1 THE TOPIC OF RESEARCH

The opening vignette illustrates the reputational consequence of organisational adaption, learning and adjustment to service delivery. Particularly, where the value of reputation is issue-specific and varies between hierarchical levels within an organisation. One of the conditions of organisational health is the unity of purpose (i.e. a strong integrated culture), which enables the ability to cope and adapt in response to new innovations, technologies, and political and economic impacts (Bruhn, 2001; Stanford, 2013). When organisations attempt to improve their service delivery, the management of reputation becomes increasingly important.

Reputation management is not necessarily a skill expected from Health Service Managers in public sector organisations. However, with engagement by the governments in tackling problems of efficiency and equity in the health sector, competition and contestability are increasingly important factors for these organisations. To gain a competitive advantage and ensure non-contestability of resources, healthcare organisations are beginning to recognise the importance of reputation. Consequently, understanding, building and managing reputation is becoming an important skill for Health Services Managers.

This chapter lays the foundation for the thesis by introducing the themes and concepts of the research and presents a summary of the theoretical foundations and methodological approach. The fields of reputation, resource-based view theory and organisational culture are presented as components of the theoretical framework. Additionally, this chapter outlines the research problem and justifications. Finally, the chapter continues with an outline of the thesis, definitions of key terms and delimitations of the scope of this research.

1.2 BACKGROUND TO THE RESEARCH

Over the last 30 years there has been growing concern for the effectiveness and efficiency of Australian health services (Degeling & Carr, 2004). As a result, health policy and reform have remained high on the political agenda, with successive governments increasing their involvement in healthcare reform in the areas of governance and finance in an attempt to improve the healthcare system (Palmer & Short, 2014).

One of the most significant reforms came in 2010, with the introduction of a National Health and Hospitals Network to drive major improvements in service delivery and health outcomes for patients (Commonwealth of Australia, 2010). The aim of this reform was to decentralise public hospital management and increase accountability by devolving responsibility for health service delivery to the local level. This was to be achieved with the introduction of local hospital networks (Hospital and Health Services [HHS]) into each state and territory (Commonwealth of Australia, 2010). Each HHS is responsible for its own budget, service delivery, quality and performance. The objectives of each HHS is to strengthen performance, improve services and shape service delivery specifically to community needs (Queensland Government, 2019). Under the HHS agreements, funding for public hospitals is based on efficiency, with the Commonwealth funding 60 percent of the efficient price (a price determined by the Independent Hospital Pricing Authority [IHPA]) and state and territory governments funding the remaining 40 percent. From 2018, growth funding that was provided by the Commonwealth government has been capped at 6.5 percent. Under the current funding model, additional funding will not be provided if the HHS is unable to maintain budget integrity. As a result, HHSs are under increasing pressure to improve efficiency and reduce costs.

Stimulating efficiency, effectiveness and productivity in market economies has been driven by competition. The notion that competition could improve elements of healthcare has gained increasing consideration (Australian Healthcare and Hospitals Association, 2016; Cutler, 2015; Productivity Commission, 2002; 2014; 2018). Competition is a key element of economic policy in Australia and is seen as the engine which drives efficiency, productivity and innovation (Commonwealth of Australia, 2003).

In 2016, the Productivity Commission was commissioned to inquire into Australia's human services with an objective to identify innovative ways to improve outcomes through introducing the principles of competition and informed user choice whilst maintaining or improving quality of service (Steering Committee for the Review of Government Service Provision, 2017). The inquiry found that the provision of public hospital services was one of the human services best suited for competition and contestability-based reform (Steering Committee for the Review of Government Service

Provision, 2017). One of the main principles of the inquiry was that healthcare should be user-focused with consumer choice the basis of service provision and delivery (Steering Committee for the Review of Government Service Provision, 2017). While competition, contestability and choice are still in the early stages of reform, it is likely that these factors will become an important part of Australia's healthcare system in the future. One of the important effects of competition, contestability and choice is reputation which can be an additional source of competitive advantage for organisations (Eckert, 2017; Walker, 2010), including public healthcare organisations when competing with industry partners to extend specialist services. With the drive for efficiency, performance and accountability to the government and the community, public healthcare organisations are under pressure to meet the objectives and consider the reputational implications of healthcare reform.

Reputation is a cognitive observation about organisations that affects actions and outcomes (Clardy, 2012). A good reputation can provide an organisation with a number of strategic benefits such as increasing profitability (Roberts & Dowling, 2002); selling products for premium prices (Dayanç Kıyat, 2019; Ponzi, et al., 2011); a significant competitive advantage (Deephouse et al., 2019; Eckert, 2017); to broaden options available to managers (Da Silva & Batista, 2007); and to meet the demands and expectation of the organisations stakeholders (Coombs, 2007; Luoma-aho & Makikangas, 2014). Essentially, the ability to meet the demands and expectations of stakeholders is crucial for public organisations and particularly so for public healthcare organisations (Szymaniec-Mlicka, 2015).

Reputation has long been considered a rare and valuable resource, particularly within private sector organisations (Barney, 1989; 1991; 2001; Szymaniec-Mlicka, 2014; 2017). Public sector organisations are beginning to understand the importance of reputation and the many benefits that are vital to survival, such as organisational performance, and attracting a highly skilled workforce (Abito et al., 2019; Deephouse & Carter, 2005; Fombrun & van Riel, 2003; Tyler, 2006). Understanding the influences of reputation on organisational performance shows that a strong reputation is a powerful tool in the search for a competitive advantage (Bergh et al., 2010). For this reason, many healthcare services in Australia are undertaking credentialing programs such as 'Magnet'. A Magnet hospital is stated to be one where nursing delivers excellent

patient outcomes, where staff have a high level of job satisfaction, and where there is a low staff turnover rate and appropriate grievance resolution stratergies (American Nurses Credentialing Centre, 2020).

Defining reputation has raised some difficulty as there is yet to be an agreed definition (Chun, 2005; Gotsi & Wilson, 2001; 2001a; Walker, 2010). Without a confirmed and supported definition, measurement methodologies are questionable and weakened (Walker, 2010). Reviewing the literature between 2000 and 2019 found 49 different, definitional, versions of organisational reputation (Agarwal et al., 2018; Barnett, et al., 2006; Walker, 2010). The multiple voices defining reputation seems to exacerbate the confusion and in a way it does, however on the basis of over twenty years of extensive literature (see Chapter 2: Literature Review) it can be concluded that a lot of work has already been done and now is the time to build on previous work. Therefore, this research does not seek to find another definition but to support Walker's (2010) definition, which provides that reputation is:

> "A relatively stable, issue-specific, aggregate perceptual representation of an organisations past actions and future prospects compared against some standard". (Walker, 2010, p.370)

The definition of reputation is important in order to align the measurement of the construct with the definitional attributes (Mahon, 2002; Walker, 2010; Wartick, 2002; 2016). For example, reputation measurement should reflect stakeholder's perceptions, rather than certain representations, such as performance targets, which are objective measures and not consistent with the perceptual nature of reputation (Masso et al., 2010). Overall, studies in relation to reputation tend to focus on measurable outputs, however, empirical studies looking at how reputation is conceptualised and formed by stakeholders are rare, and research conducted in Australia is particularly scarce. Therefore, this research addresses how reputation is conceptualised and formed by stakeholders of Australian public healthcare organisations. More specifically, this research explores how internal and external stakeholders define reputation and what dimensions of reputation form the perceptual value of reputation by exploring how staff consider reputation and how it influences their behaviour, attitudes and 'the way things are done' in the context of a large public-sector Hospital and Health Service

organisation in South East Queensland. In doing so, it examines the theoretical link between organisational reputation and organisational culture.

Both organisational reputation and organisational culture have been recognised for their critical roles in improving organisational performance and effectiveness (Alsop, 2004; Davis, 2002; Davis et al., 2014; Flatt & Kowalczyk, 2008; Fombrun, 1996; Sageder et al., 2018; Weigelt & Camerer, 1988). Previous research suggests that organisational culture may be an important predictor of reputation for an organisation (Alsop, 2004; Dukerich & Carter, 2000; Flatt & Kowalczyk, 2000; 2006; 2008; Fombrun, 1996; Fombrun & Shanley, 1990; González-Rodríguez et al., 2019; Obloj, & Obloj, 2007; Sutedjo et al., 2018; Yusuf et al., 2018) largely due to the internal culture and external reputation factors interlinking and informing each other (Gonzalez-Rodriguez, et al., 2019; Hatch & Schulz, 2000). While there is theoretical support suggesting a relationship between organisational culture and reputation, what is highlighted is the limited empirical evidence considering how organisational culture influences reputation and how the indirect effects of this relationship contribute towards a competitive advantage for the organisation. Therefore, this research aims to develop a better understanding around the relationship between these two constructs and how they influence and interact with one another.

1.3 THEORETICAL UNDERPINNINGS

This research explores the perceptual value of reputation by drawing on the theoretical perspective of resource-based view (RBV). RBV theory examines how reputation is a valuable, rare, inimitable and non-substitutable (VRIN) intangible resource that leads to a competitive advantage for the organisation (Deephouse, 2000; Roberts & Dowling, 2002). RBV theory argues that while it is necessary for organisations to possess VRIN resources, organisations must also demonstrate the ability to alter them to their full potential in order to gain a competitive advantage and superior performance (Boyd et al., 2010). Recognising and managing VRIN resources is only part of the process of RBV theory; developing and strategically managing the resources builds organisational livelihood (Tarafdar & Gordan, 2007).

Resource based view has been an influential perspective in organisational sciences, emerging in the field of strategic management (Barney, 1991). RBV central

tenant is that if an organisation is to achieve a competitive advantage over other organisations, it must have and control resources that are valuable, rare, non-substitutable and inimitable (VRIN). According to RBV strategic resources are those VRIN resources that provide organisations with a competitive advantage over those organisations that do not have these types of resources (Barney, 1991). Given the simplicity and enticing face validity, the central tenant is easily understood (Kraaijenbrink et al., 2010). Consequently, there is consistent and increasing evidence that supports this notion with researchers identifying the types of resources that meet the VRIN criteria (Barney & Arikan, 2001; Clarke & MacDonald, 2019; Crook et al., 2008).

While the central tenant of RBV is based on understanding why some organisations obtain a competitive advantage and outperform other organisations through VRIN resources (Barney, 1991) criticism of this theory can be refined to two main arguments. First, notwithstanding the popularity of RBV, it has been criticised for inconsistent, varied and antithetical resource definitions (eg., Definition references). Essentially a consensus on the definition of resources and their magnitude has yet to be established resulting in confusion over what exactly constitutes a resource (Kellermanns et al., 2014; Kraaijenbrink et al., 2010). The inclusive definitions of resources do not sufficiently acknowledge or make a distinction between input resources for the organisation and capability resources that support the organisation to manage and control the inputs (Kraaijenbrink et al., 2010). While some researchers have attempted to distinguish capabilities from input resources (Dosi et al., 2008; Eisenhardt & Martin, 2000) in the end they are all treated in the same way leaving the central tenant of RBV somewhat confusing. In addition, the lack of consideration of the fundamental differences in how different types of resources contribute to a competitive advantage for the organisation in different ways obscures the logic of the RBV central tenant. However, Barney (1991) suggests that the strength of RBV comes from this all inclusiveness, although this then suggests that there is nothing strategically favourable about the organisation other than VRIN resources.

Second, that VRIN criteria is insufficient and unnecessary in the explanation of competitive advantage for the organisation and that it is not these components of a resource that matter but rather it is the combination of resources created by the

organisation (Peteraf & Barney, 2003). In other words, it is not the value of individual resources that provide the competitive advantage for an organisation but rather the bundle of resources that are strategically developed by the organisation. This criticism does not recognise the role of individual resources, although that does not conclude that there are no resources that can be valuable for organisations. The argument here is that to establish a competitive advantage an organisation it needs a combination of resources but also managerial capability to recognise the value and take advantage of the opportunities inherent in them (Kraaijenbrink et al., 2010).

Notwithstanding these critiques, whether the resources are individually capable of providing an organisation with a competitive advantage or whether it is the bundling of the resources that establishes the competitive advantage, is not within the scope of this study. While RBV theory is mostly used to determine the strategic resources, an organisation can use to achieve a competitive advantage (Plewa et al., 2016), for this study RBV was drawn upon to identify specific resource dimensions that contribute to reputation in healthcare organisations. Reputation is a result of an aggregate and complex combination of interconnected antecedents and consequences that result in resources leveraging off other resources to generate "causal ambiguity, rareness, and intangibility" that is inimitable (Boyd et al., 2010. P. 603). Therefore, reputation from an RBV perspective is a valuable and rare intangible resource because of its difficulty to imitate and its causal ambiguity (Walker, 2010). Notwithstanding its value, the more ambiguity surrounding the dimensions that make up reputation (e.g. product quality) the greater its importance (Rindova et al., 2005) as it leads to improved organisational performance and competitive advantage (Boyd, et al., 2010). This study advances the existing research by identifying specific healthcare resource dimensions that contribute to reputation in healthcare organisations. Moreover, this study addresses the gap on how different stakeholder groups perceive reputation and specifically how the dimensions of reputation are both issue and stakeholder specific.

The application of RBV theory and reputation has been mostly examined within private sector organisations (e.g. Barney & Arikan, 2001; Hőflinger et al., 2018; Newbert, 2007; Raithel & Schwaiger, 2015). However, the lack of use within public sector does not illustrate a lack of usefulness within this context. Instead it suggests an emerging exploratory field for this theory (Kuoppakangas et al., 2019; Waeraas &

Byrkjeflot, 2012; Szymaniec-Mlicka, 2017). To assist public healthcare organisations to meet expectations and create healthcare value and responsiveness, RBV theory is useful as it is likely to assist healthcare leaders in understanding resource value and value creation as being dependant on the efficient and effective use of resources in delivering quality healthcare. Therefore, this research builds on existing theoretical understanding of RBV theory in the management of public healthcare organisations and the focus on reputation as a resource that organisations can exploit for competitive advantage, contestability and performance (Newbert, 2007; Szymaniec-Mlicka, 2017). This study does not measure the value of reputation and its influence on providing healthcare organisations with a competitive advantage as that is beyond the scope of this study. However, in order to determine the value of reputation as a resource, there is firstly a need to understand how reputation is conceptualised and formed in the minds of key stakeholders and this study addresses this gap.

1.3.1 Theoretical Lens

This research examines the perceptual value of reputation through a cultural lens. In this way, it seeks to build on existing theoretical understanding of the relationship between organisational reputation and organisational culture, by adopting a multiple cultural perspective approach (Martin, 2002). Mostly, researchers tend to adopt either an objective or subjective ideological approach to studying organisational culture (Kummerow & Kirby, 2014). The objective ideology sees culture as something that an organisation has, and therefore culture can be treated as a variable consisting of certain attributes that can be measured and manipulated (Kummerow & Kirby, 2014; Ogbonna, 1992).

Advocates using a more objective view have a more pragmatic approach in the sense that their work is in some way concerned with understanding the effects of organisational culture (Balthazard, Cooke & Potter, 2006). In contrast, the subjective ideology sees culture as something that an organisation is, and looks to the patterns and beliefs that make organised action possible (Smircich, 1983; 2007). Subjective cultural studies focus on the intangible aspects of culture and acknowledge it as a social phenomenon portrayed as systems of cognition and belief, patterns of symbolic

interpretations, and manifestations (Allaire & Firsirotu, 1984; Fandrejewska, & Wasilik, 2018; Martin, 2002).

This research incorporates both objective and subjective ideologies in order to develop a more complete cultural picture from multiple perspectives. This study adopts Martin's (2002) three-perspective approach where organisational culture can be observed from an integration, differentiation and fragmentation perspective. The integration perspective assumes that the organisation has one dominant type of culture that is organisation-wide and the assumptions, values and beliefs that make up culture are consistent and reinforced by one another (Martin, 1992; 2002). Researchers within this perspective are generally focused on a managerial perspective (e.g. Balthazard et al., 2006; Neiminen et al., 2013; Schein, 2006; Tsui et al., 2006).

The differentiation perspective focuses on cultural manifestations that have inconsistent interpretations and assumes the organisation consists of subcultures, each with its own traits and patterns of behaviour (Martin, 1992; 2002). Researchers within this perspective pay particular attention towards non-leader centred sources of culture and the relationships between subcultures (e.g. Louis, 1985; Meyerson & Martin, 1987; Parker, 2000; Small 2002; Von Zugbach, 1988). Organisational culture can also be studied from the fragmentation perspective, which recognises the uniqueness of members and assumes no cultural consensus, a constant flux, and inconsistent variations (Alvesson & Sveningsson, 2015; Martin, 2002). Researchers within this perspective are generally interested in the complications that arise from divided opinions and tensions between opposites, ironies, paradoxes or contradictions (e.g. Alvesson, 1993; Grant et al., 2013; 2016; Markowitsch, 2018; Mathew, 2019; Meyerson, 1991; Stokes et al., 2016; Weerts et al., 2018). To ensure a more complete cultural picture, similar to previous studies undertaken by Fitzgerald (2002), Eljiz (2009) and Latta (2019), this study adopts a multiple cultural perspective approach by incorporating all three cultural perspectives (integration, differentiation, and fragmentation).

1.4 RESEARCH PROBLEM / PURPOSE STATEMENT

The purpose of this research is to explore the perceptual value of reputation in public healthcare organisations, and to explore the relationship between reputation and organisational culture. Understanding the value of reputation and how it is

conceptualised and formed by stakeholders provides Health Service Managers with better insights to not only manage reputation, but also provide short and long term strategies for building and managing reputation as a valuable resource for healthcare organisations.

Hence this study investigates the perceptual value of reputation in public healthcare organisations in South East Queensland through an organisational cultural lens and addresses the following research questions:

1. *In what way is the perceptual value of reputation conceptualised about public healthcare organisations?*
2. *In what way is the perceptual value of reputation formed about public healthcare organisations?*
3. *How do internal and external stakeholders perceive the value of reputation in public healthcare organisations?*

1.5 JUSTIFICATION OF THE RESEARCH

Increasing problems associated with chronic disease and an ageing population are significantly impacting the health services in Australia and around the world, as healthcare organisations struggle to keep up with demand. This struggle is further exacerbated by increasing community expectations for higher health standards, the latest technologies and improved access to care (Hall, 2015). Despite these challenges, public healthcare organisations in Australia are required to deliver on the healthcare objectives of the governments (Federal, state and territory) and maintain performance, efficiency, effectiveness and equity of services. Fulfilling the government mandate and community expectations requires organisations to focus on strategies that improve performance and provide a competitive advantage to the organisation. This research will address the need to consider the organisational context and the value of reputation as an intangible resource that can provide the organisation with a competitive advantage. The concept of reputation for public organisations is underdeveloped in the scholarly literature, and this research offers a new perspective to reputation and reputation management in public healthcare organisations. It will provide insights into reputation in the complex environment of public healthcare and how organisational

culture relates to reputation as an important dimension for competitive advantage in this dynamic and highly essential context.

Theoretically, this research will contribute to the literature by combining reputation, resource-based view theory and organisational culture theory, with further development of the contextual factors of public healthcare organisations as moderators. For practitioners, this research will offer a new perspective to assess and understand reputation and the dimensions that influence the perceptual value of reputation for stakeholders of public healthcare organisations. In addition, application of a broader understanding of reputational value can be used to develop or modify reputation measurement instruments specific to the healthcare industry. This in turn, provides potential opportunity to measure reputation and effect short and long term strategies to build and manage reputation.

With a greater understanding of the important role of organisational culture and its relationship to reputation, this research will suggest that Health Service Managers may be able to improve the organisational culture and reputation. Furthermore, future healthcare reform initiatives may introduce further increases in competition, contestability and choice which, requires a more complete understanding of the value of reputation.

1.6 OVERVIEW OF THE STUDY

The goal of this thesis is to explore the perceptual value of reputation from stakeholders of public healthcare organisations. In particular, this research required an open mind and methods that were orientated to real-life scenarios to explore an existing problem in the field of Health Services Management. Therefore, this research adopted a constructivist world view (Creswell, 2009). Constructivism is orientated to exploring scenarios where meaning is not discovered but is constructed by the participants as they engage in the world they are interpreting (Crotty, 2003). Therefore, constructivism is well suited to qualitative studies as it allows the researcher to explore and construct meaning through rich stories and self-reflexivity.

The reason a constructivist paradigm was ideally suited to this research is twofold. Firstly, because this paradigm is orientated towards real-life scenarios, this allows for a qualitative method approach for understanding the perceptual value of reputation in the

public healthcare setting and for developing a more complete in-depth picture of reputation from multiple perspectives. The value of reputation arises from the different stakeholder perceptions of reputation and how they conceptualise and form their perceptions. Thus, the constructivist paradigm allows the researcher to analyse and interpret findings from multiple perspectives by focusing on the reality of the actions, situations and consequences of the participants. Secondly, the constructivist paradigm allows for the development of practical solutions based on theory and evidence.

This research used an ethnographic multiphase sequential research design, which was conducted in two Phases incorporating qualitative methods, as shown in Table 1.

Table 1

Qualitative Two-Phase Research

Phase	**Phase 1**	**Phase 2**
Level of analysis and perspective	Internal stakeholder Strategic organisational level (Managerial perspective) Frontline operational level (Operational, group and individual perspective)	External stakeholder Individual perspective
Study Sample	Senior managers (n=15) Frontline staff (n=16)	Community members (n=17)
Method of inquiry	Exploratory	Exploratory
Methods	Interviews, Observations, Documents	Interviews

As shown in Table 1, this research was multileveled by combining organisational, group and individual levels of analysis. The research was also multi-perspective as it considered both the strategic senior manager perspective, the operational frontline perspective and the external perspective. A total of 48 face to face, interviews were conducted with 15 senior managers, 16 frontline staff, and 17 community members (consumers) across three public hospitals and surrounding community. Additionally, this research used a multi-level cultural perspective where each level of analysis of the internal stakeholder was considered from integration, differentiation and fragmentation perspectives.

The data analysis was organised using the software program QSR NVivo 12.0 pro (QSR International 2020). Raw data analysis began during the collection phase and was broken down into manageable units where the data were synthesised and searched for themes and patterns to determine the findings. Constant review and analysis of the data were continued until it was apparent that no new themes were emerging. All of the methods used and limitations of this research are explained in detail in Chapter 4.

1.7 THESIS OUTLINE

This thesis is presented in seven chapters. The first chapter being the Introductory Chapter provides background information to the research problem, outlines the theoretical approach, and presents justification of the research and contributions, as well as a brief description of the methodology. Chapter 2 presents an overview of public health services context and a review of the literature associated with the Australian Healthcare system with a focus on healthcare reform and reputation in order to provide an understanding of current issues in this context.

Chapter 3 critically examines the literature in relation to organisational culture. The first section of this chapter provides an overview of the conceptual development of organisational culture. The chapter then discusses the confusion surrounding the definition of organisational culture and argues the relevance of organisational culture as a theoretical lens. Chapter 4 presents an in-depth discussion of the methodology and research methods used to answer the research questions and address the research gaps discussed in Chapters 2 and 3. The ethnographic, multi-phase, and sequential research design used for this research is discussed, including detail around the methods used and data analysis. The chapter concludes with a discussion of ethical the limitations of the methodology and ethical considerations for this study.

Chapter 5 presents the findings from Phase 1 of the study, beginning with a detailed analysis of participant's responses, including details of hierarchical level and stakeholder group. The focus then turns to how participants' conceptualise and form reputational value in public healthcare organisations. Chapter 6 presents the findings from Phase 2 of the study, which includes a detailed presentation of participants responses from the external stakeholder perspective.

Chapter 7 presents a final discussion of the research and draws on the literature review (Chapters 2 and 3) and analysis chapters (5 and 6) to answer the three research questions: (1) In what way is the perceptual value of reputation conceptualised about public healthcare organisations? (2) In what way is the perceptual value of reputation formed about public healthcare organisations? (3) How do internal and external stakeholders perceive the value of reputation in public healthcare organisations? This chapter also discusses the theoretical and practical contributions, study strengths, limitations and opportunities for future research.

1.8 DELIMITATIONS

This research focuses on the perceptual value of reputation as held by internal and external stakeholders within a large Hospital and Health Service in south-east Queensland. Therefore, the focus of this study is on hospital staff perceptions of reputation and the selected community perceptions of public healthcare reputation. While this research crosses into the domains of the reputation of certain hospitals, its purpose is to examine reputation from a sociological perspective (Bergh et al., 2010). Therefore, it does not include any measurement of reputation in any of the hospitals involved in the study, as this was considered beyond the scope of this study. While RBV theory is mostly used to determine the strategic resources an organisation can use to achieve a competitive advantage (Plewa et al., 2016), for this study, RBV was drawn upon to identify specific resource dimensions that contribute to reputation in healthcare organisations. In addition, this study did not include any assessment of patient outcomes or hospital performance. This study focuses specifically on how reputation is conceptualised and formed in the minds of the participants.

While the perceptual value of reputation may be different across a broad range of health services, the scope of this study was limited to public hospitals for two reasons. Firstly, because the acute care sector has undergone a number of healthcare reforms making Hospital and Health Services (HHS) separate identities, with each HHS competing for finite government resources, research funding and philanthropic donations. Hence, the potential for making the value of reputation more important for these organisations. Second, limiting the scope of this research allowed for greater depth of inquiry in a particular context that was required for this study. Therefore, this study was conducted within south-east Queensland at a large Hospital and Health

Service which incorporates five hospitals, of which three were chosen for this study: a large tertiary hospital and two major hospitals. The catchment area for the Hospital and Health service comprised approximately 23% of Queensland's population (Queensland Health, 2020), making it a major provider of public health services in the region. Given that this research was conducted within one Hospital and Health Service, the research findings are context-specific, and therefore, transferability to other contexts may be limited. Nevertheless, this research will make important theoretical, practical and methodological contributions.

1.9 SUMMARY

This research explores the perceptual value of reputation in one public healthcare organisation by applying an ethnographic multiphase qualitative research design and addressing ambiguous and underdeveloped areas of investigation. For example, by examining the link between organisational culture and reputation and by exploring how reputation is conceptualised and formed by stakeholders in public healthcare organisations. This research provides a unique perspective through which to understand reputation and through which Health Service Managers can implement strategies to build and manage organisational reputation. The following six chapters describe and examine the research process and endeavour to outline areas where management of reputation may be beneficial to public healthcare organisations.

Chapter 2: Literature Review: Explanations for Public Hospital Reputation

This chapter offers an overarching review of the scholarly literature on hospital reputation and related areas of research. This involves tying together the interconnecting and separated scholarly thinking and highlighting the relevant issues identified through diverse perspectives. The review appraises the theoretical shortcomings apparent within the literature and their consequence for empirical research. Importantly, the review is not intended as an assessment of the current state of research rather, it provides a diachronic view of the expanse of theory and concepts analogous to the topic. As such, both original and contemporary theoretical contributions are discussed wherever possible.

The chapter is structured in three parts, beginning with an examination of the concept of reputation and the definitional development through scholarly contribution. The contrasting theoretical dimensions of reputation are examined in the context of organisational research. Following this, as sensitivity to context is central to qualitative inquiry (Patton, 2015), particular attention is given to understanding the context in which this research takes place. This includes discussion on the diversity and contextual factors that explain inherent variations, patterns and themes within the Australian healthcare system, including the relationship and influence between the Commonwealth and the State and Territory governments on the public healthcare system. This governmental influence has an impact on health reform policies and on the strategic management of healthcare organisations within Australia, affecting and guiding reputation. The third part of the chapter then reviews and critically analyses reputation management implications for public healthcare organisations and the reputational considerations of stakeholders.

2.1 REPUTATION AND PUBLIC HEALTHCARE ORGANISATIONS

2.1.1 Why reputation and what is reputation?

To understand the value of reputation in public healthcare organisations, the concept of reputation must be understood first. Since the early 1990's corporate reputation has featured in business and management literature (Rindova et al., 2010). Scholarly thinking has considered the reputation of a cooperation to be its attributes derived from its past actions (Weigelt & Camerer, 1988), its fame and esteem (Hall, 1992), its overall appeal (Fombrun, 1996) and a signal of key characteristics (Fombrun & Shanley, 1990). Reputation also constitutes superior organisational performance (Alniacik et al., 2012; Deephouse & Carter, 2005) because it is a valuable intangible asset that may contribute to competitive advantage (Eckert, 2017; Hall, 1992; Schwaiger & Raithel, 2014) and reliable, superior financial performance (Roberts & Dowling, 2002).

Reputation is a cognitive observation about organisations affecting actions and outcomes (Clardy, 2012). A good reputation can provide an organisation with a number of strategic benefits such as increasing profitability (Roberts, & Dowling, 2002); selling products at premium prices (Fombrun & Rindova, 1996; Quagrainie et al., 2003); and attracting skilled professionals (Fombrun et al., 2000; Fombrun & Rindova, 1996; Turban & Cable, 2003). For example, Turban and Cable (2003) found that high-quality job applicants were attracted to organisations with a good reputation and were more likely to accept lower wages from those organisations. A good reputation has also been shown to widen the opportunities available to organisational managers (Da Silva & Batista, 2007); and enhance the ability to meet the demands and expectations of an organisations stakeholders (Coombs, 2007; Luoma-aho & Makikangas, 2014). For example, Carmeli et al., (2006) found that a positive reputation was likely to influence a range of behaviours, attitudes and affective commitment to an organisation.

The effective use of reputation is more common within some research areas than others. Walker (2010) surveyed the field of organisational reputation and concluded that the discipline was largely unrefined and underpinned by inconsistent and varying theories. Ten years later, Veh et al., (2019) in their systematic review of reputation literature, found that the inconsistencies and varying theories continue to dominate reputation literature. Beyond the inconsistency of the concept, organisational

reputation has been investigated in several different disciplines and, therefore, from varying perspectives (economic, strategic, marketing, organisational, sociological and accounting) (Eckert, 2017).

Beyond academia, reputation has mostly been observed within private organisations through rankings such as the Corporate Reputation Index and Fortunes Most Admired Companies (Tischer & Hildebrandt, 2014). Much of the reputation literature has focused on private organisations (e.g. Aksak et al., 2016; Dentchev & Heene, 2004; Kelley et al., 2019; Odriozola & Baraibar-Diez, 2017) and non-profit organisations (de Quevedo-Puente & Perez-cornejo, 2020; Fillis, 2003; Pérez-Cornejo et al., 2020; Rim et al., 2016; Standifird, 2005). The ranking and comparison of organisations can raise questions of solidarity and legitimacy in public sector organisations because on this scale, someone wins, which means that someone must also lose (Waeraas & Byrkjeflot, 2012; Kuoppakangas, 2015). For public sector organisations and particularly public healthcare organisations, it is more complex as there are more expectations of similarity in values, quality and service delivery (Kuoppakangas et al., 2019).

Although reputation management is beginning to emerge in the public sector arena (Kuoppakangas et al., 2019), studies suggest that the reputation of public organisations is not formed in the same way as it is in private organisations (Luoma-aho, 2007). This has resulted in a number of studies considering reputation management in public organisations problematic (For example Leijerholt, Chapleo, & O'Sullivan, 2019; Leijerholt, Biedenbach & Hultén, 2019; Suomi & Jarvinen, 2013; Waeraas & Byrkjeflot, 2012), particularly because of the scarcity of autonomy to operate independently (Waeraas & Byrkjeflot, 2012). For example, public organisations can create their own vision and mission goals, but they must align with the political mandate under which they operate, irrespective of how positive or negative stakeholders perceive that vision and mission. In healthcare, politics may become visible, for example, in terms of the government allocating more resources to certain healthcare organisations with the aim of creating world-class healthcare (Commonwealth of Australia, 2020), while other healthcare organisations try to improve their reputation with fewer resources.

A key characteristic of organisations with strong positive reputations is their uniqueness and distinction from competitors (Waeraas & Byrkjeflot, 2012). However, public organisations are more likely to be viewed as similar because of their common characteristics as political, rule orientated, and often hierarchical organisations (Waeraas & Byrkjeflot, 2012). Hence, public sector organisations may struggle with uniqueness which makes reputation management problematic as reputation as a concept alludes to comparison among organisations (Fombrun & van Riel, 1997). Waeraas and Byrkjeflot (2012) note that public sector organisations face stronger public expectations of quality, service provision, values and solidarity between organisations. Making the management of reputation in public organisations a balancing act between acquiring legitimacy and building reputation (Sataoen & Waeraas, 2015; Waeraas & Sataøen, 2015). Some studies examining public organisations have reported challenges in building uniqueness and reputations in order to differentiate them from their competitors (For example Chapleo 2004; Suomi & Jarvinen, 2013).

Accordingly, it follows that reputation management in public healthcare organisations does not mean the same as reputation management in a private organisation. The scholarly focus of reputation in mostly private organisations would indicate that research in public contexts, and more specifically public healthcare contexts, might benefit from a more complete and explicit understanding of organisational reputation. A key purpose of this chapter is to address this deficit.

2.2 THEORETICAL DIMENSIONS OF REPUTATION

Previous research motivated by gaps in understanding the concept of reputation has looked at reputation through different theoretical perspectives (For e.g. see, Berg et al., 2010; Jensen et al., 2012 Rindova, et al., 2010; Rindova & Martins, 2012). Varying theories have been used in both conceptual and empirical papers examining reputation (Walker, 2010). Some of the invoked theories include stakeholder theory (Cable & Graham, 2000), social identity theory (Turban & Greening, 1997), game theory (Pineiro-Chousa et al., 2016; Jaramillo & Srikant, 2010), economic theory (Rindova et al., 2005), transaction cost economic theory (David & Han, 2004; Williamson, 2008) and attribution theory (Flanagan & O'Shaughnessy, 2005). The key theoretical perspectives that feature prominently in the literature include institutional theory (Staw

& Epstein, 2000) signalling theory (Basdeo et al., 2006; Dentchev & Heene, 2004) and resource-based view theory (Bergh et al., 2010; Roberts & Dowling, 2002).

2.2.1 Institutional theory

Institutional theory has been used to examine how organisations achieve positive culture and legitimacy within their context to grow their reputation (Deephouse & Carter, 2005; Staw & Epstein, 2000; Walker, 2010). To do this, organisations must actively work towards building their reputation, with more emphasis on looking to their peers for cues to appropriate behaviours (DiMaggio & Powell, 1983; Marquis & Tilcsik, 2016). This means that building a reputation takes consideration of the specific environmental context in which the organisation is situated (Walker, 2010).

Institutional theory has remained an influential perspective within the field of organisational studies and strategic management, and increasingly so, within the public sector research field (Andrews-Speed, 2016; Yang & Konrad, 2011). The basic premise of institutional theory within public institutions is that they are organised configurations that are predisposed to institutionalisation processes; for instance, they reflect as well as produce eclectic values, norms, rituals and identities about themselves, society and polity (Dolan & Connolly, 2018; Yang, & Konrad, 2011). That is, organisations may behave in ways that do not lead to improving reputation per se; however, these same behaviours may improve the chance of organisational success and ultimately reputation through demonstrated adherence to structures and processes that are considered 'legitimate' within their broader social and political environment (Davis, 2016; Dolan & Connolly, 2018).

2.2.2 Signalling theory

Signalling theory has been used to explain how reputation is formed by the information signals sent by an organisation, as well as from stakeholder perceptions and understanding of the organisation's behaviour (Fombrun & Shanley, 1990; Shamsie, 2003; Yusuf et al., 2018). The perceptions and understandings indicate how stakeholders interpret the information signals sent by the organisation (Fombrun & van Riel, 1997). The signals and perceptions are incorporated to explain the formation of a reputation as an aggregate consequence of ongoing creations between organisations, stakeholders and other actors in the organisations' environment. (Rindova, 1997).

However, the ongoing applications can neglect the stability of signalling strategies and may result in incomplete information on reputation. Organisations must send out the right signal to the right stakeholder to achieve effective reputation management (Dentchev & Heene, 2003). Hence, signalling theory includes building and maintaining reputation based on the organisational images that are projected.

2.2.3 Resource-based view theory

Resource-based view of the firm theory examines how reputation is a valuable, rare, inimitable and non-substitutable (VRIN) intangible resource that leads to a competitive advantage (Deephouse, 2000; Roberts & Dowling, 2002; Wernerfelt, 1984). Developed in the mid-1980s and early 1990s, Resource-based view (RBV) theory argues that while it is necessary for an organisation to possess VRIN resources, organisations must also demonstrate the ability to alter them to their full potential in order to gain a competitive advantage and superior performance (Boyd et al., 2010). RBV has become one of the most prominent and influential theories for "describing, explaining and predicting organisational relationships" (Barney et al., 2011, p. 1300). However, recognising and managing VRIN resources is only part of the process of RBV theory; developing and strategically managing the resources builds organisational livelihood and reputation (Tarafdar & Gordan, 2007).

Reputation from an RBV perspective is a valuable and rare intangible resource because of its difficulty to imitate and its causal ambiguity (Szwajca, 2018; Walker, 2010). The more ambiguity surrounding the components that make up reputation (e.g. product quality, technical hardware, human capital (knowledge, experience, expertise, relationships, training), material capital and organisational capital (formal and informal structures and networks), the greater its importance as it leads to organisational performance and competitive advantage (Boyd et al., 2010; Kuoppakangas et al., 2019; Rindova et al., 2005). Despite the theoretical prominence of RBV theories within private sector organisations (Barney & Arikan, 2001; Boyd et al., 2010; Deephouse, 2000; Hoflinger et al., 2018; Newbert, 2007; Powell & Dent-Micallef, 1997; Schroeder et al., 2002; Raithel & Schwaiger, 2015; Rindova et al., 2010; Roberts & Dowling, 2002; Wiklund & Shepherd, 2003) the perspective has received only limited attention within public sector research, although interest is beginning to grow (Andrews et al., 2016; Ferlie & Ongaro, 2015).

While the three (institutional, signalling, RBV) theories associated with reputation feature prominently in the literature, researchers that used RBV theory were more closely aligned to the five identified attributes defining reputation. These being stakeholder perception of issue-specific reputation, measured against some standard, over time (Walker, 2010). RBV theory's close alignment with these reputational attributes highlights the applicability of RBV theory in the study and measurement of organisational reputation. Despite the prominence of RBV theory within private sector scholars, the perspective has received only limited attention within public sector studies, though interest is developing (Andrews et al., 2016; Ferlie & Ongaro, 2015). The large application of RBV theory and reputation within private sector organisations and the limited use within the public sector does not illustrate a lack of usefulness within this context. Instead, it suggests an emerging exploratory field for this theory (Klein et al., 2010; Kuoppakangas et al., 2019; Szymaniec-Mlicka, 2017; Waeraas & Byrkjeflot, 2012).

2.2.4 Resource-based view theory for public sector organisations

The usefulness of expanding RBV theory in the management of public organisations is the efficiency-based explanation of sustainability and performance that has been valued by some scholars as enabling organisations to survive or even thrive in turbulent environments (Barney & Clark, 2007; Fredericks, 2005; Krupski. 2012). Support in the literature on the use of RBV theory reflects a transforming theory specifically focusing on resource and capabilities that organisations can exploit for competitive advantage, contestability and performance (Newbert, 2007; Szymaniec-Mlicka, 2017).

Public organisations and, in particular public healthcare organisations are externally justified with their existence dependent on the provision of services for public purpose (Bryson et al., 2007). To assist public healthcare organisations to meet expectations and create healthcare value and responsiveness, RBV theory is useful as it is likely to assist healthcare leaders in understanding resource value and value creation as being dependant on the efficient and effective use of resources in delivering quality healthcare.

Public healthcare organisations are facing dynamic economic, financial and social challenges and are searching for solutions that translate into greater adaptability and efficiency from an already turbulent and uncertain environment (Bryson, et al., 2007). Greater adaptability and efficiency are essential to ensure sustainability and performance and to meet the demand for insight and transparency surrounding the nature and management of public resources (Klein, et al., 2010; Szymaniec-Mlicka, 2017). Within the Australian context, the performance and sustainability of public healthcare organisations are important for the allocation of government resources. This is because of an increased reliance on performance assessments by the government emerging over recent years (Bennett, 2013). As such, the reputation of healthcare organisations has become increasingly important. However, to fully understand and manage reputation, it requires defining.

2.3 DEFINITIONAL DEVELOPMENT OF REPUTATION

Defining reputation has raised some difficulty as there is yet to be an accepted definition (Chun, 2005; Gotsi & Wilson, 2001; 2001a; Szwajca, 2018; Veh, Gobel & Vogel 2019; Walker, 2010). Without a confirmed and supported definition, measurement methodologies are questionable and weakened (Szwajca, 2018; Walker, 2010). Many definitions of reputation have emerged in the literature. Barnett et al. (2006) in a review of the literature between 2000 and 2003, found 49 different versions defining reputation. Recent scholars continue to cite varying definitions for reputation (Bustaman et al., 2020; Szwajca, 2018). The diversity is largely as a result of the confusion surrounding the terms – identity, image and reputation (Clardy, 2012; Szwajca, 2018; Walker, 2010). These terms are often used interchangeably and lack consistency in their use (Clardy, 2012; Walker, 2010). For example, Gray & Balmer (1998) define 'organisational identity' as, "distinct characteristics of the organisation…what the organisation is"; 'organisational image' as "the mental picture of the company"; and 'reputation' as "the estimation of the company by its constituents" (pp.695-697).

Alternatively, Chun et al., (2019) define 'organisational identity' as "the employees' view of the company"; 'organisational image' as "the view of the company held by external stakeholders", and 'reputation' as "a collective term referring to all stakeholder's view of reputation including identity and image" (pp.113-114). While

there is a lack of resolution between these terms, there does appear to be agreement that each of these terms are individually distinguished (Clardy, 2012).

Despite the consistency challenges of a clear definition of reputation, scholarly thinking suggests that reputation is characterised by five main attributes: (1.) reputation is based on perceptions; (2.) it is the aggregate perception of stakeholders; (3.) it is comparative; (4) it can be positive or negative; (5.) it is relatively stable and enduring (Szwajca, 2018; Walker, 2010). Attempts to define reputation within the paucity of literature has consistently identified the use of all or some of the five attributes of reputation (e.g. Bustaman et al., 2020; Cable & Graham, 2000; Deephouse, 2000; Fombrun & Rindova, 1996; Rhee & Haunschild, 2006; Rindova et al., 2005; Szwajca, 2018; Walker, 2010; Weigelt & Camerer, 1988; Whetten & Mackey, 2002).

Fombrun's (1996) definition of corporate reputation is frequently cited in the literature and contains varying degrees of these five attributes. Walker (2010) building on Fombrun's (1996) definition, clearly outlined, in his definition of reputation, the five attributes that have been empirically identified since 1996:

> A relatively stable, issue-specific aggregate perceptual representation of an organisations past actions and future prospects compared against some standard. (p.370).

At first it would seem that the multiple voices redefining the definition of reputation exacerbates the confusion and in a way it does. However, based on over 20 years of extensive literature defining reputation, it can be concluded that a lot of work has already been done and that now is the time to build on previous work and establish conformity and consistency. For the purposes of this study Walker's (2010) definition outlined above was used.

2.3.1 Defining reputation for measurement

The definition of reputation is important in order to align the measurement of the construct with the definitional attributes (Mahon, 2002; Walker, 2010; Wartick, 2002). The construct of organisational reputation suffers from a lack of consistency and this confusion is largely reflected in the range of methods that are used to measure reputation (Clardy, 2012). Reputation has been measured using several methods with

the most common being Fortune's Most Admired Companies (FMAC) which takes an aggregate perception of executives, directors and financial analysts on companies financial performance (Brown & Perry, 1994; Fryxell & Wang, 1994; Lewellyn, 2002; Walker, 2010). Other measures include, media reputation from various newspaper articles (Deephouse, 2000); and character scale instruments. For example, the Reputation Quotient Index, which is a 20-item instrument measuring, emotional appeal; products and services; vision and leadership; workplace environment; social and environmental responsibility; and financial performance (Fombrun & van Riel, 2003).

The operationalisation of reputation measurement requires close ties to the definition of the construct (Mahon, 2002; Walker, 2010; Wartick, 2002). The five attributes outlined in the definition each have measurement implications: (1) reputation should examine the perceived reputation and should be measured as stakeholder perceptions and not objective measures such as market share (Fang, 2005); (2) it is the aggregate perception of all stakeholders but needs to be issue-specific (for example an organisation may have different reputations for different issues, i.e. a good reputation for performance but a bad reputation for employee conditions); (3) reputation is comparative which makes the measurement flexible to be compared with a number of possible standards (e.g. prior reputation; industry competitors); (4) measurement of reputation can be positive or negative and many studies have examined only organisations that have a good reputation. Studies that examine both have the potential to provide more insight into organisational reputation (Walker 2010); (5) reputation is relatively stable and enduring, which highlights some implications for reputation measurement methods when considering longitudinal or cross-sectional studies. Longitudinal research may be more valuable as research has demonstrated organisational reputation is stable, although, given the stability, conclusions from cross-sectional studies are likely to be more credible than studies examining unstable or short-lived concepts (Veh, Gobel & Vogel, 2019; Walker, 2010).

Reputation measurement within public sector organisations has had little influence within the field of organisation studies and strategic management (Andrews et al., 2016). The basic premise of reputation measurement is dependent on the reputational issue. The five attributes identified in the definition of reputation are all relevant when seeking to understand and measure organisational reputation. As Walker (2010)

suggests, these attributes contribute to the notion that organisations can have multiple reputations on distinct and differing issues and as such, researchers examining reputation must determine the reputation for what and according to which stakeholder? Organisations can learn to capitalise on their reputation by exploring the reputational issue within the particular context; however, they need to be prepared to understand how stakeholders conceptualise and form reputation in order to measure and manage their reputation. Without this understanding, organisations are likely to misinterpret the reputation being measured or the ability to influence reputation. It is this gap in the literature on how reputation is conceptualised and formed by stakeholders of public healthcare organisations, which this study seeks to explore.

2.4 CHALLENGES FOR REPUTATION MEASUREMENT IN PUBLIC SECTOR ORGANISATIONS

The five attributes associated with the definition are all important when considering the measurement of organisational reputation (Walker, 2010). Research suggests understanding and measuring reputation in public sector organisations requires the distinction between one aggregate perception of reputation and one issue-specific aggregate reputation (Walker, 2010). The distinction between one overall aggregate perception of organisational reputation and the issue-specific aggregate reputation perspective allows for the notion that public organisations can have multiple reputations on different issues. For example, the reputation of the organisation as a service provider or the reputation of the organisation as an employer. However, a true reputational measurement can only result from a sampling of representative stakeholders on a conceptually relevant and issue-specific set of criteria (Andrews et al., 2016; Fombrun, 1996; Walker, 2010).

Reputational research in the public organisational arena is sparse and may be largely due to a number of inherent problems that most public organisations face, such as political constraints on management strategies (Waeraas & Byrkjeflot, 2012), and difficulty with consistency, uniqueness and excellence (Kuoppakangas et al., 2019). While the value of reputation is well defined within the private sector (Fombrun, 2001), the notion of reputation as a valuable resource for public organisations presents some challenges. This is because statements conveying a negative image of public organisations have been heard for years with the general perception of public

organisations as being too big, wasteful, slow, unreliable and inefficient, and not sufficiently transparent (Waeraas & Byrkjeflot 2012). Bureaucracy, by which public organisations are characterised, is used often as a derogatory term that makes it easy to forget the values it was originally supposed to embody, such as progress, rationality and efficiency (Bryrkjeflot & du Gay 2012; Olsen 2005).

Governments and public figures are concerned about citizen's dissatisfaction with public sector services and with organisational reputation as a whole (van de Walle 2013). In response, many public organisations are taking matters into their own hands by adopting image-building concepts such as reputation (Dolnicar & Lazarevski, 2009). Strong reputations serve as a competitive advantage, and for public organisations, it is a valuable political asset that can be used to generate public support, achieve delegated autonomy and discretion from politicians, and for recruiting and retaining valued employees (Carpenter et al., 2012; Kuoppakangas et al., 2019).

Coming to the realisation that reputational value for public healthcare organisations is multifaceted and involves different stakeholders, the traditional private corporation approach is rapidly paving the way for a more performance-based model that recognises and involves an additional consequential perspective to consider over and above the service delivery relationship. It highlights the constructed effectiveness of key individual stakeholders' perception of an organisations service provision (Green & Griesinger, 1996). For internal stakeholders, an organisations perceived performance influences their behaviour towards the organisation (Willems et al., 2016). In particular, it can influence an organisations ability to attract resources, professionals and also affect employees' commitment to, and decision making for the organisation (Willems et al., 2016). Managing reputation as a resource that potentially affects performance may provide public healthcare organisations with a competitive advantage for funding opportunities, philanthropic donations and the ability to attract high-quality professionals (Boyd et al., 2010).

Public sector reputation can be understood to consist of several levels. On the macro level, it is affected by the socio-political climate, world and economy trends; on the meso-level, the trustworthiness and performance of institutions; and on the micro-level, the public services provided and the public servants' competence (Fombrun & van Riel, 2003; Luoma-aho, 2007; Stenvall, 2000;). Public healthcare reputation is a

derivative of the organisations conduct over time and is formed in the minds of the stakeholders (Luoma-aho, 2007). Scholarly thinking on the reputation performance relationship has highlighted inconsistent findings, mostly due to the measurement of reputation. Reputation is based on stakeholder perceptions; however, most studies have measured reputation through surveys, with the most widely used being Fortune's Most Admired Companies (FMAC). The FMAC indices represent perceptions about an organisation through the business community (usually CEOs and financial analysts), which may be different from the perception of the organisation by the general public and key stakeholders specific to organisations (Kaur & Singh, 2020; Caliskan et al., 2011). The inherent limitations of these indices have questioned their applicability and usage as a universal measurement tool (Brown & Perry, 1994; Kaur & Singh, 2020; Kuoppakangas et al., 2019; Walker, 2010). Respondents are asked to rank various organisations, some of which they may be unfamiliar with, which again questions the credibility of the scale and the credibility of ranks assigned to organisations (Kaur & Singh, 2020).

In addition, the strong association with financial performance and personal prejudice incorporated with this instrument limits its use for accurate benchmarking between industry competitors (Fryxell & Wang, 1994; Kaur & Singh, 2020). Subsequently, some scholars have highlighted the inability of the instruments using a survey method like FMAC to fully incorporate multiple stakeholder perceptions about an organisation or about specific reputational issues (Tomak, 2014; Kansal et al., 2014). Hence, the perception of other stakeholders and the reputation issue being measured needs to be considered when measuring reputation. While some studies have added additional issue-specific reputation measurements (Kaur & Singh, 2020; Tomak, 2014) without understanding how reputation is conceptualised and formed in the minds of stakeholders, a truly accurate reputation measurement cannot be suitably developed. In the same way, without an accurate reputation measurement instrument, a true picture of the reputation performance relationship cannot be confirmed.

Before embarking on hospital performance and its association with reputation, it useful to explore the Australian Healthcare system, its complexities and the reforms that have shaped the health system in Australia and placed greater attention and importance on performance.

2.5 THE AUSTRALIAN HEALTHCARE SYSTEM

2.5.1 Healthcare decision-making structure

The role of the Australian government in delivering healthcare services is to improve the health and wellbeing of all Australians and to provide safe and affordable healthcare, now and into the future (Commonwealth of Australia, 2019). The Commonwealth, State and Territory governments each have a vital role in healthcare as funders of health services, as service providers, and as the regulators of healthcare services (Daley et al., 2019). Importantly, the responsibility of government in Australia is multilayered and complex but essentially falls under two main areas. Firstly, the political role and responsibility of setting Australia's health policy. Second, the economic role and responsibility for funding healthcare services.

Uniquely, the role of government in Australia's healthcare system is shared among the Commonwealth, states and territories, and local governments (Duckett & Wilcox, 2015). The Commonwealth government is responsible for Australia's medical services through the Medicare scheme, which is funded by Australian taxpayers (Duckett & Wilcox, 2015). The commonwealth is also responsible for the Pharmaceuticals Benefits Scheme (PBS), which helps make medicines cheaper for Australians. In addition, the Commonwealth supports and regulates private health insurance and monitors and supports the efficiency and effectiveness of Australia's primary health services (Commonwealth of Australia, 2019). A further responsibility includes the provision of hospital and medical services to eligible veterans (Palmer & Short, 2014). The states and territories have primary responsibility for managing and administering public hospitals. However, there are some differences between the states and territories in the funding model used and the governance structure under which hospitals and health services are managed. The states and territories are also responsible for the licensing, monitoring, inspecting and regulation of private hospitals, aged care facilities and health premises. Local government responsibilities include environmental health protection, health education activities and community-based and home care services (Palmer & Short, 2014).

Historically, the sharing of responsibilities by governments has challenged the delivery of national health policies (Duckett & Wilcox, 2015). Earlier governments have argued that the Commonwealth should leave health matters to the states and

territories as a direct result of tensions experienced by the states implementing Commonwealth health policies and initiatives (Palmer & Short, 2014). However, Australia's Commonwealth Constitution gives power to the Commonwealth to make laws about the provision of medical benefits and hospital services. Hence, providing no legal, constitutional basis for healthcare being the sole responsibility of the states and territories. History has shown that neither the states and territories nor the Commonwealth have any interest in being solely responsible for the Australian health care system (Hall, 2015). In addition, decisions made by one government seem to provide little if any consideration of the implications those decisions will have on other areas of the healthcare system. As a result, there is often a shifting of blame and a ducking of responsibility from one government to another when failure strikes (Commonwealth of Australia, 2006; Hall, 2015). For example, when budgets are blown and/, or there is a shortage of beds, states and territories blame the Commonwealth for insufficient funding. In turn, the Commonwealth blames the states and territories for poor, inefficient budget management (Hall, 2015). As such, the division of responsibility for healthcare between the levels of government, as well as rising demand and costs for healthcare services, has been the basis for ongoing healthcare reform in Australia.

Traditionally, publicly delivered health services are fraught with problems, such as technical insufficiency and resource inefficiency (Harding & Preker, 2003). At the systemic level, resources often flow disproportionately to the requirements, and to make matters worse, the public sector is often lax at effectively managing and tracking costs (Alexander, 2001). Such inattention to expenditure and inefficiencies reduces the ability to identify and deliver efficient and effective service delivery (Harding & Preker, 2003). Inattention to expenditure has a flow-on effect as new and innovative services tend to be funded when health services have a reputation of being well managed and high-performing. Hence, the importance of a competitive edge for public healthcare organisations is vital to ensure additional funding for new innovations and services.

From mid-1970, there has been growing concern for the effectiveness, efficiency and performance of Australian health services (Degeling & Carr, 2004). As a result, health policy and reform have remained high on the political agenda, with governments increasing their involvement in healthcare reform in the areas of governance and finance

in an attempt to improve the health care system performance (Palmer & Short, 2014). The reforms have included changes to the responsibilities held across the governments (Duckett & Wilcox, 2015). For example, to improve the commitment for the governments to work together and have more transparency over funding models, the Commonwealth, state and territory governments in 2011 replaced the previous five-yearly public negotiation funding agreement, and set the Commonwealth contribution to public hospitals at 40 per cent with states/territories contributing around 51 per cent to public hospital funding. The remaining 9 percent comes from individuals through out-of-pocket expenses, private health insurers and accident compensation schemes (Australian Institute of Health and Welfare, 2019; Council of Australian Governments, 2020a).

Previous to 2017, Commonwealth efficiency growth funding has been uncapped, providing 45 per cent for all activity growth above the prior year. However, from 2017 the Commonwealth growth funding has been capped at 6.5 per cent of funding, with approximately 1.6 per cent consumed in cost escalation (Commonwealth of Australia, 2018). This growth funding cap is a significant gap that will not be enough to meet current and future demand (Australian Medical Association [AMA], 2017). As a result, health reforms have been driven through agendas and agreements to reduce costs, increase efficiencies and increase transparency through performance reporting, comparisons and competition. Public reporting of hospital performance is thought to be a key strategy for influencing the consumers of healthcare in their choice of healthcare service (Hibbard et al., 2005). Performance reporting promotes consumer choice and can affect the reputation of a health care organisation (Hibbard et al., 2005). For example, healthcare organisations that have a good performance in the key indicators will be seen as having a good reputation for the provision of healthcare services (Luoma-aho, 2007). In other words, it can contribute to the legitimacy of the organisation.

Notably, government agendas and agreements have been largely influenced by the Council of Australian Governments (CoAG). CoAG was established in 1992 and dmanaged matters of national significance that need coordinated action by all Australian Governments (Council of Australian Governments, 2020). Members of CoAG include the prime minister, state premiers, territory chief ministers and the president of the

Local government Association, who meet to develop, drive and monitor national policy reforms aimed at improving the lives of Australians. For example, the intergovernmental agreement on competition and productivity-enhancing reforms, which is aimed at improving Australia's economic performance in several areas, including health.

2.6 AUSTRALIAN HEALTHCARE REFORM

Major reforms driven by the Commonwealth government since 2006 have focused on access, delivery, equity, effectiveness and efficiency (Commonwealth of Australia, 2020a). Each new reform agenda has been aimed at increasing accountability, responsibility and government monitoring. For example, in 2008, the Commonwealth government established the National Health and Hospitals Reform Commission (NHHRC) to develop a sustainable health plan that would provide efficiencies and improvements in performance (Duckett & Wilcox, 2015). In 2010 the Australian Institute of Health and Welfare (AIHW) launched the *'my hospitals'* website to monitor, compare and report to the public on performance information for public and private hospitals in Australia (Australian Institute of Health and Welfare, 2020).

In 2008, the National Health and Hospitals Reform Commission (NHHRC) was established to provide a 'blueprint' for design and a plan of action to manage and identify the current challenges facing the Australian health system. The NHHRC released its 2009 report on a national plan for health reform with 100 recommendations to transform Australia's health system. For example, the commission identified the need to improve hospital accountability and recommended publicly reporting on performance against a national set of indicators that measure access, efficiency and quality of care (Commonwealth of Australia, 2009). The report by the commission pressures the government to respond to the challenges and contribute towards a sustainable, high quality, responsive health system (Bennett, 2009). As such, health reform will continue to remain up front and centre on the government's political agenda to which health administrators will need to respond.

Significantly, in 2009 Activity Based Funding (ABF) was introduced to provide a nationally consistent funding approach for public hospitals (Eagar et al., 2013). The National Health Reform Agreement was signed by the Commonwealth government in

August 2011 which commits ABF funding to public hospitals were practicable (Commonwealth of Australia, 2011). While ABF models have been used for funding Australian hospitals since the early 1990s, some of the states and territories had a significant portion of their funding based on other models, such as block funding. The ABF funding model characterises hospital funding based on the activity (mix of patients) they treat, using product identification and classification systems (Eagar et al., 2013). Funding is based on the Price and the Volume of services delivered (Commonwealth of Australia, 2018). Additionally, ABF has supported the implementation of eHealth digital information systems that give more choice, control and transparency within the health system, and more importantly, reduce costs, increase efficiencies and performance (Commonwealth of Australia, 2018). In short, the consequence of these health reforms signifies the focus on transparency, performance measurement and comparison. This has forced Hospital and Health Services to view performance outcomes as a competitive measure for future funding provisions.

One of the most significant health reforms came in 2010 with the introduction of a National Health and Hospitals Network to drive major improvements in service delivery and health outcomes for patients (Commonwealth of Australia, 2010). The aim was to decentralise public hospital management and increase accountability by devolving responsibility for service delivery to the local level, with the introduction of Local Hospital Networks (called Hospital and Health Services (HHS) in Queensland) into each state and territory (Commonwealth of Australia, 2010). The HHSs are responsible for the delivery of health services as agreed between the Department of Health and each Hospital and HHS (Queensland Health, 2020). These negotiated agreements outline the health services mix and volume, teaching, research and other services provided by the HHS (Queensland Health, 2020). Each HHS is responsible for its own budget, service delivery, quality and performance. The objective of the HHS is to strengthen performance, improve services and allow each local HHS to shape their service delivery specifically to their local community needs (Queensland Health, 2016).

Under the Local HHS, funding for public hospitals is based on efficiency, with the Commonwealth funding 60 per cent of the efficient price, a price determined by the Independent Hospital Pricing Authority (IHPA) and state governments funding the remaining 40 per cent. The efficient pricing means that HHS's that operate using less

than the efficient price for that service they can preserve and reinvest the surplus of funds. In other words, if an HHS delivers a service for less than the efficient price funding they receive from the government, they can keep those surplus funds to use within their HHS (Council of Australian Governments, 2020a). This is important to note because HHS's that are efficient will have more opportunity to spend surplus funds on new and innovative services. Hence, public healthcare organisations with a reputation of efficiency and performance will be likely to also have a positive reputation for new services and innovation. This, in turn, is more likely to distinguish the organisation from competitors in the industry, attract highly sort after professionals and loyal supporters (Baer et al., 2018).

Despite the benefits of being able to preserve funds, there are three major implications of the efficient pricing policy. Firstly, the efficiency pricing assumes that additional funding will not be provided if the HHS is unable to maintain budget integrity. Under the previous funding model, there was the ability for hospitals to negotiate additional funding from the state. However, under the current funding agreement, additional funding would only be negotiated along with additional activity and not to fix inefficiency. Secondly, the agreement sets out that the Commonwealth is responsible for growth funding however, the growth funding is capped at 6.5 per cent, which means that growth beyond that will have to be funded by the individual HHS's. Finally, as a result of the efficient pricing, HHS's are under more pressure to improve efficiency and reduce costs.

Australia's health system is founded on the principle that all citizens should be provided with "*timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country*" (Council of Australian Governments, 2012, p. A-2). Healthcare reforms have been implemented to ensure this objective by focusing on improving efficiency, effectiveness, productivity and performance. With substantial financial commitment, relatively minor improvements in efficiency, effectiveness and productivity, can have a notable positive impact on an individual's quality of life and on the local community's welfare (Commonwealth of Australia, 2019). Stimulating efficiency, effectiveness, productivity and performance in market economies have been driven by competition. The notion that competition could improve these elements in healthcare has gained increasing consideration (Arrow, 1963;

Australian Healthcare and Hospitals Association, 2016; Cutler, 2015; Hewitt, 2018; Gaynor et al., 2011; Goddard, 2015; Productivity Commission, 2002; 2014; 2017; 2018; 2018a).

2.6.1 Competition Implications of Healthcare Reform

Competition is a key element of economic policy in Australia, seen as the engine which drives efficiency, productivity and innovation (Commonwealth of Australia, 2019). In 1993, the Hilmer Committee (Commonwealth of Australia, 1993) found "*widespread community support for a National Competition Policy that would increase efficiency, improve international competitiveness and ultimately standards of living*" (Commonwealth of Australia [Hilmer Committee Report], 1993, p.iii). The Hilmer Committee proposed a National Competition Policy (NCP) that comprised a set of principles, laws and processes to ensure any anti-competition conduct needed to be explicitly justified; fostering competitive neutrality between government and private businesses when they compete; and *"reforming the structure of public monopolies to facilitate competition*" (Commonwealth of Australia [Hilmer Committee Report], 1993, p. xvii). To give effect to the recommendations set out by the Hilmer Committee, CoAG endorsed agreements that set out the strategies required to coordinate and implement the reforms, with the objective of improving living standards in Australia (Commonwealth of Australia, 2003). To address the central principle of the NCP, that arrangements that detract from competition should be retained only if they can be shown to be in the public interest, gave rise to a review of health-related legislation (*Medical Practice Act 1992* [NSW]; *Dentist Act 1984* [SA]; *Nursing Act 1992* [Qld] *Health Act 1937* [Qld]; *Private Health Facilities Act 1999* [Qld]; *Nursing Homes Act 1988* [NSW]; *Private Hospital and Nursing Homes Act 1981* [NT]).

In 2005, the Productivity Commission (PC) did a review of the NCP arrangements (Productivity Commission, 2005). While the focus of the NCP was to wind back barriers to efficiencies and free up competition, the PC Review (2005) recommended that a coordinated national reform should extend to areas beyond the NCP and focus on areas such as health and aged care (Productivity Commission, 2005, p.xxxvii.). The PC Review (2005) assessed the need for ongoing legislation review and looked for opportunities to "*strengthen transparency and gatekeeping mechanisms*" for new and amended legislation containing restrictions on competition (Productivity Commission,

2005, p. 255.) Mindful of the challenges facing Australia's ageing population and increasing healthcare costs, the review concluded that further reform is needed to improve living standards and community wellbeing. Importantly, the review highlighted the complexity of coordinating this task and the extent of coordination failure to date, suggesting that reforms in healthcare should be tackled through separate nationally coordinated initiatives (Productivity Commission, 2005).

In 2008, the NHHRC, in their recommendations to transform Australia's health system, determined that to promote autonomy and system responsiveness, consumer choice and provider competition were fundamental to an innovative, sustainable and efficient system (Commonwealth of Australia, 2009; Le Grand, 2009). The NHHRC proposed that individuals should be able to select a 'health and hospital plan' of their choice to deliver on their Medicare entitlement (Commonwealth of Australia, 2009). While a tax-funded community insurance scheme had been proposed to achieve this, in response to stakeholder feedback, the NHHRC recommended extending the current system with a reformed model called *Medicare Select* (Commonwealth of Australia, 2009).

Under *Medicare Select,* all Australians would be given a government-operated health and hospital plan that would provide the opportunity to move to another plan operated by a not-for-profit or private enterprise, with the funding following the individual. Essentially the plans would compete for membership based on premium prices, product range, quality and reputation (Commonwealth of Australia, 2009). Health and hospital plans would receive funds from the Commonwealth government on a risk-adjusted basis and through contracting arrangement plans that would purchase services to meet the full healthcare needs of their members (Commonwealth of Australia, 2009). For the market to be reasonably competitive, it would require the ability to change plans to be easy, with the threat of consumers changing plans placing increasing pressure on service providers to perform well. However, recognising the technical and policy changes required for the implementation of *Medicare Select*, the NHHRC recommended exploring the benefits and risks over the next two years. As a result, when the NHHRC report was launched, *Medicare Select* was absent from the principles that would inform future health care reform (Scott, 2009).

With the introduction of the National Health and Hospitals Network, the *National Healthcare Agreement (2011)* and *National Health Reform Agreement (2011)* addressed ways to assess the performance, efficiency and governance of the health system. However, competition-based reforms to support these objectives were either included within the performance reporting and funding arrangement or absent (Council of Australian Governments, 2012). The drivers associated with competition and choice were not included.

In 2013, the Australian government changed, and one of the first initiatives was the establishment of a *National Commission of Audit* (NCoA). The NCoA was commissioned to examine the scope for efficiency and productivity improvements across all areas of Commonwealth expenditure, including healthcare (Commonwealth of Australia, 2014). In considering healthcare reform, the Commission suggested a universal health insurance arrangement and that such an arrangement would inject greater competition and therefore efficiencies into the Australian health care system. However, a commitment to increased competition or choice was notably omitted from the final report.

In 2015, Australia's competition policy, laws and institutions were reviewed by the *Competition Policy Review Panel (Harper Review)* to determine whether they remained fit for purpose considering the challenges and opportunities facing Australia in the foreseeable future (Commonwealth of Australia, 2015). The Harper Review recommended a new set of competition principles that would assist in directing the government's commitment to competition reform (Hewitt, 2018). Competition was welcomed if it was in the public interest and did not impede on the long-term wellbeing of the public (Commonwealth of Australia, 2015). The healthcare sector was expressly recommended by the Harper review (2015) as being amenable to competition reform to ensure innovative ways to deliver high quality and efficient human services.

In 2016, the Productivity Commission was requested to inquire into Australia's human services with an objective on innovative ways to improve outcomes through the introduction of competition and informed user choice (Productivity Commission, 2017). The inquiry found that the provision of public hospital services was one of the six human services best suited for competition-based reform (Productivity Commission, 2017). One of the main principles of the inquiry was that healthcare should be user-

focused with consumer choice the basis of service provision and delivery (Productivity Commission, 2017).

In summary, competition in Australia's healthcare system has been frequently recommended, with an increasing momentum since 2005. Appendix A (Healthcare Reform Strategies) sets out the persistent strategies that have arisen from healthcare reform considerations since 1993. While competition, contestability and choice are still in the early stages of reform, it is likely that these factors will become an important part of Australia's healthcare system in the future. Particularly since other successful jurisdictions, such as the United Kingdom, have had competition policy as an integral part of their National Health Service. One of the important effects of competition, contestability and choice is reputation. Reputation can be an additional source of competitive advantage for organisations (Szwajca, 2018; Walker, 2010). Therefore, with the drive for efficiency, performance and accountability to the government and the public, healthcare organisations are pressured to meet the objectives of efficiency and performance and consider reputational implications of healthcare reform.

2.6.2 Reputation and Management Implications of Healthcare Reform

Recent healthcare reforms discussed above have implications for the reputation management of healthcare organisations. Reputation has long been considered a rare and valuable resource, particularly within private sector organisations (Barney, 1991; Klein et al., 2010; Szymaniec-Mlicka, 2014). However, reputation management is becoming increasingly important in public healthcare organisations (Szymaniec-Mlicka, 2014). Public sector organisations are beginning to understand the importance of reputation and the many benefits that are vital to survival, such as a highly skilled workforce and easier recruitment (Deephouse & Carter, 2005; Fombrun & van Riel, 2003; Tyler, 2006). Understanding the influences on organisational performance forms the basis of the strategic management field of inquiry. Studies linking reputation to performance show that a strong reputation is a powerful tool in the search for a competitive advantage (Bergh et al. 2010).

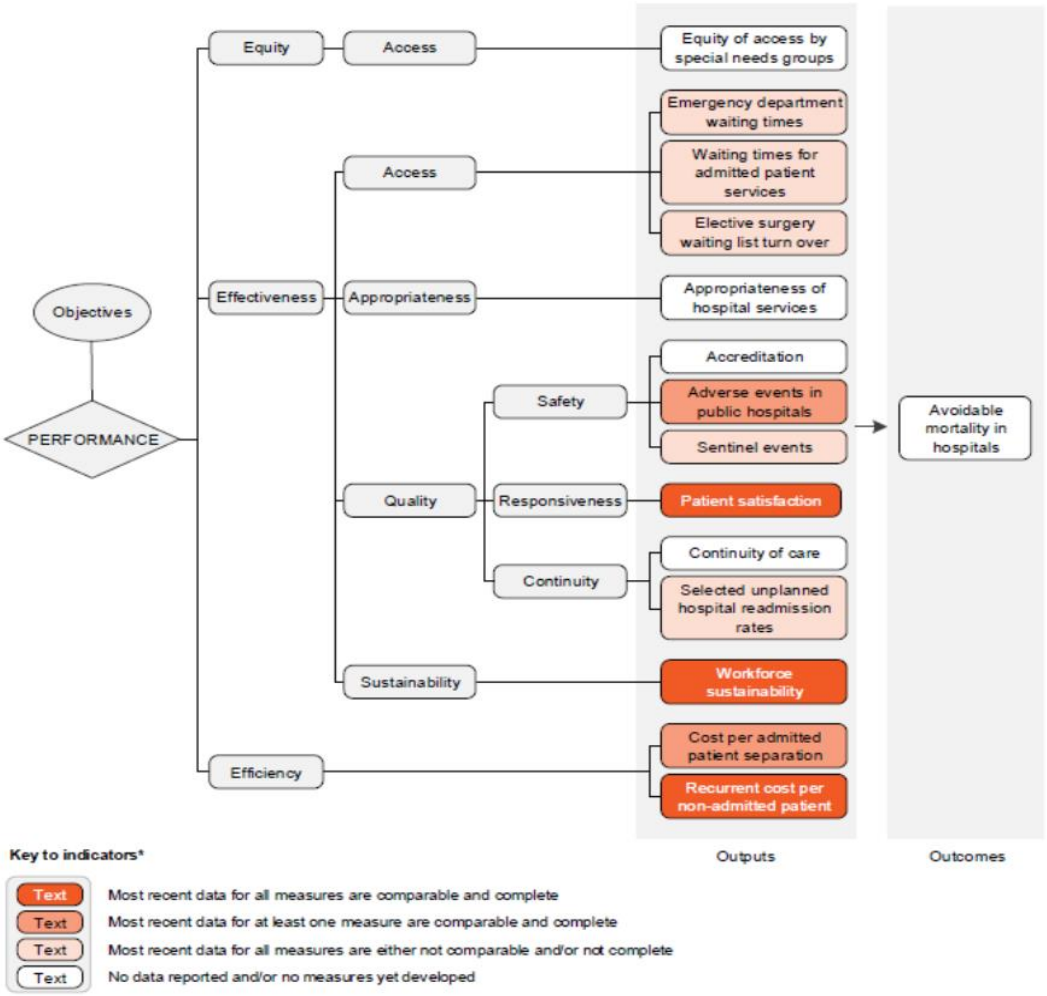
2.7 PUBLIC HEALTHCARE SECTOR PERFORMANCE

Public hospitals in Queensland are linked to government set key performance indicators and measures. The measures are used to compare hospitals within and

between jurisdictions (Australian Institute of Health and Welfare, 2020). Figure 1. Public hospital performance indicator framework identifies the key performance indicators for public hospitals in Australia are based on equity, effectiveness and efficiency of health services.

Figure 1

Public hospital performance indicator framework.



Source: https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/health/public-hospitals.

Figure 1 above outlines equity, effectiveness and efficiency as the three main objectives of healthcare delivery in public hospitals in Australia. Each of the objectives is distinguished between outputs and outcomes of service delivery. Equity is linked to access and the importance of access by special-needs groups as an outcome indicator of the government's objective to provide hospital services equitably. Effectiveness is

linked to access, appropriateness, quality and sustainability as output indicators and avoidable mortality in hospital as the quantifiable outcome indicator. Effectiveness indicators monitor the government's objective to provide timely and accessible services to all Australians. Efficiency performance output indicator is based on cost per admitted patient separation and non-admitted patient as indicators of the government's objective to deliver services in an efficient manner. The aim of this performance indicator framework is to provide a transparent and comparative reporting system for all public Hospital and Health Services in Australia.

In addition, Queensland Health has established a performance framework for delivering the government mandate of a high-performing health system for Queenslanders. The framework sets out the performance requirements, measures and reporting structure in which the Department of Health monitors and assesses the performance of public sector health services in Queensland (State of Queensland [Queensland Health], 2020a). The performance reporting has major implications for managers of Hospital and Health Services in respect to ongoing budgetary allocations. In other words, with budget allocation linked to performance targets of efficiency and effectiveness of each hospital, managers of healthcare services need to ensure that their service is efficient and maintains budget integrity whilst providing high-quality care. This means that both senior managers and frontline clinicians work together and commit to high quality, efficient service delivery for Australian consumers. Consequently, now more than ever, healthcare organisations will need to pay attention to reputation management to optimise and influence all aspects of performance to ensure a competitive advantage.

Notably, the use of comparable performance targets for hospitals has raised questions as to the exclusivity of the indicator leading to tunnel vision of other important performance imperatives (Masso et al., 2010). In other words, too much emphasis on targets can shift focus from assessing the overall performance of hospital services. For example, emergency department access targets resulted in departments directing their efforts on achieving the target at the expense of other performance areas such as quality and staff well-being (Mortimore & Cooper, 2007). As such, budget allocation for hospitals is likely to be based on criteria that do not accurately reflect the true indicators of the performance of the hospital and may result in reduced budget

allocation, yet working with a decreased budget may impact on the hospital's performance. This then becomes a paradoxical situation from which the healthcare organisation cannot escape. Scholarly literature offered very little reflection on how various factors triggered by mechanisms operating with healthcare organisations might be prioritised or positioned to bring about a performance outcome.

Consequently, the move to performance benchmarking highlights the importance of competitive advantage and the strong implications for reputation management. The public healthcare sector has been influenced by efficiency and competitive advantage methods used by private healthcare sector managers (Richardson, 2002; Dedman et al., 2011; Duckett & Wilcox, 2015). For example, the Casemix development program and the Australian Refined Diagnosis Related Groups (AR-DRGs) development program are specific programs introduced by the Australian government to facilitate the adoption of targeted managerial strategies to measure performance and reduce costs (Duckett & Wilcox, 2015). Hence, the service of health is heavily influenced by the business of health, with direct implications for Health Service Managers and clinicians. The pressure and accountability for efficient and effective health service management will require strategic reputation management and clear competitive advantage strategies to ensure the responsibility of fulfilling the government mandate and community expectations.

Despite a steady stream of research into the reputation-performance link, uncertainty continues to exist on two main levels: the nature of the relationship and the direction of its influence (Kaur & Singh, 2020; Boyd et al., 2009). While a number of studies point towards the existence of a strong relationship between reputation and performance (Alvarado-Vargas, 2013; Anderson & Smith, 2006; Boyd et al. 2010; Eberl & Schwaiger, 2005; Hall & Lee, 2014; Lee & Jungbae Roh, 2012; McGuire et al., 1990; Raithel & Schwaiger, 2015; Roberts & Dowling, 2002; Sarstedt & Schloderer, 2010; Wang & Berens, 2015; Zhang & Rezaee, 2009) the influence and direction of the relationship remains unclear. Analogous to the chicken and the egg paradox, the dilemma still exists as to whether reputation influences performance, whether performance influences reputation, or whether both reputation and performance influence each other. Scholars examining the relationship between hospital performance and reputation indicate the need for more rigorous future research focus on

the reputation-performance relationship. In particular, taking care to distinguish antecedents, such as reputation, from contextual perplexities and adequately explore the true indicators of hospital performance. To effectively examine this relationship, the true understanding of the determinants of reputation for public healthcare organisations needs to be explored, and this can only be achieved by establishing how reputation is conceptualised and formed by the stakeholders of these organisations. This study seeks to explore this gap.

2.7.1 Reputational considerations of organisational strategy changes in response to healthcare reform

The complexity of the public healthcare system requires the sector to be more strategic, especially as resources become more restrained and politicians insist that their policies are delivered on (Buse et al., 2012). A key consideration of health reform is the introduction of competition and contestability into public healthcare, making reputation management at the forefront of both strategic and clinical decision making. With the drive for efficiency, performance and accountability to the government and the public, healthcare organisations are pressured to meet these obligations and consider reputational implications of healthcare reform into strategic management.

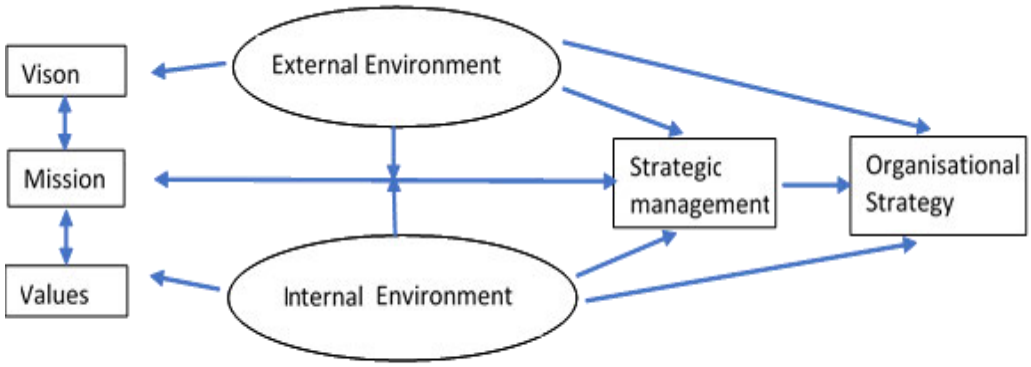
To be successful, healthcare organisations must be willing and able to effectively and creatively manage in an uncertain internal and external environment (Harris, 2006). Organisational strategy and design are key elements of the adaptability and survival of organisations in highly competitive and complex environments (Harris, 2006). Healthcare organisations are inherently unpredictable and non-linear as components of the system, internal (professionals and managers) and external (patients, family, community, political) have multiple disruptions, changes and interdependencies (Martin, 2018). Yet, the ability to change quickly in response to environmental shifts is critical to the success of organisations.

Consequently, there are several factors that will impact the development and adaptability of organisational strategy. These factors are summarised in Figure 2. The external environment within which the public healthcare organisation operates has a number of elements that can directly or indirectly affect the organisational strategy as well as the successful achievement of its objectives (Harris, 2006). For healthcare organisations, understanding the changes taking place outside of the healthcare

organisation requires consideration of both the general environment and the healthcare environment (Ginter et al., 2018). While conceptually different, the impact that these two environments can have on healthcare organisations are important (Ginter et al., 2018). The general environment can be considered as having a more indirect, albeit important, impact on healthcare organisations and generally encompasses trends occurring in the community as a whole (Harris, 2006). For example, fiscal policy and spending on infrastructure. To the contrary, the healthcare environment takes in trends affecting healthcare more specifically. For example, trends in the cost of healthcare for community members. Both general environment and healthcare environments are complex, multifaceted entities and to strategically manage healthcare organisations in these environments is challenging.

Figure 2

Factors affecting the design of organisational strategy



Adapted from Harris (2006, p. 657).

Organisations in the public sector sometimes adopt a system of 'muddling through' these environments, which is not the most efficient and effective means of managing their complexity (Buse et al., 2012). This type of approach offers minimal chance for development and is not adaptive and responsive to the problems of the organisation (Richardson, 2002). Moreover, opportunities are often missed (Richardson, 2002).

To assist organisations to function in a highly turbulent environment and to manage its scarce and valuable resources effectively and efficiently requires a well-developed strategic process (Richardson, 2002). Goods and services should be provided effectively and efficiently at minimum cost to ensure the public dollar is managed responsibly (Hope & Muhlemann, 1997). Resource management is essential for healthcare organisations, and understanding the value of resources like reputation will assist organisations in applying successful reputation management strategies to ensure optimal effectiveness. The preamble to this thesis outlines the importance of clearly aligning strategy and innovation with key stakeholders to ensure opportunities for innovation and new services are not missed. Hence, the importance of strategically managing reputation as a valuable resource in public healthcare organisations. This research will explore the value of reputation from key stakeholders: those who manage; work within, or use healthcare services.

2.7.2 Reputational considerations of stakeholder implication and response to healthcare reform

The aim of the Australian healthcare reform agenda for organisational efficiency, effectiveness and cost reduction will be achieved by setting performance targets to measure hospital performance (Duckett & Wilson, 2015). Essentially, a major component of healthcare reform is focused on influencing the behaviour of those at the front line of health service delivery. Driving quality performance and getting the best value for the health dollar by reducing inefficiency and waste has largely been led by making clinicians accountable and responsible for cost efficiency and budget integrity (Fulop & Day, 2010).

Healthcare reform agendas affecting and placing increasing responsibility on frontline clinicians is not new. While prior to the 1980's strategic decision making for healthcare organisations was dominated by the influence of clinicians (Alexander, 2001). The decisions on resource use were largely at the discretion of clinicians who determined which resources and where resources were needed, with the role of management to respond to those decisions and provide the required resources (Alexander, 2001). However, the 1980's saw major changes to this process when the healthcare system in Australia started to experience significant budgetary constraints. The fiscal restraints impacted on the elasticity of hospital budgets and the free flow of

resources previously experienced. For example, changes to resource allocation and accountability moved from administrative managers to clinicians, where the resource implications of practice were now a consideration for service delivery by clinicians.

In addition, hospitals initiated various organisational structural changes to management and leadership models as a way of maximising an advantage over the continual budgetary constraints (Fulop & Day, 2010). For example, healthcare organisations aligned divisional structures with services that are closely aligned, such as the surgical departments, perioperative department and intensive care department under the same clinical directorate, working together rather than as separate entities (Maddern et al., 2006). Hence the clinical directorates are a management cost centre overseeing several related clinical services.

The clinical sub-units, often called 'Clinical Directorates' (Dedman et al., 2011), were first introduced in 1974 at Baltimore's Johns Hopkins Hospital (Llewellyn, 2002). The model resulted in significant changes to the organisational structure of hospitals. With medical specialties grouped together to created one single entity that had full budgetary and clinical decision-making authority. The strategy was designed to place the responsibility for managing the diminishing healthcare resources into the hands of those who use them, notably medical and nursing practitioners (Dedman et al., 2011). The benefit of this organisational structural change was to have greater medical input into the prioritisation and development of health service strategies, enhance patient coordination and navigation, improve the communication by removing the silo effect of specialties working within their own sphere, and create more efficiency and effective healthcare spending (Dedman et al., 2011; Disken et al., 1990; Llewellyn, 2002;).

The clinical directorates became the new way of working and impacted not only senior managers but also on the frontline staff as well. However, having clinical directorates is not always seen as advantageous (Braithwaite & Westbrook, 2005). For instance, clinical directorates are comprised of a conglomerate of interacting subcultures, such as doctors, nurses and allied health professionals. Each subculture has its own distinct patterns of behaviour and attitudes to clinical and managerial work and change (Morgan & Ogbonna, 2008). Hence, the more powerful and vocal players within the directorate may overpower other less powerful subcultures and tensions and conflict may result.

Therefore, meeting the organisational expectations required by structural changes can influence employees' perception of organisational reputation. Employees increasingly identify with the organisation through their perceptions of reputation and the pressure and strain experienced by organisations to perform and meet expectations are often paralleled at the employee level (Baer et al., 2018). The reputation-performance induced strains can affect employee attitudes and behaviours and can lead to both benefits and burdens for employees (Maslach et al., 2001).

The reputational considerations of stakeholder implications and response to healthcare reform are important on two main levels. First, the reforms are performance and efficiency based, which affects the resource allocation, service delivery and overall reputation of the organisation. Second, the healthcare reform can influence the behaviour and attitudes of employees, which in turn potentially effects the overall reputation of the organisation. Hence, how stakeholders conceptualise and form their perception of reputation is important to know in order to influence and manage the overall reputation of the organisation.

2.8 CHAPTER SUMMARY

This chapter sought to provide an overarching review of the concept of reputation and the scholarly contribution to this construct. The contrasting theories relevant to reputation were examined and their role within organisational research. The Australian healthcare system was presented with a review of the development of the healthcare system through governmental reform. Particular attention was given to the introduction of competition relevant to healthcare and performance and its effect on reputation. A number of key observations and conclusions were drawn from the review: i) the theoretical landscape is awkward; ii) there are a large number of challenges to reputation and reputation measurement in public organisations (e.g. uniqueness, legitimacy, values, quality, service delivery, solidarity); iii) there is more governmental focus on performance and competition in public healthcare organisations, but uncertainty exists on the reputation-performance relationship; iv) little understanding of how reputation is formed and conceptualised by stakeholders of public healthcare organisations, resulting in an overall poorer understanding of reputation and reputation management.

The review of theories and context presented herein provides the structural scaffolding for a second review of the literature (as per Chapter 3) in which empirical support for relevant explanations are examined.

Chapter 3: Literature Review: Organisational Culture and Reputation

3.1 WHY ORGANISATIONAL CULTURE AND WHAT IS ORGANISATIONAL CULTURE?

Organisational culture is widely considered one of the most significant factors in understanding healthcare organisational performance (Scott et al., 2003; Mannion et al., 2009). It can be said that while researchers conceptualise and explain the very nature of organisational culture, practitioners tend to signify the management of organisational culture as a component to provide explanation and justification for organisational challenges and performance (Jacobs et al., 2013). As a result, there have been a plethora of studies into measuring and understanding organisational culture over the past few decades (Bailey et al., 2019; Curry et al., 2018; Martin, 2002; Schein, 1990).

For the purpose of this research, organisational culture is the lens used for exploring and understanding the perceptional value of reputation from key stakeholders connected to public healthcare organisations in Queensland, Australia. Therefore, this research determines that organisational culture can be defined as a "system of shared beliefs and values that guides behaviour (Wood et al., 2011) and can be informally described as "how things are done around here" (Braithwaite et al., 2017; Martin, 2002; Parker, 2000).

This research seeks to highlight the meaning behind the attitudes and behaviour of stakeholders in their perception of reputation value. Using Martin's (2002) three perspective theory of organisational culture provides this research with a wider range of insights than would be available from a single perspective viewpoint. This framework provides a conceptual sweep to identify commonalities and differences in shared meaning between the subcultural groups of frontline staff and senior managers in their perceptional value of reputation. The first part of this chapter provides an outline of the conceptual development of organisational culture and discusses the competing views that have developed throughout the literature. The competing views can be broadly categorised from two perspectives: culture as something an organisation *has*; and

culture as something an organisation *is.* Culture, as something an organisation *has*, sees culture as a variable and related in some way to organisational performance. It is under this section that Schein's (1990) model of the three levels of culture is discussed.

Following this, culture as something an organisation *is*, highlights the perspective of organisational culture as a root metaphor. In other words, under this perspective organisational culture is subjective and looks to the patterns and beliefs that make organised action possible. The chapter will then discuss the combining of these two perspectives in a way that they can be effectively regarded as complementary rather than opposing, as this is the most suitable position for this research which seeks to understand the perceptional value of reputation in public healthcare organisations.

The next part of the chapter reviews the literature to define organisational culture and outlines the difficulties with reaching an agreed definition amongst researchers, particularly concerning both subjective and objective perspectives, which feature prominently in a large portion of the definitions. As this study adopts a multi-perspective approach to understanding organisational culture, it requires a definition of culture that incorporates both the objective and the subjective perspectives. As such, the definition of organisational culture adopted for this research incorporates both perspectives and is most appropriate for this research.

The next section of this chapter discusses the use of organisational culture as a theoretical lens for this research to explore organisational life. This section discusses Martin's (1992) three perspective mode, which uses a range of complex variables as a method to interpret patterns of behaviour in an organisation. This way, organisational culture can be studied through three different lenses: integration, differentiation, and fragmentation. The appropriateness of this multi-perspective approach for this research is discussed, showing how each lens provides a different perspective of the culture within the organisations under study. It argues that a multi-perspective approach is required in the context of this research in order to develop a complete cultural picture to understand the value of reputation in public healthcare organisations.

Finally, the organisational culture - reputation relationship is discussed, highlighting that culture may be an important predictor of reputation for an organisation. Highlighted is the limited empirical evidence considering how culture and

reputation influence each other, which justifies the importance of this research in addressing this gap by exploring this relationship using a multi-perspective cultural approach.

3.1 CONCEPTUAL DEVELOPMENT OF ORGANISATIONAL CULTURE

The construct of culture has a long history in anthropology and has been used in early writings on organisations (Alvesson & Berg, 1992; Trice & Beyer, 1993), significantly by Pettigrew (1979), who introduced culture to organisational studies. Pettigrew (1979) legitimised the concepts of beliefs, ideology, language, ritual and myths in the study of organisations (Alvesson & Berg, 1992; Schneider et al., 2017; Schneider et al., 2013). His emphasis on the relevance of beliefs, myths and values for understanding what organisations are provides an instructive basis for researchers and practitioners (Schneider et al., 2017; Parker, 2000), resulting in a vast array of books (e.g. Alvesson, & Sveningsson, 2008; 2015; Gogheri et al., 2013; Martin, 2002; Schneider, 1990; Wood, 2004) conceptual papers (e.g. Alvesson & Sandberg, 2014; Martin & Siehl, 1983; Schein et al., 2014; Schein 2015) empirical studies (e.g. Araujo et al., 2019; Fu & Chan, 2014; Kanungo & Jain 2013; Lordanides et al., 2015; Naranjo-Valencia et al., 2016; 2017; Ranaei et al., 2013; Singer et al., 2009) and review articles (e.g. Braithwaite et al., 2017; Hofstede, 2016; Jung et al., 2009; McLean 2005; Runtu et al., 2019; Schneider et al., 2013; Scott et al., 2003) being published, which circumscribe to psychological (positivist), sociological (constructivist/interpretivist) and anthropological (pragmatic) epistemologies (Allaire & Firsirotu, 1984). However, despite the extensive research, there is little agreement among scholars on a clear meaning of 'organisational culture' or on how it can or should be observed or measured (Scott et al., 2003).

3.1.1 Culture – something the organisation 'has' or something an organisation **'is'?**

The conflicting views of organisational culture can be broadly grouped into two perspectives: that culture is something an organisation has or something an organisation is. That is the perspective of culture as a variable on one hand and culture as a root metaphor on the other (Kummerow & Kirby, 2014). It is important to understand both perspectives of organisational culture in order to determine the perspective of culture that is most appropriate for this research and to understand the strengths and limitations

of each. The following sections review the literature relevant to both perspectives in more detail, concluding with a justification of the use of a multi-perspective approach in the context of this research.

3.1.2 Organisation **'has'** *culture*

Culture as a variable perspective is objective and has been underlined with the basic assumptions that culture is related in some way to organisational performance (Kummerow & Kirby, 2014). When culture is viewed as something, an organisation has, it becomes a very powerful organisational tool (Ogbonna, 1992). Advocates for this view have a more pragmatic approach in the sense that their work is in some way concerned with understanding the effects of organisational culture. For example, how culture affects the organisational performance and adaptability to change (Balthazard et al., 2006; Smircich, 1983).

In this way, culture is seen as something that is created by those in authority positions and is relatively consistent throughout the organisation (Mouton et al., 2012; Schein, 1983; 1992; 2004). For example, Balthazard et al. (2006) examined the association between different cultural styles and various individual and organisational level performance drivers, assessed culture in terms of the behavioural norms and expectations required for those seeking to fit in the organisation. Balthazard et al. (2006) highlight that the specific attributes that represent culture can be quantitatively measured, analysed and used by management to inform organisational development and change interventions, as well as providing important cultural profile data of high and low-performing organisational units. Therefore, culture, as something an organisation has, is seen to shape behaviour, gives members a sense of identity and establishes well recognized and accepted premises for decision making (Kummerow & Kirby, 2014; Ogbonna, 1992).

This perspective is supported by several scholars (e.g. Hofstede 1984; Ouchi & Wilkins 1985; Schein, 1990) and has gained increasing support over the last few decades (Kummerow & Kirby, 2014; Schneider et al. 2013; Scott et al. 2003). While debates exist on how to study organisational culture and on what perspectives of organisations should be the focus, there is increasing focus on the organisational

performance consequences of organisational culture (Brown, 1998; Mannion et al., 2018; Oliver, 2011; Schein, 2017; Wilkins & Ouchi, 1983).

In this view, organisational culture is either seen as an internal dependent variable to measure outcomes of organisational activities and processes or as an external dependent variable explaining differences in the attitudes of employees (Smircich, 1983). Researchers adopting this perspective are usually pragmatic in their approach in regard to organisational effectiveness and organisational change (Alvesson, 2002; Parker, 2000; Schneider et al., 2013). This approach is typically comparative and explains the use of surveys as the preferred method of data collection, exploring the attributes of an organisation that characterise the effective from the ineffective attributes (Sackmann, 2011; Schneider et al., 2013). For example, measures included variables at the individual (e.g. patterns of behaviour, job satisfaction, communication and role clarity) and organisational level (financial performance, return on investment, operating cash flow, sales measures and overall organisational performance) (Sackmann, 2011; Schein, 1990; Schneider et al., 2013).

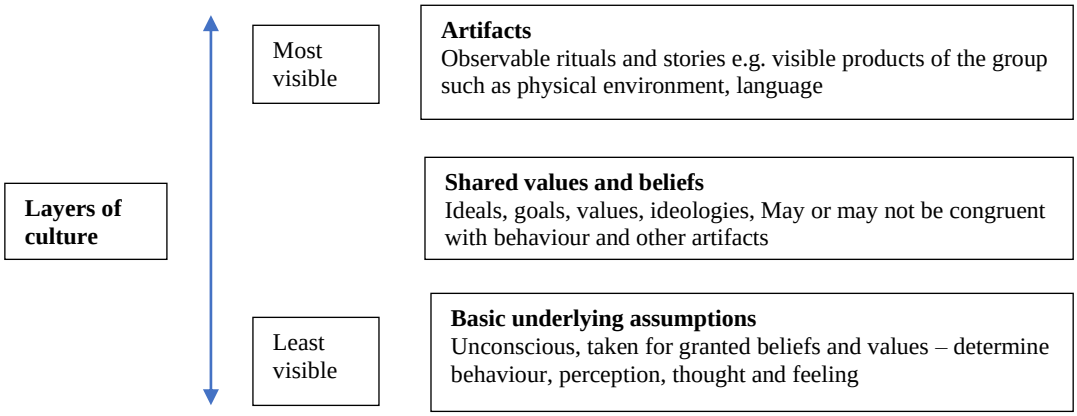
Researchers coming from the perspective that organisations *have* culture have defined culture as the system of accepted meanings and patterns of behaviour. For example, Pettigrew (1979) defined organisational culture as "*the system of publicly and collectively accepted meanings operating for a given group at a given time"* (p.574.) and Schein (2004) defines culture as:

> "A pattern of shared basic assumptions that was learned by a group as it solved its problems of external adaptation and internal integration that has worked well enough to be considered valid and, therefore to be taught to new members as the correct way to perceive, think and feel in relations to those problems". (p.17).

According to Schein (1990), organisational culture can be analysed at three different levels, observable artifacts, shared values and basic underlying assumptions. See Figure 3 outlining Schein's (1990) model of organizational culture.

Figure 3:

Three levels of culture



Source: Schein (1990)

Artifacts

According to Schein (1990; 2015), visible artifacts are the phenomena that are observed, heard and felt when encountering a new group with an unfamiliar culture. These include the architecture of the physical environment such as office layout, language; technology and products; the artistic creations such as style (clothing, manners of address and emotional displays; the myths and stories told about the organisation; the published list of values; and observable rituals and ceremonies (Schein, 1990; 2015). Martin & Siehl (1983) explain that observable culture has a significant effect on shaping the attitudes and behaviours of employees. In other words, the observable culture is the explicit behaviour pattern that a group displays. Included in this level are the organisation's formal descriptions of how the organisation works, such as charters and organisational charts (Schein, 2015). According to Schein (2015), the most important consideration about the artifacts level is that while this level is easy to observe, it is very difficult to interpret. As such, when new to an organisation and observing artifacts, some of them will not make sense without asking some questions, and the longer time spent in the organisation, the observations will become clear as people explain "*why we do it that way*" (Schein, 2015, p. 18). However, to really understand this level of culture, those new to the organisation must find out why they do it that way which leads to the shared values and beliefs level of culture.

Shared values and beliefs

According to Schein (1990; 2015), when groups take joint action and together observe the outcome of those actions, they have a shared basis for determining values and beliefs. However, only those beliefs that have been tested and continue to work reliably in solving the groups' problems will become transformed into assumptions. Bettenhausen and Murnighan (1985) explain this level as social norms, which are less visible but very powerful form of social control over individual action. In other words, the social norms work in the sense of reducing uncertainty in critical areas of the functioning of the group (Schein, 1990; 2015). The beliefs and values that provide meaning to a group may not necessarily be congruent with the beliefs and values of effective performance. That is, organisational values that reflect desired behaviour may not be reflected in the observed behaviour (Argyris & Schon, 1978; Schein, 2015). The espoused beliefs and values often leave aspects of behaviour unexplained and hence limits the full understanding of the entire culture (Schein, 2015). As Schein (2015) explains, to gain a full deeper understanding of the entire organisational culture requires an understanding of the underlying basic assumptions.

Underlying basic assumptions

Underlying basic assumptions are the essence of culture and represent the "*taken-for-granted beliefs about reality and human nature*" (Hatch, 1993, p. 659). They are the beliefs and behaviours that are so profoundly embedded that they can go unnoticed. The interpretations may reflect "*deeply held values*" that become basic assumptions that are so well understood that they are difficult to articulate (Martin, 2002, p. 47). Culture as a set of basic assumptions determines what things mean and what actions to take in a variety of situations (Schein, 2015). According to Schein (1990; 2015) culture at this level provides members with a sense of identity and values that provide confidence (Hatch & Schultz, 2004). In other words, at this level, culture provides members with an understanding of who they are, how to behave with other members and self-worth.

Extending Schein's model

Hatch (1993) extends Schein's theory and proposes the Cultural Dynamics Model, which draws on symbolic-interpretive perspectives. The model adds symbols as a fourth level and focuses on the links between the levels rather than on the levels themselves. These links include manifestation, realization, symbolism and interpretation. While Schein's view focuses on what artifacts and values reveal about basic assumptions, the Cultural Dynamics Model focuses on how culture is created by assumptions, values, artifacts, symbols as well as the processes that link them. The model suggests that the links between the levels work in both directions and that over time adjustments are made back and forth through the process of reflexivity and cultural consciousness to achieve alignment or consistency between the levels.

Commensurate with this approach, the more modernistic approach to culture tends to refer to 'hard' and 'soft' dimensions of organisational culture. The 'hard' dimensions include logos, mission statements, style of the buildings, uniforms, organisational performance and structures, and production procedures. These 'hard' dimensions of organisational culture are designed to accentuate and definitively promote the adopted ethos of the organisation. In contrast, the 'soft' dimensions include individual attitudes, values, team spirit, and organisational rituals (Stokes et al., 2016). Within this modernistic normative perspective of culture, a strong culture is one where the 'soft' dimensions of culture align with the 'hard' dimensions of the espoused culture of the organisation. Lack of alignment between the two dimensions can result in a weak culture which will ultimately cause variations in the organisation's performance (Tan, 2019). Therefore, organisations with strong management-focused cultures seek alignment between the members' values and beliefs and the mission and values of the organisation (Balthazard et al., 2006; Stokes et al., 2016; Tan, 2019).

Developing and fostering a strong culture is considered critical in achieving organisational objectives and improving performance (Briody et al., 2018; Tan, 2019). However, strong cultures can prevent organisations from adapting to changes within the external environment (Gogheri et al., 2013). Davies et al. (2000) highlight that while the more visible elements of culture, such as artefacts and values, can be manipulated, the underlying assumptions, beliefs and attitudes of individual members is likely to be more difficult to change and align to those desired by the organisation.

The theoretical concepts around the levels of culture and the ability of the organisation to build a culture to facilitate the behaviour of staff that is desired by the organisation to improve performance has implications for this study, given the context and topic of this research. This thesis advances that the value of reputation is perceptually different at different levels of the organisation. While senior manager culture focuses on performance efficiency and productivity, frontline clinician cultures are more focused on safe quality care and d the integrity and reputation of their health discipline (Golenko, 2017). In the context of this research, the organisational values are developed within the external environment by the Queensland Department of Health. Additionally, professional values are developed externally through professional registration bodies such as the Australian Health Practitioners Registration Authority (AHPRA) and through clinical training and education programs. Therefore, the level of adjustment and change within the organisation to achieve cultural alignment is prohibitive. This lack of alignment has resulted in organisational culture, in some of the hospitals, that is hierarchical, fractured and combative, which suggests that superimposing one type of culture over another with conflicting ideologies will not change the culture and may create further malalignment of values and beliefs (Golenko, 2017).

Culture as something an organisation 'has' perspective is especially useful in the context of this research as organisational culture is seen objectively as a variable that can explain the value of reputation in terms of organisational performance and competitive advantage. However, culture as something the organisation 'is' focuses on the unique aspects of culture, taking a subjective view that culture can be inconsistent throughout the organisation and not easily controlled by management.

Organisation 'is' culture

In contrast to the organisations have culture perspective, which sees culture as a variable view that is in some way linked to organisational performance, the perspective that culture is something the organisation *is*, sees culture as a root metaphor and not something the organisation *has* but rather something the organisation *is* (Smircich, 1983). According to Smircich (1983) research from this perspective is subjective and looks to the patterns and beliefs that make "*organised action possible*" (p.348). In this

way, culture is seen as a social phenomenon portrayed as systems of cognition and belief, patterns of symbolic interpretations, and as manifestations of unconscious processes of the mind (Allaire & Firsirotu, 1984; Smircich, 1983). As such, organisations are regarded as metaphors of organisations as 'little societies' and thus comprising of social systems equipped with socialisation processes, social norms and structures showing significant and distinct cultural traits (Allaire & Firsirotu, 1984). Similarly, organisational culture can be seen as an organisations identity that is unique, integral and socially constructed (Allaire & Firsirotu, 1984; Smircich, 1983). In this way, the culture can be inconsistent throughout the organisation and not easily controlled by management (Fitzgerald, 2002; Martin, 2002; Meyerson, 1991).

While the perspective of organisations 'have' culture largely focuses on culture as a variable with shared aspects that are in some way related to organisational performance, the perspective of culture as something an organisation 'is' tends to focus on the unique aspects of culture. For example, Eldridge and Crombie (1974) provide that "*while the uniqueness of individuals is expressed in their personality, the individuality of organisations may be expressed in terms of their differing cultures*" (p.88). See also (Peters, 1978; Rossi & O'Higgins, 1980; Van Maanen & Barley, 1985). This concept of uniqueness suggests that cultural traits and characteristics are exclusive to an organisation and not found in any other organisation. Although, Kreiner & Schulz (1995) argue that the edges of culture are permeable and likely to be penetrated by external environmental influences, such as members crossing boundaries as part of their job (i.e. clinicians' commitment to their professional identity). As such, unique characteristics that members believe to be particular to a context within the organisation are often found in other organisations.

Focusing studies within the boundaries of the organisation may not adequately deal with the impact of environmental influences on the contents of cultures (Martin, 2002). Hence, culture and subcultures being studied across boundaries are better described as occupational cultures (Martin, 2002). Furthermore, members may be part of multiple cultures at one and may permeate cultural boundaries of an organisation (Nightingale, 2018; Parker, 2000). Nightingale (2018), in her study of culture in the National Health Service (NHS), suggests that occupational subcultural characteristics can permeate the cultural boundaries of the organisation and that members may identify

with a number of cultural entities simultaneously. This notion of occupational, cultural characteristics crossing cultural boundaries of an organisation has important implications for this research. Given that health professionals often have a strong professional identity and occupational culture (Dixon-Woods et al., 2014; Nightingale, 2018; O'Neill et al., 2014), it is likely that the cultural characteristics of this group will reflect their occupational culture and this, in turn, may or may not be consistent with the cultural characteristics of the organisation (Nightingale, 2018).

Culture as something an organisation 'is' perspective is especially useful in the context of this research as it adopts a more ideational approach, rather than focusing on the material aspects of culture (Alvesson, 1993; Hartel & Ashkanasy, 2011; Kummerow & Kirby, 2014; Smircich, 1983) and can be used to investigate the symbolic interpretations and meaning of explicit manifestations of culture (Martin, 2002; Kummerow & Kirby, 2014). Based on interpretive processes, researchers often adopt an emic (inductive) approach aimed at understanding an employee's perspective of their experiences within an organisation and how these constructed experiences shape the culture of the organisation (Kummerow & Kirby, 2014; Martin, 2002). As such, qualitative methods are generally preferred as they aim to develop deep, rich and thick descriptions of members' experiences (Geertz. 1973; Martin, 2002; Parker, 2000). As the perceptional value of reputation is varied among stakeholders, understanding stakeholder perspectives of their experiences and how these are constructed provides the understanding of the value of reputation.

Developing a deeper rich understanding of the meanings constructed by different members to aspects of culture, such as language, symbols and patterns of behaviour, is uniquely beneficial to this research. This is because it helps to explain the varying perceptions of the value of reputation and the conflicts between hierarchical groups. In addition, using a cultural lens provides insights into ways that senior managers and frontline staff can work towards overcoming historical tensions and work towards collectively shaping a culture that is mutually cohesive and beneficial to the organisation and its members.

3.1.3 Combining the two perspectives

Bringing attention to the substantive differences between the perspectives of organisations have culture and culture is something an organisation is, does not necessarily imply that the two perspectives are incompatible (Kummerow & Kirby, 2014). However, the two perspectives are often portrayed as opposing one another (Martin, 2002; Parker, 2000). On the contrary, Alvesson (1993; 2002) provides that they can be effectively regarded as complementary. For example, deep level understandings provided through culture as a root metaphor perspective can be used to inform decision-making about effective courses of action provided through culture as a variable perspective.

In addition, Alvesson (2002) notes that there are a number of organisational culture studies that do not easily fit into either culture as a root metaphor or culture as a variable perspective, and as such, lie somewhere in between the two perspectives. Furthermore, there are some dimensions of organisational life that are more tangible, although no less important, than others and may not be as easily captured under the culture as a root metaphor perspective (Kummerow & Kirby, 2014). Thus, as Alvesson (2002) notes, many researchers, while approaching culture as a root metaphor, will also address non-cultural aspects of organisations in their work, such as empowerment.

Using a combined approach to studying organisational culture was provided by Morgan and Smircich (1980), who justified the use of a combined approach through a framework that shows culture as a root metaphor perspective and culture as a variable perspective, as a continuum rather than distinct paradigms. Consistent with this idea, Mouzelis (2008) suggests that objectivism and subjectivism are interrelated and are unable to be separated completely. Similarly, Parker (2000) suggests that the lines between the two perspectives are blurred at best and generally overlap. Alvesson (1987) suggests that cultural studies should be permitted to develop unrestricted to a particular perspective as the more rigid the perspective, the theoretical rigour is likely to be lost in the interest of practicality. Likewise, Cunliffe (2011) suggests that the approach to studying organisational culture should reflect the range and overlay of theoretical assumptions.

Whether the subjective or objective perspectives are considered as separate or overlapping, there is considerable support for using both perspectives and adopting a

multiple perspective approach (Kummerow & Kirby, 2014; Martin, 2002; Mouzelis, 2008; Parker, 2000; Smircich, 1983). As such, a multi-perspective approach is most suitable for this research which seeks to understand the perceptional value of reputation and its impact on explicit and implicit manifestations of culture. Reputation is often linked with organisational performance and competitive advantage. However, understanding the constructed perceptional value of reputation from stakeholders requires the use of both perspectives to fully explain reputation and its value within the context of public healthcare organisations. The next section will outline the difficulties with defining organisational culture and will justify the definition adopted for this research.

3.2 DEFINING ORGANISATIONAL CULTURE

Organisational culture has suffered from confusion surrounding the definition, with many definitions created and little agreement amongst researchers. The difficulties in reaching an agreed definition for organisational culture are provoked by the array of meanings that culture has in everyday language (Scott et al., 2003). Most of the definitions highlight two common theoretical features, that being 'shared' and 'unique'. For example, Davis (1984) held that culture is "*the pattern of shared beliefs and values that give members of an institution meaning and provide them with the rules for behaviour in their organisation"* (p. 1) and Louis (1985) provides that culture is *"a set of understandings or meanings shared by a group of people. The meanings are largely tacit among the members, are clearly relevant to a particular group, and are distinctive to the group"* (p. 74). However, not all researchers agree that culture is shared or unique, and while most share a common frame of reference, the word 'shared' and the concept of 'unique' fail to elicit agreement among cultural researchers (Martin, 2002). That is, some definitions identify conflict between opposing points of view rather than that which is shared. For example, Mills (1983) provides that:

> "…cultural arrangements of which organisations are an essential segment, are seen as manifestations of a process of ideational development located within a context of definite material conditions. It is a context of dominance but also of conflict and contradiction in which class and gender, autonomous but overdetermined are vital dynamics. Ideas and cultural arrangements confront actors as a series of rules of

behaviour; rules that in their contradictions, may variously be enacted, followed or resisted". (p. 366)

Although, even Mills (1983) definition does presumptively acknowledge some sharing of points of view by subcultures. What is highlighted in Mills' (1983) definition is the emphasis on material conditions in which ideations develop. The material manifestations include conditions of work in the organisation, such as salary, wellbeing, that characterise work at different levels of an organisation's structure (Martin, 2002). Czarniawaska-Joerges (1992) suggest that the material manifestations in organisational culture must be considered in studies in order to provide a rich understanding of the disparate differences within hierarchical levels. In other words, working conditions such as the frontline staff endurance of day-to-day complex patient care or the relative quiet and luxury of the executive level need to be considered in order to gain a rich in-depth understanding of the culture as it is likely to highlight the intergroup conflicts (Martin, 2002).

Other approaches to defining organisational culture have considered material conditions as important abstract considerations; however, are not defined as being part of culture. In other words, the material conditions such as pay, reporting structures and policies are not part of the cultural structure. The cultural structure consists of elements such as beliefs and values that emerge and explain the material conditions (Martin, 2002). For example, Davis (1984) provides that culture is "*the pattern of shared beliefs and values that give members of an institution meaning and provide them with the rules for behaviour in their organisation"* (p.1). Whether material conditions are defined as important to a cultural study but not part of the cultural manifestations, or on the other hand, whether material conditions are considered as part of the cultural manifestations, both aspects highlight the importance of considering the material conditions that characterise the cultural context (Martin, 2002).

This study adopts a multi-perspective approach to understanding organisational culture and, as such, requires a definition of culture that incorporates both the objective and the subjective perspectives. As such, the definition of organisational culture adopted for this research incorporates both perspectives and is most appropriate for this research. This definition was provided by Fitzgerald (2002) and adapted from Martin (2002) as:

> "Understanding organisational culture is having an in-depth insight into patterns of overt (material) and covert (Ideational) behaviour that link manifestations of assimilation, association and disintegration together. These manifestations are linked by consistencies (integration), consistent inconsistencies (differentiation) and webs of ambiguity (fragmentation). Organisational culture is the social construction with the organisation and is determined by the level of permeability of boundaries of normality, effective group differentiation and lack of sustained cohesion or of sustained fragmentation". (pp. 23-24).

This definition is most appropriate for this research as it incorporates bother objective and subjective manifestations of culture that can be shared or unique. Importantly, this definition also incorporates the three perspectives of culture (integration, differentiation and fragmentation) and acknowledges that culture can be influenced by the external environment and by members belonging to more than one subculture simultaneously. Hence, this definition provides the basis for understanding the perceptual value of reputation from internal and external stakeholders.

Thus far, this chapter has justified the use of a multiple perspective approach for this study that combines both the subjective and objective perspectives to develop a complete in-depth understanding and picture. The following section provides the theoretical lens that will be adopted for this research.

3.3 ORGANISATIONAL CULTURE AS A THEORETICAL LENS

Researchers have used organisational culture as a lens to explore organisational life. The conceptualisation of organisational culture proposed by Martin (1992; 2002) considers culture to be a lens for studying organisational behaviour, which incorporates both the subjective and the objective perspectives. Martin's (1992; 2002) three perspective model uses a wide range of complex variables as a method to interpret patterns of behaviour in an organisation. In this way, organisational culture can be studied through three different lenses: integration, differentiation and fragmentation. Each lens provides a different perspective of the culture within an organisation (Martin, 2002; Meyerson, 1991). Notably, these perspectives have been used effectively together in organisational culture research in organisations (Braithwaite et al., 2010;

Markowitsch, 2018; Mathew, 2019; Weerts et al. 2018;) which supports the appropriateness of the multi-perspective approach for this research as each lens provides a different perspective of the culture within the organisation.

3.3.1 Integration perspective

The integration lens examines organisational culture from a functionalist perspective which focuses on those manifestations that have mutually consistent interpretations (Martin, 2002). A functional view of organisational culture is promoted to provide managers with easy solutions to organisational problems (Jung et al., 2009). The integration perspective assumes organisation-wide sharing of beliefs and assumptions and assumes that the elements that make up culture (such as, basic assumptions, values, behavioural norms, stories and rituals) are consistent with and reinforced by one another (Kummerow & Kirby, 2014; Martin, 1992; 2002). Further, the integration perspective allows the researcher to view what is shared and understood between members of the organisation and becomes the norms of behaviour. For example, in the healthcare setting members may work for the organisation because they believe in caring for the patient which aligns with the organisational values of being patient focused. Therefore, it would be expected to see behaviours indicative of caring and prioritising patient care. This was highlighted in the study by Braithwaite, et al. (2010) of a teaching hospital where the integration perspective found members of professional groups (doctors, nurses, allied health) individually aligned to the broader hospital values.

The integration perspective is useful in the context of this research as it can be used as the starting point to identify the expectations of the organisations, not only with regard to how it wants members to behave but also how it wishes to be perceived by external stakeholders, including consumers, community and government. It was used to create a framework for the research by identifying the 'hard' aspects of culture such as the mission, vision, objectives, and values. It was also used to identify the symbols such as the physical layout of offices and patient care areas and to identify the organisational structure, policies and procedures, different professional uniforms and the way members communicated with one another.

While having a number of benefits as stated above and being influential with many scholars and practitioners, the integration perspective also has its limitations. As suggested by Martin and Meyerson (1988), the integration perspective is naive of the expectation that organisational contexts in which conflicts of interest are endemic should be characterised by consistency and consensus. Linstead et al. (2004) argue that the explicit manifestations of shared culture represent the espoused values of the organisation culture, which is over-reliant on the role of leadership to sell or impose on the rest of the organisation. From this perspective, leaders are regarded as highly influential in terms of both shaping and changing organisational culture (Martin, 1992; Martin & Meyerson, 1988). Organisation wide culture is designed to entice employees to 'buy in' to the behaviours expected of the organisation, regardless of their own individual values and beliefs (Denison, 1984; 1990; 2012; Kotter & Heskett 1992; Lincoln & Kalleberg, 1990; Markowitsch, 2018; Mathew, 2019; Weerts et al. 2018).

Although, what is seen, is not always what is true, and where cultures are most visible is where one can expect the deepest conflict and difference of opinions (Fulop et al., 1999; Mathew, 2019). It is the divergence of opinions and discordance with the attitudes, beliefs and values between members, groups and organisation that leads to the emergence of subcultures and countercultures (Linstead et al., 2004; Markowitsch, 2018; Weerts et al. 2018). In the context of this research, the senior manager approach represents the integrative perspective. Although, the divergence of opinions and discordance in the attitudes, beliefs and values between the organisation and frontline clinicians and professional groups suggests that there are likely pockets of subcultures that need to be examined from a differentiation perspective.

3.3.2 Differentiation perspective

The differentiation perspective focuses on cultural manifestations that have inconsistent interpretations (Martin, 1992; 2002). Researchers within this perspective often pay particular attention to non-leader cantered sources of culture (Louis, 1985; Meyerson & Martin, 1987; Parker, 2000; Von Zugbach, 1988). These researchers, however, differ in their analysis of units of differentiation by which to characterise the field. For example, some scholars see culture as a product of social structures such as departments and/or professions and groups (Parker, 2000). Organisational members who share strong values with some but not all the members of the organisation are

described as manifesting subcultures (Trice & Beyer, 1993). Differentiation can occur on the basis of demography within an organisation or, in the case of this study, subcultures can emerge from a functional (senior manager) and professional (frontline staff) divide. Personal characteristics that are similar to other members can encourage the development of subcultures, including ethnicity, occupation groups, age, division structure (Trice & Beyer, 1993). Some of these relationships expand across organisations, particularly similar industry organisations or professional bodies. For example, clinicians can develop a shared relationship through membership of their professional body, which can be seen to represent a distinct subculture.

Subcultures in healthcare organisations can represent differences in values and beliefs as well as professional education and, as such, can be seen as occupational and professional subcultures. Subcultures can proceed along vertical (hierarchical) or horizontal (functional) lines and may also emerge based on networks or personal contact at work and friendship (Martin, 2002). The subcultures can coexist with other cultures and can unify members through the use of symbols, resources and other forms of meaning (Clegg et al., 2005; Fitzgerald, 2002; Markowitsch, 2018; Weerts et al. 2018). The relationship between subcultures can be mutually reinforcing, conflicting, and independent (Bartunek & Moch, 1991; Louis, 1985; Martin, 2002; Mathew, 2019; Stevenson & Bartunek, 1996; Trice & Beyer, 1993) or can lead to dominance over other subcultures that are seen to have unequal access to power and resources within the organisation (Callan et al., 2007; Lok et al., 2011; Morgans & Ogbonna, 2008). For example, in the healthcare setting, clinicians are part of a dominant subculture with their professional authority and autonomy providing them with power and influence over decision-making about clinical practice and resources.

The differentiation perspective was used in this research to compare attitudes and beliefs and perceptions of organisational culture between subgroups with those of the organisation. Using this lens provided an understanding of the distinguishable values, beliefs and attitudes of the various subcultures and how subcultures in public healthcare organisations experience tension or conflict as the impact of this on other members of the organisation. However, the differentiation approach on its own has limitations as this perspective does not account for ambiguity, although cultural manifestations from this perspective may seem ambiguous (Richter & Koch, 2004). As such, this study also

considers inconsistent and ambiguous behaviours that are examined from a fragmentation perspective.

3.3.3 Fragmentation perspective

The fragmentation perspective on organisational culture recognises the uniqueness of members and acknowledges the uncontrollable uncertainties, contradictions and irreconcilable differences (Martin, 2002; Meyerson, 1991). According to Alvesson & Sveningsson (2015), this perspective acknowledges that cultural patterns can be unpredictable, fluctuating and inconsistent, which may be as a result of members belonging to multiple subcultures and the interactions of members between subcultures. Fragmentation includes more than the ambiguity that develops from ignorance or confusion (Martin, 2002). It also encompasses the complications that arise from divided opinions and includes irreconcilable tensions between opposites, ironies, paradoxes or contradictions (see, Alvesson, 1993; DiMaggio, 1997; Hatch, 1993; Markowitsch, 2018; Mathew, 2019; Meyerson, 1991; Weerts et al. 2018).

The existence of ambiguity is refuted by Schein (1990), who argues that the concept of shared meanings is core to the definition of culture, and as such, if there is extreme ambiguity and lack of consensus, then there is no organisation, at least not in a cultural sense. However, Meyerson (1991) provides that ambiguities can be both normal and abnormal parts of an organisations culture, but most cultural studies consciously ignore the ambiguity because the focus of researchers is on objective tangible aspects of culture. In the context of this research, ambiguity may be a characteristic of a healthcare organisations culture and as such needs to be considered. However, a focus on the fragmentation perspective as a single lens assumes that the integrative and differentiated perspectives do not coexist within an organisation (Markowitsch, 2018; Martin, 2018; Martin, 2002; Weerts et al. 2018).

3.4 SINGLE AND MULTI-PERSPECTIVE CULTURAL STUDIES

According to Martin (2002) researchers of organisational culture usually adopt a single perspective study through either integration or differentiation or fragmentation. Most single perspective studies tend to look at organisational culture through the integration or differentiation perspective and generally adopt the organisations have culture view (Martin, 2002). These studies tend to emphasise social norms and shared

meanings of culture. In contrast, studies that adopt a multi-perspective lens assume that all three perspectives coexist in the organisation (Markowitsch, 2018; Martin, 2002; Martin, 2018; Weerts, et al., 2018). This multidimensional view is appropriate to understanding organisational culture as organic, responding to internal and external influences. Hence, understanding that the culture of the organisation is constantly changing. According to Fitzgerald (2002), these perspectives are also hierarchical with the dominant culture among senior managers more likely to be characteristic of an integrated culture, while the dominant type of culture among lower-level managers is more consistent with differentiated, and frontline members more likely to be dominated by a culture that is characteristic of a fragmented culture. However, the three perspectives are not merely three levels of analysis; the three levels differ from each other on all three levels of analysis (Martin, 2002). The three perspectives each conceive a culture in radically different terms: as unified, as a collection of subcultures, or as a gathering of fleeting, issue-specific concerns constantly in a state of flux (Martin, 2002). According to Martin (2002) each level of analysis should be examined from each perspective, as outlined in Table 2.

Table 2

Levels of analysis and the three perspectives

Level of analysis	Perspective		
	Integration	**Differentiation**	**Fragmentation**
Organisational	Consensus throughout the organisation; goal is assimilation and conformity	No organisation-wide consensus; organisation is cluster of subcultures	Issue-specific attention with no consensus; patterns of issue activation in flux
Subcultural	No important subcultural differences; subculture can represent whole	Relation of subcultures can be Enhancing Conflicting Independent	Subcultural boundaries uncertain, fluctuating, blurred, nested, over-lapping
Individual	Self-unified, constant, a member of the culture	Self-composed of multiple subcultural identities	Self-fragmented, in flux; no central unity.

Source: Martin (2002, p. 152).

As shown in Table 2 one of the three perspectives will not provide a more accurate description of culture at a particular point in time, all three levels are relevant at any point in time (Martin, 2002). Ensuring that all levels are examined from each perspective helps to view the world in a particular, socially constructed way, stemming from the viewpoint of the researcher and the characteristics of the context and the members being studied (Martin, 2002). Thus Martin's (2002) three perspective model is relevant for this research as it highlights understandings of the cultural manifestations and interpretations from all levels, within the complexity of public healthcare organisations. The multi-perspective approach was applied: First, this study incorporated both explicit (subjective) and implicit (subjective) manifestations of culture. Second, it examined these manifestations of culture and the perceptional value of reputation at an organisational, group, and individual level. Third, these levels of analysis were examined through integration, differentiation, and fragmentation cultural lenses to determine the culture – reputation relationship.

3.5 CULTURE AND REPUTATION

Previous research on reputation suggests that culture may be an important predictor of reputation for an organisation (Alsop, 2004; Aminu et al., 2018; Dukerich & Carter, 2000; Flatt & Kowalczyk, 2000; 2008; Fombrun, 1996; Fombrun & Shanley, 1990; Gonzalez-Rodriguez, et al., 2019; Sutedjo, et al., 2018) largely due to the internal

culture and external reputation factors interlinking and informing each other (Gonzalez-Rodriguez, et al., 2019; Hatch & Schulz, 2000). While a number of scholars cite a culture – reputation relationship, the empirical testing of this relationship (Alsop, 2004; Dukerich & Carter, 2000; Eberl & Schwaiger, 2005; Flatt & Kowalczyk, 2008; Fombrun & Shanley, 1990; Rindova, et al., 2005) has been limited within the healthcare sector. However, researchers that have tested this relationship within the healthcare sector highlight that organisational culture has emerged as a predictor of reputation (e.g. Braithwaite, et al., 2010; Luxford et al., 2011; Smallman & John, 2001).

A potential relationship between reputation and culture was suggested by Weigelt and Camerer (1988) who advanced that because culture influences strategy implementation and performance then using straight forward logic, culture would also support reputation building activities, particularly where unwritten rules guide employees in their response to unforeseen and ambiguous situations. Similarly, some researchers propose that culture is related to the organisations identity and identity is related to reputation (Alsop, 2004; Davis et al., 2014; Fombrun, 1996; Hatch & Schulz, 2000). This notion was confirmed by Flatt and Kowalczyk (2008) in their empirical study of 104 organisations. The authors found that a strong organisational culture positively influences reputation and suggest the culture creates the context for employees to align their perception of their organisation's reputation through cultural norms and shared values towards organisation goals. The authors also found that the relationship between culture and financial performance is mediated by reputation, suggesting both a direct and indirect effect that culture has on performance. While there is theoretical support suggesting a relationship between culture and reputation, what is highlighted is the limited empirical evidence considering how culture and reputation influence each other and how the indirect effects of this relationship contribute towards a competitive advantage. This research addresses this gap in the literature by exploring the reputation – culture relationship using a multi-perspective approach.

3.6 SUMMARY

This chapter has reviewed the literature in relation to cultures in organisations and the conceptual development of organisational culture. It concludes that in order to develop a complete picture of organisational culture within the context of this research,

a multi-perspective approach was required in order to obtain a more complete picture of the phenomenon under study.

Chapter 4: Methodology

Chapters 2 and 3 concluded that scholarly knowledge on the topic of reputational value is somewhat confined and fractured, with a limited understanding of the relationships and interdependencies between various aspects and interpretations and how they may interact to illuminate understanding.

Qualitative research is well suited to areas that are underdeveloped and where understanding how people experience and interact within their social world is important (Merriam & Grenier, 2019). Additionally, qualitative studies are capable of answering 'how' and 'why' factors affect the ways in which individuals construct reality, which must be explored in order to begin the inductive process of understanding organisational reputation from stakeholder perspectives (Mason, 2002). As suggested by Mason (2002):

> "Through qualitative research we can explore a wide array of dimensions of the social world, including the texture and weave of everyday life, the understandings, experiences and imaginings of our research participants, the ways that social processes, institutions, discourses or relationships work, and the significance of the meanings that they generate". (p. 11)

This chapter is structured in three parts. Part one, outlines the aims and objectives of the research and outlines the research questions that were used to guide this study. Part two, contemplates the assumptions that might influence the research process and design. Methodology (distinct from method (Hyett et al., 2014) is discussed, along with providing an introduction to the interpretivist / constructivist perspective.

Part three, describes the research approach, including the construction and integration of an interpretivist / constructivist method using a multi-phase, sequential, qualitative research design using an ethnographic tool kit, underpinned by Denzin and Lincoln's (1994) foundational qualitative approach. The research design allows for examination of stakeholder perceptions of the value of reputation within a complex public healthcare system, where the government promotes reputation through

fundamental values of integrity, customers and patients first, accountability, respect and engagement (State of Queensland [Queensland Health] 2020a).

4.1 STUDY AIMS AND QUESTIONS FOR RESEARCH

4.1.1 Research aim

This study aims to explain how and why the perceptual value of reputation is influenced by various environmental, organisational and cultural factors. Little is known from the literature regarding how reputation is conceptualised and formed by stakeholders, both internal and external to hospital and healthcare services, especially ways in which the identified dimensions of reputation may interact. This study seeks to address this gap of evidence and understanding.

4.1.2 Research objective

The objective of this study is to contribute to the development and understanding of the dimensions of reputation. While recognising the limits of empirical generalisability for qualitative inquiry, the main objective of this study is to contribute to the body of knowledge about how reputational value is conceptualised and formed. In addition, this research explores how the dimensions of reputation can be harnessed or developed, to facilitate robust reputation management strategies to increase the likelihood of competitive advantage and performance improvement in the public healthcare context.

4.1.3 Research questions

Addressing the deficiencies evident within the scholarly literature, a three-part research question was developed for an in-depth qualitative exploration of a large Hospital and Healthcare organisation, located in South East Queensland. Generating and discovering the answers to the research problem and question requires obtaining detailed knowledge from the field of inquiry (Creswell, 2014). Therefore, the research questions are essentially how and why questions established to foreshadow the approach to inquiry. They ask how internal stakeholders (frontline staff, senior managers) working within, and external stakeholders (community members) using public hospital and healthcare services, value reputation, and how reputation impacts on decision making and actions in general. Hence, the research questions were developed to

explore and understand the perceptions and views of both internal and external stakeholders on reputation in south-east Queensland public hospitals.

The research questions are aimed at explaining what the research intends to understand about factors affecting reputation and what influence reputation has over decision making and competitive advantage for Hospital and Health Services. Accordingly, the research questions allowed the researcher to consider reputation from a cultural perspective. Learning about groups and subgroups to be able to understand and describe its richness and complexity was an essential part to this research as it helped the researcher search for logical cohesive patterns in the behaviours and ideas of the participants.

Multi-perspective cultural studies have shown that executive and senior management positions commonly view culture from an integrative perspective (i.e. culture viewed in relation to unanimity and consistency) (Daymon, 2000; Fitzgerald, 2002; Kappos & Rivard, 2008). Employees with a more clinical focus tend to view culture from either a differentiation or ambiguity perspective with complexity existing at all levels within the organisation (Daymon 2000; Fitzgerald, 2002; Kappos & Rivard, 2008). Therefore, the research questions provide a platform for reflective and contextual learnings and understandings of reputation from the three cultural perspectives that will provide the researcher with a complete picture of the phenomenon under study (Tracy, 2013).

Thus, the research questions guiding the research are:

RQ. 1 *In what way is the perceptual value of reputation conceptualised about public healthcare organisations?*

RQ. 2. *In what way is the perceptual value of reputation formed about public healthcare organisations?*

RQ. 3. *How do internal and external stakeholders perceive the value of reputation in public healthcare organisations?*

4.2 METHODOLOGY

4.2.1 Research assumptions

When it came to choosing which research design to use for this research, it required consideration of the criticisms and limitations of each method as well as clearly recognising that methodological choices are about flexibility and appropriateness (Patton, 1988; 2015). Making the clear philosophical and methodological assumptions that underpin research design is particularly important to the integrity of the research findings (Marsh et al., 2018). However, many veiled assumptions penetrate research designs as a consequence of the researcher's fundamental beliefs about the nature of the world and existence (ontology), the theory of knowledge and how it is acquired about the world (epistemology) and the nature of values and valuation that form the basis of the search to know about reality (axiology) (Rawnsley, 1998; Turner & Risjord, 2007; Varpio & MacLeod, 2020).

The researcher's position in relation to these assumptions, whether or not manifestly considered by the researcher, will influence the selected research design (Goldkuhl, 2012). The varied positional approaches adopted by researchers to ontological and epistemological questions are often contested, characterised as conflicting positions, often between the broad positions of positivism and interpretivism (Goldkuhl, 2012; Marsh et al., 2018). Where positivists adhere to a realism ontology and seek to establish independent causal relationships between social phenomena, thus establishing explanatory, predictive truths (Creswell, 2014; Marsh et al., 2018), interpretivism assumes that the social world is relativistic and can only be understood from members of the social group who are directly involved in the activities being studied and are, therefore, more cautious about truths (Falconer & Mackay, 1999).

The research design employed for the current study is informed by the interpretivist/constructivist stance: a subjectivist ontology and epistemological position, as a double hermeneutic understanding (one level – the world is constructed by the actors; the other level – the actors' construction is interpreted by the researcher), (Lowndes et al., 2017) and therefore, a broader, balanced approach in response to the perceived weaknesses of positivism and critical realism (Lowndes et al., 2017; Michel, 2012). The positivist research methodology emphasises experimentation research from the natural sciences, including lab-like environments and randomised controlled trials,

which eliminate the complexity of the external world (e.g. social and psychological influences). The critical realist tradition takes a middle ground between positivism and interpretivism and can be seen as a variable separate approach within organisational management research (Greenhalgh, 2004; Greenhalgh et al., 2009). Although, the attempt to unify method in the natural and social sciences in accord with the ontology positioned by critical realism is where tension arises with this approach (Cruickshank, 2017). The difficulty seen with the critical realist ontological assumptions is the transitive dimension and the intransitive dimension seem mutually exclusive of each other, thus lacking "a deeper appreciation of the ontological significance of science and language as human activities and potentialities" (Michel, 2012, p. 209). In contrast, interpretivist research designs are often associated with qualitative research, putting the sense-making and process of those studied at the centre of the research, mostly using abductive logic of inquiry to make sense of experiences within social structures (Alharahsheh, & Pius, 2020; Goldkuhl, 2012).

The rationale for adopting an interpretivist/constructivist stance goes beyond the researcher's personal affinity with interpretivism but is also informed by the suitability of the approach for a qualitative, ethnographic multi-phase study.

4.2.2 Interpretivism

Researchers use interpretivism to explore and analyse the meanings that humans bestow upon their own and other's actions (Myers, 2009). As suggested by Myers (2009) "interpretive researchers assume that access to reality, either given or socially constructed, is only through social constructions, such as, language, consciousness, shared meanings and instruments" (p. 38). Interpretivism is empirical in nature, but the approach is different to the traditional scientific methods used by the physical sciences.

While inspired by a number of qualitative concepts and approaches (see, Patton, [1990] highlights 10 traditional approaches and Tesch, [1990] lists over 40 different approaches), the interpretive approach relies on naturalistic methods of inquiry, such as interviewing, observations, and analysis of documents. The interpretivist allows the focus of the research to be on understanding what is going on in a given context by the consideration of varied realities from, different human perspectives; researcher

involvement; the context under study; and the meanings and motives of actions (Neuman, 2014). Interpretivist researchers assert that the world is socially or in a roundabout way constructed and therefore a distinct feature of this approach is based on a constructivist lens (Carson et al., 2001; Lowndes et al., 2017).

The interpretivist researcher often adopts an exploratory approach in order to study what is going on in particular contexts and situations, to reach an understanding of the characteristic orientations of the study participants (Lowndes et al., 2017). In essence, for researchers working within this approach, the understandings and interpretations of social phenomena directly affect outcomes. That is, the interpretations and meanings of social phenomena can only be understood and established within language, contexts or behaviours. Hence, the focus of interpretivist is exploring the language or behaviours and "establishing the interpretations and meanings they attach to social phenomena" (Lowndes et al., 2017, p. 189). This research sought to understand the perceptual value of reputation within public healthcare organisations, using a cultural lens. The key tenets of ontological assumption and epistemological stance are briefly summarised herein.

4.2.3 Subjectivist Ontology and epistemology

Ontology is the "study of being" (Crotty, 1998, p. 10) and "raises basic questions about the nature of reality and the nature of the human being in the world" (Denzin & Lincoln, 2005, p. 183). The ontological debate is that reality exists independent of human consciousness and experience (objectivism), or reality exists within our consciousness and only through experience (subjectivism) (Levers, 2012). As an interpretivist, the core ontological assumptions adopted for this research see reality as a social construction. Hence, individuals create meanings through language, routines, behaviours and symbols. The researcher identifies with a constructivist assumption about human nature.

Constructivism holds that "meaning is not discovered but constructed" (Crotty 2003 p. 42). Meaning emerges when it is consciously thought about with meanings constructed by human beings as they engage in the world they are interpreting (Crotty 1998). The epistemological stance is to understand how reality is created through exploration of pure subjectivity. As such, this approach is well suited to qualitative

studies as it allows the researcher to explore and construct meaning through rich stories and self-reflexivity (Creswell, 2009; Creswell & Poth, 2018). In this research, meaning is constructed by the participants involved in the study and by the researcher in the analysis and comprehension of those meanings.

A subjectivist ontology and epistemology using a constructivist lens is well suited to this research as it is orientated toward real life scenarios and this allows for a qualitative method approach. This approach is critical for understanding the value of reputation in the healthcare setting and for developing a more complete in-depth picture of reputation from multiple perspectives. The value of reputation arises from the different stakeholder perceptions of reputation and its value in public healthcare services. Thus, the adopted research paradigm allowed the researcher to construct, analyse and interpret the findings from multiple perspectives by focusing on the reality of the actions, language, situations and consequences of the participants. Further, the research paradigm allowed for the development of practical solutions based on theory and evidence.

4.2.4 Interpretivist qualitative exploratory research

The strengths of qualitative research allowed the researcher to understand the meaning for the participants in the study, including their experiences and actions they are involved in (Maxwell, 2013; Menzel, 1978). The face credibility of qualitative research, and the focus on particular contexts and their meaning for participants in these contexts, make it particularly suitable for researcher collaboration with their participants (Brydon-Miller et al., 2011; Maxwell, 2013; Pushor, 2008; Somekh, 2009; Tolman & Brydon-Miller, 2001). Qualitative research also allows for searching for meaning within the data collected, by using the perceptions and descriptions of the research participants.

In terms of this research, qualitative research is justified as it allowed for an understanding and to learn the meaning that the key stakeholder participants hold of the perceptional value of reputation. This required being involved in the research process, interacting with the participants, and observing their patterns of behaviour. Being part of the research involved providing an interpretation of the value of reputation and its impact according to the research participants. In addition, researching within the natural

setting of the participants provided the ability to examine the construct of reputation according to the participants and to consider the value of reputation and its impact on decision making in the context of public healthcare services.

Creswell and Poth (2018) point out that qualitative research allows for data to be collected in the natural setting of the participants. Being in the natural setting provides opportunity to understand, describe and analyse the organisation's culture from multiple perspectives. As highlighted by Bryman (2016) qualitative research can "describe and analyse the culture and behaviour of humans and their groups from the point of view of those being studied" (p.46), which, for this study, are those working within or using public healthcare services. Greib et al., (2015) also provides that understanding the individual behaviours and norms around those behaviours requires an in-depth understanding of the individual within their environment and, that this is best achieved by the researcher interacting with the participants, observing patterns of human behaviour and thought in the natural setting.

Researching an organisation's culture can be approached from two main perspectives; the insider perspective and the outsider perspective. These approaches were defined by Pike (1967) as the emic (inductive) approach and the etic (deductive) approach (Onwuegbuzie & Johnson 2006). The emic approach is the inside approach, where the emic perspective is the perspective of the insider. This approach uses qualitative methods to obtain content specific points of view from participants by the researcher immersing themselves in the culture and developing relationships with the participants (Tracy, 2013). The etic approach is the outside approach, where the etic perspective is that of the objective outsider looking in and studying the group (Onwuegbuzie & Johnson 2006). A prominent feature of etic research is that observations can be made in and across different settings that are similarly aligned (Morris et al., 1999).

Traditionally, emic and etic approaches to research have been divided with some researchers using a single method in their inquiry (Onwuegbuzie & Johnson, 2006). As Currall & Towler (2003) show generally, qualitative researchers relied upon the emic approach, whilst the etic approach was preferred by quantitative researchers. However, recent literature supports the use of both approaches, to maximise knowledge gained (Creswell, 2014; Currall & Towler 2003; Fetterman 2010; Hofstede 2016; 1984; Morris

et al. 1999; Onwuegbuzie & Johnson 2006; Tracy, 2013). For this research, a combination of both approaches provided a balanced and complete view of the issues in relation to the perceptional value of reputation in the public healthcare setting in South East Queensland. That is, in the hospital where the participants worked so that up-close information on the perception of reputation could be gathered. Thus, participant behaviour within their context and the influence of the context on their behaviour could be observed.

Being involved in the research process also allowed for an interpretation of the perceptual value of reputation according to the research participants. Most notably, qualitative research allowed for the adoption of a cultural lens to observe behaviour and ensure that those behaviours are positioned in a meaningful and culturally relevant context (Fetterman, 2010). In this study, more emphasis was placed on the experience of the participants in the study. To understand the perception of reputation from internal stakeholder groups (frontline, senior manager) it was important to interpret the shared patterns of culture in these groups and qualitative research methods facilitated and enhanced the interpretations and understandings.

Additionally, qualitative research provides for "rich, thick description" (Creswell, 2014, p. 202) of the views and perceptions of the research participants. The extensive use of words, examples and stories told by the participants provides rich descriptions and explanations to reinforce the interpretation and understanding of the phenomenon under study (Creswell, 2014). In other words, the thick, rich description provided an enhanced explanation based on how participants are influenced by some situations and events. For this research, rich descriptions and explanations provided by the participants reinforced the interpretation and understanding in relation to the value of reputation in public healthcare services within South East Queensland.

Further, qualitative research is well suited to community-based research with participants in the study. Part of this research involved understanding the perceptional value of reputation from consumers of healthcare, thereby gaining a community perspective. The lived experiences of consumers of healthcare provided an external research lens, which provided a complete perspective of the value of reputation.

As this research involved exploration of the perceptional value of reputation from both internal (frontline staff, senior managers) and external (local community members) stakeholders, it was well suited to qualitative methods. This was because it preserved chronological flow and observed the consequences of events, which allowed for deriving at more rich explanations (Miles et al., 2020). Conducting this research in two phases allowed for the ability to refine phase 2 of the study from the findings from phase 1. This led to serendipitous findings in relation to the value of reputation within public healthcare.

Qualitative research methods are further justified by facilitating the development of both theoretical and practical implications to the social science field of inquiry. In this study the perception of reputation was examined from cultural, and resource-based view theoretical perspectives. With the use of both inductive and deductive reasoning, qualitative research facilitated credible, rigorous and authentic findings to gain a rich understanding of reputation, particularly within south-east Queensland public healthcare services.

In summary, qualitative research is justified as it:

- Enabled the researcher to present an interpretation of the participants construct of reputation, particularly reputational value;
- Allows the researcher to get close to the research participants' reality;
- Allows the researcher to understand the context and culture in which the participants act by collecting data in the natural setting;
- Allows for the preservation of chronological flow; and
- Allowed the researcher to use both inductive and deductive reasoning when building knowledge and advancing reputation theory.

Therefore, qualitative research was considered by the researcher to be the only appropriate and comprehensive way to advance theory in this research due to the applicability to the purpose, objectives and the ability to assist with answering the research questions.

4.3 RESEARCH STRATEGY AND DESIGN AND STRATEGY

This section describes the decision-making process and procedural steps taken throughout each stage of the research process. Included is the research design and detailed steps through the completion of data analysis. The section ends with a description of the decisions.

4.3.1 Research design

When it came to choose which research design to use for this research, it required consideration of the criticisms and limitations of each method, as well as clearly recognising that methodological choices are about flexibility and appropriateness (Patton, 1988; 2015). Determining the research design was based on the nature of the research problem, personal experiences of the researcher, and the audience under study (Creswell, 2014). Reviewing methods used in organisational culture research has shown that the choice of method is best determined by the way organisational culture is conceptualised, the purpose of the investigation, the intended use of the results, and the availability of resources (Bellot, 2011). Howe and Eisenhart (1990) support this idea, stating that it is not about the orthodox methodology, rather it is about whether the method chosen provides the data to answer the research question(s), whether the background assumptions are coherent, and whether the method is applied well enough that the results are credible. Therefore, a multi-phase research framework using an ethnographic toolkit was selected as the most appropriate methodology for this research. The use of an ethnographic toolkit allows for openness to inquiry and to research the culture and social organisation of the group under study (Wolcott, 2008).

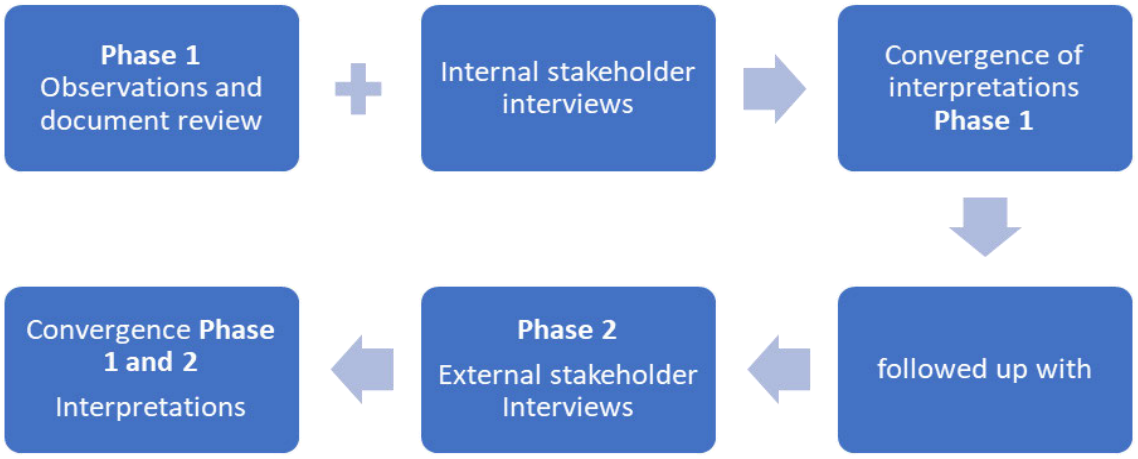
Culture has been described as a toolkit that consists of the symbols, stories, rituals and world-views, which individuals use in varying configurations to solve different kinds of problems and from which people devise their strategies of action or their persistent ways of ordering action through time (Swidler, 1986, p. 273). For this study, the metaphor of an ethnographic toolkit is used to highlight the abundance of cultural tools that assist the qualitative researcher in exploring cues and determining what is occurring in a particular social environment or interaction during fieldwork (Reyes, 2020; 2018). The tools include the researchers own identities, education, background and characteristics and are used to understand the field under study (Reyes, 2020; 2018). The ethnographic toolkit shapes how the researcher understands, explores and

experiences fieldwork as a social phenomenon and emphasises interpretive reflexivity through all stages of the research and provides theoretical and methodological language to the understanding of that experience (Lichterman, 2017). Moreover, the use of an ethnographic toolkit for this research provided the researcher with the interpretive reflexivity need to reveal cultural cues and convergences.

For this research, the study was conducted over two phases (see Figure 4). The first phase of the study was an exploration of public hospital employee's perception of reputation, using a cultural lens, in which interview (n=31) and observation data were collected from a sample of public hospital internal stakeholders (employees) at three public hospitals within South East Queensland. From this initial exploration, the qualitative views of participants were used to develop and frame the interview questions for the external stakeholder group participants (phase 2). In phase 2 of the study, consumers of healthcare services (local community) were interviewed (n=17) to understand their perception of the value of reputation within public healthcare services.

Figure 4

Research design



Research design adapted from Creswell (2014).

The design of this study allowed investigation of multiple perceptions of the value of reputation from key internal stakeholders, which then informed the development and framing of the semi-structured interview questions for phase two (external stakeholder).

In other words, the development and framing of healthcare-specific reputation perception questions for consumers were informed by Phase I of the research design. The scope and transferability of the qualitative findings were then able to be assessed (Bryman, 2016).

The following section outlines the research protocol used. The setting, study population and purposive sampling techniques are discussed, along with the recruitment processes. A discussion is provided on the data collection methods used for this research, which includes document analysis, observations, and semi-structured interviews.

4.3.2 Setting and study population

The site chosen for this study was a large public hospital and healthcare service. The focus of this study was on internal and external stakeholder perceptions of reputation and its perceptual value as perceived by its key stakeholders. This research was interdisciplinary, and its purpose was to examine reputation from anthropological and sociological perspectives. The Hospital and Health Service (HHS) understudy was located in Queensland Australia and the surrounding community was selected to take part in this research to obtain external stakeholder perspective on reputation of public healthcare organisations. The HHS was invited to participate as this health service had a large range of services and hospitals within its catchment area. It was also the HHS at the centre of the preamble to this thesis.

The selection of the Hospital and Health Service was based on size, location and healthcare services delivered to ensure a large representative sample. The HHS services a population of over one million people, which is approximately 23 per cent of Queensland's population, with a catchment that spans 3,856 square kilometres (State of Queensland [Queensland Health], 2016). The HHS is the major provider of public health care, teaching, research and other services. It provides these services through five major hospitals and several community health centres and oral health facilities (State of Queensland [Queensland Health], 2016). For the purposes of carrying out this research, site-specific approval was obtained from three of the HHS' largest facilities, a tertiary hospital (780 beds, with responsibility for some specialist state-wide services); a major hospital centre (436 beds); and a major health centre, 172 beds) (State of

Queensland [Queensland Health], 2016). The major metropolitan hospitals were selected based on having tertiary, metropolitan and regional hospital facilities, which allowed for a more diverse perspective on hospital reputation. These hospital settings and surrounding community were ideally suited as they provided the opportunity to explore 'real life' scenarios and the participant's perceptions of the value of reputation in public healthcare across south east Queensland.

The diversity of the hospitals and community groups provided an opportunity to examine and contrast how the organisation and groups value, and are influenced by, reputation. This diversity also allowed for an analysis of the organisational culture from different internal stakeholder perspectives and different levels within the organisation, particularly how reputation is influenced by culture. In addition, these differences allowed the researcher to contrast the varying perceptions of reputational value from external stakeholders and how reputation may influence decision-making.

Phase 1 data were collected between January 2019 to June 2019. At that time the HHS employed 15,759 employees of which 56% were in clinical roles (i.e. medical, nursing, allied health, environmental) and 53% of permanent staff were in were in full-time positions (State of Queensland [Queensland Health], 2016). During this period, the HHS had a workforce diversity mix of 1.12% who identified as aboriginal or Torres Strait Islander; 18.4% non-English speaking background; and 73.5% women (State of Queensland [Queensland Health], 2016). Access to the sites was facilitated through existing connections between the research team and the HHS. These contacts provided the opportunity to determine the 'gatekeeper' (Tracy, 2013). Key sponsors within the HHS were nominated by the research team who were positioned within the hospital, to ensure that access was obtained through the correct channels.

The study population for internal stakeholders consisted of all staff working within the hospitals. This included Board members (n=2), executive (n=9), managers (n=4) (clinical and non-clinical); front-line clinical staff (n=13) (medical, nursing and allied health); and non-clinical staff (n=3), (administrative, financial and environmental support staff). For this research, it was important to include all staff covering all hierarchical levels and professional groups in the study population. The reason for the inclusion of these groups and levels was two-fold. Firstly, the perceptional value of reputation on individuals and the individual's level is likely to differ. Therefore, if only

one group or level of staff were represented in this research, then the findings may have been misleading and resulted in a misrepresentation of the organisations culture. Secondly, including these groups and hierarchical levels allowed for comparisons to be made between the professional groups and levels.

From May 2019 to September 2019, data were collected from consumers (external stakeholder/community members) of public healthcare. At the time of conducting the research the south-east Queensland population group was 51% female, 2.2% Aboriginal and Torres Strait Islander, 80.9% aged over 15 and 92.7% employed (Australian Bureau of Statistics (ABS), 2016). During this data collection period community members living in the HHS catchment area were invited to participate in the research.

4.3.3 Sampling method

Purposeful sampling is the primary sampling method used in both phase 1 and phase 2 of this study. Purposeful sampling is a method that "intentionally selects a group of people that will best inform the researcher about the research problem under examination" (Creswell & Poth, 2018). In other words, purposeful sampling allowed the flexibility of selecting a sample group of participants that were able to provide data that would answer the research questions and contribute to the evolving theories (Creswell & Poth, 2018). Patton (1990) suggests "the (purposeful) sampling strategy must be selected to fit the purpose of the study, the resources available, the questions being asked, and constraints being faced" (p.181-2). For this research, purposeful sampling provided the ability to obtain a good mix of participants that fit the purpose of the study, which was understanding the perception of reputational value from internal and external stakeholders.

In addition to purposive sampling, the use of snowball sampling was also used in this research. This method takes advantage of recommendations and referrals, from research participants, of other people who meet the criteria of the research and are likely to be information rich (Creswell & Poth, 2018). Patton (1990) suggests "by asking a number of people who else to talk with, the snowball gets bigger and bigger as you accumulate new information-rich cases" (p. 176). The referrals obtained during this research allowed the researcher to access information rich participants, particularly from internal stakeholders within the HHS. This sampling method provided access to several

internal stakeholders who were directly involved in programs and departments that had been the subject of media reporting on the organisation. The sampling method also assisted with gaining balanced participant representation based on gender, hierarchical and age. If these referrals had not occurred the researcher might have missed the opportunity to include them in the research and gain their perception of the value of reputation. Additionally, not having the right participants may affect the outcome of this research (Creswell & Poth, 2018). As such, purposive and snowball sampling techniques enabled the researcher to gain access to a wider and complete range of internal and external stakeholders within south-east Queensland.

The sampling methods used in this research provided the ability to recruit a comprehensive sample group for both Phase 1 and Phase 2 of this research. For Phase 1. The selection of participants for the interviews was based on the employee's response to an email requesting volunteers to participate in this study. Senior managers and front-line operational employees were selected for this study as they were able to provide the different cultural perspectives of reputation in the organisation. Participants were also selected based on their hierarchical and professional sub-group level within the organisation. These professional sub-groups are defined as:

1. Senior managers: Executive / director / assistant director / executive / manager / Board member.

2. Frontline staff: Nursing / medical / administrative / Health practitioner / environmental staff.

In addition, the researcher purposefully sought out ethnographic interviews and discussions during the observation phase of the study when opportunities arose. Voluntary participants to the Phase 1 study were excluded if they were not a current employee of the organisation. For example, agency nurses were not selected as they are employed by individual professional agencies that supply workers on a temporary day to day basis and are ultimately not part of the organisation's employees.

For Phase 2 of the study purposive sampling provided the opportunity to target and select research participants that were part of the south-east Queensland community. Due to the large population within the HHS catchment area, purposeful sampling was used to obtain a representative selection of consumers rather than relying on the

idiosyncrasies of chance that would only be representative of a large sample (Maxwell, 2013). An important goal of the research was to adequately capture the heterogeneity in the population to ensure that the conclusions drawn in the research adequately reflect the range of variation rather than only typical members.

4.3.4 Recruitment

Recruitment of the research participants was different for each phase of this research. In Phase 1, the HHS was contacted, and after approval had been granted from the Executive team, the organisation subsequently agreed to participate in the study. An initial discussion took place with a senior manager of the organisation where the aims of the study were described in detail. From this discussion, several recommendations for key interview informants were obtained. The discussion was followed up by an email which included the research aims and objectives and the research advertisements (Appendix G), information sheets (Appendix B senior managers and Appendix C frontline participants), consent forms (Appendix E) and the ethics and site-specific approval forms (Appendix J) (discussed later in this chapter). The senior manager agreed to proceed with the research and forwarded the information on to the staff of each of the three hospitals via group email.

In addition to the group email, the researcher posted research advertisement, information sheet and consent forms on the staff notice board of the hospitals. Included on the noticeboards was tear-off contact details for the researcher and a list for potential participants to leave their name and contact details if they were interested in participating in the research. The researcher was then able to follow up with interested people and organise suitable time and location for the interviews to take place.

Phase 2 of the research involved community participants. Recruitment of community members progressed through research advertising, information sheets and consent forms being posted on the community centre notice boards. A list of tear-off contact details of the researcher and for potential participants to leave their name and contact details were included with the information. The notice boards in 32 community centres in south-east Queensland were utilised for this research. This process resulted in the researcher able to follow up on interested participants and organise a time and location for the interview to take place.

4.3.5 Sample size

Phase 1 involved internal stakeholders and Phase 2 included consumers of healthcare (local community members). There were several factors that determined the sample size for this research. These were the geographical size of the area in south-east Queensland, the number of hospitals within the HHS, the number of willing participants, the people that could most appropriately answer the research questions and the time constraints and resources available to the researcher (Tracy, 2013). In determining these factors, it is often difficult at the onset of research design to know how many interviews will be enough, as the answer is ambiguous at best (Kvale, 1996). However, the sample size is critically important (Tracy, 2013). With these constraints in mind the researcher was mindful of maximising the information gained and to keep an open analytical perspective to ensure rich, in-depth information was collected.

Determining the sample size depends largely on the richness of the data, which for qualitative studies the quality of the data collected is preferred to quantity (Tracy, 2013). If there are not enough interviews the contribution from this research will be shallow. If there are too many interviews it may result in an overwhelming amount of data (Tracy, 2013). Therefore, the sample size used in this research required careful consideration. In qualitative research, the prevailing sample size is generally determined by saturation (Malterud et al., 2016). Meaning, the sample size should be sufficiently large and varied to get across the aims of the study (Patton, 2015; Marshall, 1996). Lincoln and Guba (1985) recommend that sample selection and size should be enough to the point of redundancy. In other words, maximising the information gained and ending when there was no new information forthcoming.

For this study the sample size for Phase 1 consisted of senior managers (n=15) and frontline staff (n=16) giving a total of 31 interviews. In Phase 2 of this study, external stakeholders from the community were interviewed (n=17) to explore their perception of the value of reputation in public healthcare services. Sampling was ended once saturation was reached and no new information was coming forward.

4.3.6 Method of data collection

For this study the researcher used three data collection techniques: these included document analysis, observations and semi-structured interviews. Document analysis,

observations and interviews were undertaken in Phase 1 during January 2019 to June 2019. Phase 2 semi-structured interviews were undertaken from June 2019 to September 2019.

4.3.7 Documents

Access to key organisational documents (see Appendix K) were obtained, including publicly available annual reports, health service survey reports, historical information and media reports. Access to documentation not publically available (e.g. Staff survey report 2016-2018) was provided by the Health Service following permission to access this information provided by the organisations Executive. The benefit of document collection is to authenticate and enhance data collected during the interviews and observations (Yin, 2017; Patton, 2015). In other words, documents provide information about what is learned from the documents but also, they can be a stimulus for paths of inquiry that can be pursued during the interview or observation process (Patton, 2015).

Documentary analysis was used to compile a picture of reputation relevant events over the period under study. For instance, health service strategic planning documents and reports provided an outline of the vision, mission and values – which helped to make sense of the desired organisational culture. Further, the documentation allowed data collection through interviews and observations to be verified and reflected upon, as necessary. Conflicting and incongruous evidence between interviews, observations and documentary sources prompted further exploration and analysis, helping to build a descriptive picture of the health service, its history and reputation building strategies.

4.3.8 Participant observation

Participant observation was part of the data collection process for this research. Observation was used by the researcher within Phase 1 of this study to observe the reactions both verbal and non-verbal (see memo Appendix L: Memo – field observations). Participant observation involved data gathering from the fieldwork by the researcher watching, interacting and asking questions and then reflecting on those observations (Lofland & Lofland, 1995). Being a nurse and understanding the complexities of the healthcare system enabled the researcher to be a complete participant and be fully engaged with the people being observed (Creswell, 2013). The

advantages of observing behaviours are that the researcher had first-hand experience with participants and can record the information at the time of observation. It is this observation that makes it possible to explore topics and note phenomenon being observed (Creswell, 2013). Importantly, while the researcher's position provided advantages there were necessary steps taken to minimise bias and the risks associated with bias (For further detailed discussion on bias, see 4.6.1).

The observations were recorded in a reflective journal by the researcher during the data collection process. The entries in the journal were comprehensive and detailed and included paraphrases of participant quotes (see Appendix M: Reflective journal memo). In addition, the researcher was able to record emotions and behaviours of the participants as well as the researchers own thoughts and perceptions, which added to the reflective process during data analysis. For example, a participant said: "oh I love this place sometimes" and was observed rolling her eyes whilst saying it. The observation prompted further inquiry into the statement made, to explore the meaning.

4.3.9 Interviews

Individual semi-structured interviews formed the primary means of data collection for this research. The use of interviews was to allow the researcher to enter into the participants' perspective and begins with the "assumption that the perspective of others is meaningful and knowable and can be made explicit" (Patton, 2015, p. 426). In other words, the interviews permit the researcher to find out what is in, and on, the mind of the participants to gather their stories (Patton, 2015).

Qualitative interviews are useful tools that can generate worthwhile data necessary for the inquiry (Rubin & Rubin, 2005). Semi-structured interviews allow for some variance in the questions, but all the participants are asked the same questions (Shank, 2006). The use of semi-structured interviews enables the researcher to delve into topics and expand the questioning, particularly if the participant does not understand. The interviewer is able to clear up any misunderstandings and allow the participant time to be orientated to the topic, thereby facilitating relevant responses (Creswell, 2014).

Another advantage of interviews is that it allows the researcher to take note of spontaneous reactions, which would not be available from written forms of data

collection (Creswell, 2014). In addition, it may be necessary to carefully restructure questions when it is shown by the participant's reactions that they are sensitive to a topic. The interviewer can shape the questions more delicately than would be possible from other techniques, thus providing the ability to elicit relevant information.

On the contrary, the difficulties with interviews can be that the interviewer asks questions in a way that may subtly bias the response from the participant (Babbie, 2016). The interviewer needs to be careful with the questions so that they are not asked in a way that may reduce or prevent relevant responses (Babbie, 2016). In addition, semi-structured interviews can be similar to normal conversation and the interviewer needs to remind themselves that this is not the case and care should be taken to make sure the interviewer is listening more than talking (Brinkmann & Kvale, 2018; Creswell, 2014). For the purpose of this research the interviewer conducted the interviews in a relatively informal manner to ensure that the participants were relaxed and open to communicating and sharing their stories. The aim was to build a rapport with the participant and make them feel comfortable sharing their stories and experiences around reputation value for public health services.

Forty-eight semi-structured interviews were conducted, in two phases. Thirty-one interviews were conducted with internal stakeholders of the Hospital and Health Service under study (Senior Managers, n=15; Frontline staff, n=16). The semi-structured interviews allowed the researcher to approach each interview with an open mind and with a set of open-ended questions that explored the topic of reputation (see Appendix D research interview questions). The open-ended questions encouraged the participants to respond in their own words and to express their own personal perspectives and focus on the response, rather than the interviewer. (Denzin & Lincoln, 2011; 1994; Patton, 2015). The open-ended questions also allowed the interviewer to follow particular lines of inquiry (Yin, 2017). This facilitated themes of relevance to emerge from the discussions which then could be explored further. In other words, open-ended questions were clear in structure so that the participant could understand what was being asked. This facilitated a smooth transition between topics, but also allowed for additional information to be collected (Patton, 2015; Punch, 2005).

Participants were recruited through their response to an invitation email. Arrangements for interview locations and times were guided by the participant's

preference, and arranged either through executive assistants, or the researcher and participant directly. Each interviewee provided written consent and their anonymity and confidentiality was strictly upheld throughout all research data storage and transfer, in accordance with Griffith University, data storage standards and protocols. The semi-structured interviews were audio-recorded and transcribed by the researcher. The transcriptions were then stored in the qualitative data management computer software program QSR NVIVO 12^{TM} (QSR, International 2020). Field notes were taken during interviews to record points of interest and observations that were made during the interview but not otherwise recorded.

4.4 METHOD OF DATA ANALYSIS

Having addressed the design and procedural stages of the research, the following stage to be discussed is the analysis of the interviews, observations, documents and field notes. The ethnographic toolkit used in the research was chosen to create interpretive explanations rather than direct conclusions (Kuhn & Woog, 2005). Hence, the focus throughout the analysis of the research data was to understand and find meaning in the value of reputation in public healthcare organisations from the key stakeholders, both internal and external, who work within or utilise the healthcare services.

Miles et al., (2020) suggest that there is no single customary blueprint for the analysis of ethnographic data and the major analytic challenge for the researcher is in finding the descriptions and explanations that still include the inconsistencies and contradictions inherent in social life. Therefore, bringing about a meaningful understanding from the raw data is a process that relies on the exploration of relevant themes. Such a process rests on the researcher's competence and ability to engage with the raw data (O'Leary, 2014). Bogden and Biklen (1982) define the data analysis process as:

> ".... a process of systematically searching and arranging the interview transcripts, field notes and other materials that you accumulate to increase your own understanding of them and to enable you to present what you have discovered to others. Analysis involves working with data, organizing it, breaking it into manageable units, synthesizing it,

> searching for patterns, discovering what is important and what is to be learned and deciding what you will tell others". (p.145)

Using this as a guideline initiated to analyse the data during the early stages of collection, the data were organised, categorised and aligned. Hammersley and Atkinson (2019) suggest that identifying the categories is central to the process of analysis when using an ethnographic approach to research. The process of analysis required active reorganisation and coding of the data into themes and noting the patterns to assist in the path of discovery (Boeije, 2010; Hammersley & Atkinson, 2019; Miles et al., 2020). Coding the data provided prompts for deeper reflection of the meanings and began the process of analysis.

4.4.1 Thematic analysis

A thematic analysis of the data obtained in this study was chosen for its iterative process to make sense of the data (Creswell & Clark 2007; Hammersley & Atkinson, 2019). The data analysis process in this study began with coding the data and breaking it down into smaller units and labelling each unit (Creswell & Clark, 2007). Charmaz (2000) describes coding as the critical link between the collections of the data, to explanation of their meaning. In this research, the data was coded using the computer software program NVivo after manually transcribing each interview. Each code represented a more general idea, theme or category (Silverman, 2019). In doing so, order was created within the raw data. In this way, coding assisted with the reassembly of the data so that it could be approached from different perspectives. The coding process was undertaken through six levels, each time revaluating and analysing the codes, exploring relationships and themes (see Appendix N: Level 6 codes)

The coding process involved the data sources from interview transcripts, field notes and memos being added into the NVivo project in files, which assisted with the organisation of the sources, classifications, codes and themes. In doing so, it allowed for the integration and comparison of the different data sources obtained in the study. The aim was to identify convergences but also contrasts of the data collected. Thematic analysis of the data included identifying theme connections from multiple perspectives of participants and examining links and connections between concepts (Bryman, 2016; Tracy 2013). The coding process through NVivo used a six staged approach.

Step 1: working with the data

The first step in the data analysis involved working with the data. This stage began during the data collection stage (interviews and observations) itself when the researcher started thinking about the data (Gibbs, 2002). As the data was collected throughout the research period the researcher began analysing and working with the data. This process of working with the data includes interpreting, transforming and making sense of data (Hammersley & Atkinson, 2019; Silverman, 2019; Wolcott, 1994).

Working with the data was a reiterative process, which began and continued throughout all of the data collection process and through to the final stages of data analysis and reporting of the findings. In this study, qualitative data was compiled from the various sources i.e. interviews, observations, field notes and memos. An important aspect of working with the data included ensuring and maintaining the validity of the data. To ensure the construct validity of the research, transcripts were provided to the participants for review prior to finalising the transcript for coding (Yin, 2017). This is a member checking process where the participants in this study were asked to review the transcripts from the semi-structured interviews that were conducted and make any comments, agreements or disagreements. If there was disagreement, it was resolved by discussing the section of the transcript with the participants and thereafter correction was made on the transcript. This occurred with one transcript where the transcribed notes reflected an incorrect timeframe for the story being discussed and was quickly resolved through correction of the transcript.

Step 2: Data Organisation

Immediately following collection, the data were organised so to enable ease of analysis. The first level of organising data entailed transcribing all the data and saving it into a word processing program i.e. MS Word using different folders and giving catalogued coded file names. Before data were imported into the NVivo program, the data files were modified to ensure there was compliance with the software. This involved ensuring the files contained no incompatible objects (e.g. files that were in formats that would not open within the NVivo program). The easiest way to do this was

to convert the MS Word files to rich text format files. These files included the interview transcripts of all the participants, observation field notes, and memos.

Once each transcript had been imported into NVivo, the first level of organising data included a first round of coding. The process of coding within qualitative research is extremely important as it ensures a thorough analysis of the data (Strauss, 1987). In fact, Strauss (1987) highlighted the essentiality of coding because "any researcher who wishes to become proficient at doing qualitative analysis must learn to code well and easily. The excellence of the research rests in large part on the excellence of the coding" (p.27). In essence, the coding process is a continual process of identifying sections of text that demonstrate theoretical or descriptive interpretations. Gibbs (2002) describes the qualitative coding process as "a way of organising or managing the data. All the original data were preserved. Codes were added to the data. In fact, typically, text may be densely coded; not only will most text be assigned a code, but much will have more than one code attached to it" (p.4). Using NVivo software provided the ability to organise the data with separate files for codes able to be linked to the transcript data.

This research used an ethnographic tool kit for data collection in order to explore cultural meanings and explanations that may yield reputation management or building implications. Hence, the data analysis coding process was framed around an interpretive description of the data which provided direction in the development of an interpretive account of the interactions, social constructions and textualisation of culture into the analytic strategy (Thorne, 2000; Thorne et al., 2004). To do this, the process of data analysis, utilised open and axial coding (Strauss & Corbin, 2007). Open coding, included defining and developing categories, organised with the use of NVivo software. The categories were designed based on their characteristics and properties. Keywords and sentences were selected from the transcript text, through reflective reading and then identifying the appropriate and relevant category. This process resulted in a large number of codes in the initial stages.

Axial coding was then used to group some of the codes close together as they began to form common themes. This was achieved by connecting relevant items, words, sentences and passages of a document to a node either newly developed or an existing node (or category). A node is not just mere labelling, it is a way of "…connecting a theoretical concept or idea with passages of text that in some way

exemplify that idea" (Gibbs, 2002, p.57). Node development entailed interpretive, subjective, analytical thinking, particularly in determining the credibility and rigour of the coding process. For example, when participant 1 (FL1) said "*They don't really listen to us, we want them to see the struggles we are having and actually listen to us".* If the literal meaning of what FL1 said, was labelled, it could be titled as 'frontline views', but following the subjective process, the node was titled as "Barriers". Table 3 provides an example of the conceptualisation involved in creating and categorising nodes.

Table 3

Examples of nodes and their properties developed in this study.

Nodes	**Characteristic properties of nodes**
Communication	Communications internal to the organisation and external to the organisation. Aspects of communication, media, social media, HHS website. Participants' thoughts on communication and communication strategies. What thoughts and feelings are experienced when faced with certain challenges through communications?
Culture	Behaviours, patterns of behaviour. Observed, voiced, stories, rituals
Reputation definition	What reputation means, how it is defined by internal and external stakeholders. Building blocks of reputation defined by stakeholders
Consumer choice	Does reputation have a role in consumer choice, views, feelings, advantages and problems regarding public health service choice

The initial round of open coding for the first participant totalled 237 nodes. Initially, coding was very dense with the first few data. However, it was soon discovered that doing this resulted in increasing numbers of nodes. In addressing this issue, longer passages were selected as it resulted in an easier to understand content as well as context, and this assisted with understanding the overall meaning within the context (Gibbs, 2002). In this study, the context was important because the actions and behaviours can be understood more comprehensively and subjectively when studied in the setting in which they occur (Bogden & Biklen, 1982).

Consequently, while the shorter passages were easier to code, as they were less complex, they lacked the reference to their original context and made thematic analysis more difficult. As stated by Thorne et al., (2004) it is important to code with clear structural decisions "to avoid clinging to the assumptions with which they entered the study or, conversely, to prevent premature closure a way of making sense of the emerging conceptualizations" (p. 5). Having discovered this in the early stages of the first few collections of data, the subsequent coding involved disciplined reflexivity and analytical structure to facilitate broadened conceptual linkages. Following on from the initial node development, subsequent coded texts were added to existing nodes if the text supported the existing node. However, if new information arose from the coded texts, then another node was added. Progressively, node development began broadening in terms of depth and width of rich interpretations from the data.

Step 3: Condensing data into manageable units

As discussed above, axial coding followed the open coding process (Strauss & Corbin, 1990). This involved refining, developing and conceptualizing loosely related ideas, within the data, into increasingly meaningful relational patterns. The approach involved condensing the data into logical, manageable units of analysis. To do this, listed nodes were selected and merged in the NVivo Node Browser to form hierarchically arranged tree nodes. Some examples of tree nodes identified in this research included:

- **Barrier** (manager, environment)
- **Culture** (team, unit, organisation)
- **Value** (tangible, intangible)

Creating and condensing the data was done by organising the identified relationship between nodes and categorising the nodes as either a parent, child or sibling node. This allowed for the relationships between the data to facilitate moving in and out of the detail in an iterative manner.

Figure 5 shows an example of this relationship between the identified nodes in this study. For example, the node 'Barrier' referred to as the parent node and this node had two children i.e. manager and environment. The 'manager' node had 2 children i.e. 'support', 'communication'. Through NVivo nodes that share the same parent were

referred to as siblings. In this study, 'barrier' had two siblings i.e. 'manager' and 'environment'. As the analysis progressed and patterns and themes within the data were ordered into parent nodes or became parent nodes, sense-making and meaning was increasingly understood within the complexity of the data.

Figure 5

Example of a tree structure

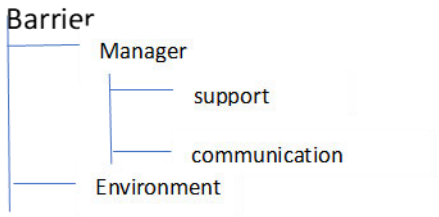


Figure 1. *An example of a tree structure*

Further refining of the coding process was continued in this stage. The reiterative process from time to time involved codes being uncoded and recoded with intersubjective construction of knowledge with mindfulness of the positioning of the researcher. As a result of thorough and rigorous coding, new categories of data began to emerge, and this resulted in new and interesting discoveries.

Step 4: Integrating the data

Constant reviewing of the data resulted in tidying up of the lists of free nodes and refining the definitions of each tree node. In that way, flexibility in the analysis of the data assisted with the development of new branches and modification of the trees resulting in a more critical reflective analysis of the data. Field notes and observations made during the data collection process were integrated and analysed. Some researchers refer to this as metadata, the reflective data that is written during the life of the study (Gibbs, 2002). In this study, the metadata was recorded using memos, annotations, and conceptual drawings (see examples of these in Appendix H Research Memo and Appendix I Conceptual drawings). Keeping the metadata from the beginning of the data collection process was important as it assisted with facilitating alternative conceptual emphases and intrigues, which arose during analytical and critical thinking.

NVivo has inherent features that assist with the analytical and critical reflection process. Some of the features included the ability to record and write reflections about the data through annotations and memos. In qualitative data analysis, the data collection and analysis inform one another, and as a result, the shape and direction emerge as "new possibilities arise and are considered" (Thorne et al., 2004. p. 5). As the researcher, it was important to be sceptical of the immediately apparent and continue to create the themed tree structures that challenged the immediate conceptualisations. Hence, to broaden, rather than narrow, the conceptual connections, it was important to be mindful of seeking out alternative relationships and divergent associations from the data. By doing this, it was possible to constantly examine and re-examine the data for alternative emerging themes to assist in the quest for logical rich understandings that acquiesced theory to be transformed by the logic of the data (Thorne et al., 2004).

Through NVivo, the reflections were able to be linked to any unit of text or passage in a document. The memos written during the data analysis process were theorising write-ups of inductive reasoning about codes and their relationships, as they arose throughout the coding process. Sometimes these writings were very short, a sentence or a paragraph, and sometimes they were longer consisting of few pages (For example, see Appendix H Research Memo). However, when it came to writing memos, some basic guidelines were adhered to, such as writing the memo as soon as it came to mind, dating and time stamping the memos to keep consistency with the audit trail of analysing. The process of reflections through memos and annotations assisted with the development of the analysis and identification of surprising and interesting themes and patterns.

Step 5: Emerging patterns

Following the integrating of the data, the data was then analysed for emerging patterns and themes of how reputation was conceptualised and formed. In other words, attempts were made to compare the patterns with patterns from past studies, knowledge or theory. In this study, the researcher anticipated obtaining evidence that would support reviews of literature of reputation and the theoretical underpinnings of this study, i.e. socio-constructivism through the analysis of the research objective of how reputation is conceptualised and formed, and how the dimensions of reputation can be

developed to facilitate reputation management strategies, that are likely to increase competitive advantage and performance for public healthcare organisations. Hence, searching for patterns was an important activity in this qualitative study, as it involved determining and discovering all related issues regarding the value of reputation. For example, the NVivo search tool provided the ability to conduct a wide range of searches from simple to complex. This was an important task to ensure that an exhaustive and complete search was conducted of the data. See Appendix O (NVivo search query), for an example of the search queries for the relationship between reputation and culture. This search yielded 876 references through 47 files, providing an exhaustive but more complete picture of this pattern in the data.

Consequently, the search for emerging patterns was a crucial step in the data analysis process for this qualitative study, as it entailed comprehending, recognising and interpreting how stakeholders perceived reputational value. Once this was understood, the patterns emerged of the dimensions of reputation. While these findings did not emerge in the sense of having their own agency (Morse, 1994) they were ultimately generated and determined by the researcher's conceptualisations and interpretations of the data. As such, it was important for the researcher to be aware of their role in driving the interpretation of the data and therefore was an essential element in generating findings. This awareness is essential for the credibility and interpretive authority of the researcher (Thorne, 1997).

Step 6: Determining and generating the findings.

The final stages of this qualitative study involved what and how to report and write the findings. Since the data was explored to investigate the 'what' and 'how' of reputation, a descriptive and structured approach consisted of explaining and building the phenomenon. While there were an infinite number of interpretive possibilities and foundations of interest, the core of this qualitative study was the answering of the research question. Through the analytical building approach, the researcher inductively explained how internal and external stakeholders perceive and value reputation. The patterns and themes were ordered into a narrative that outlined how reputation is conceptualised and formed in the minds of stakeholders of public healthcare organisations. How stakeholders thought about reputation exposed the dimensions of

reputation which exposed the perceptual value of reputation. While maintaining contact with the research objectives, constant assessment of explanations with those from previous studies, and from identified patterns that linked and matched those relevant studies, were explained.

4.5 RESEARCH QUALITY AND RIGOUR

Several aspects of research quality were considered for this study and a number of strategies engaged in order to maximise research rigour and circumvent biases. While quantitative researchers from the positivist tradition use validity and reliability methods to establish trustworthiness (Houghton et al., 2013; Tobin & Begley, 2004), qualitative research notions of trustworthiness are more reliant on credibility, dependability, transferability and confirmability (Guba & Lincoln, 1994; Lincoln & Guba, 1985; Shank, 2006; Tracy, 2013; Williams & Hill, 2012). According to Lincoln and Guba, (1985); and Guba and Lincoln, (1994) trustworthiness and authenticity are more feasible than reliability and validity standards as they reflect that there is a possibility of more than one absolute account of social reality. 'Credibility' essentially relates to the linking of the research findings with whether or not participants agree with the findings, or whether a reader can understand the findings in order for the researcher to demonstrate the truth of the study's findings (William & Hill, 2012). 'Dependability' is a bit like the notion of reliability and refers to the consistency of the data interpretations (William & Hill, 2012). 'Transferability' refers to the degree to which the research can be transferred to other contexts and settings with other participants (Korstjens, & Moser, 2018). 'Confirmability' is akin to objectivity and relates to how a researcher accounts for their own perspectives and research interests and how the interpretations are clearly derived from the data, Confirmability is achieved through researcher reflexivity (Korstjens, & Moser, 2018; Williams & Hill 2012).

Strategies to maximise research rigour are summarised in Table 4. Of particular benefit was the use of respondent validation/member checking. This was accomplished by providing the participant with an account of the transcript from interviews, conversations and from what was observed by the researcher by watching the participant during field observations. This validation was achieved by seeking confirmation that the findings and impression are congruent with the participants, which provides the ability to seek out areas and reasons for lack of consistency (Bryman,

2016). This exercise proved useful as some participants expanded on the examples and experiences they provided clarifying some of the areas of interest.

Table 4

Research rigour strategies

Research rigour	Strategies employed to enhance research rigour
Credibility	• The use of multiple sources of data from interviews, observations, and documents to provide rich source of data for analysis and allowed for constant revision of the data to illuminate the research question. • Participant diversity from both internal and external stakeholders. Diversity was not only cultural but included professional and hierarchical level within the organisation. • Ensuring an accurate audit of evidence. • Participant validation/member checking by providing transcripts to the participants of the interviews to seek confirmation that the findings and impressions were congruent with the participants.
Dependability	• Recording and describing the research steps taken throughout all stages of the study project from beginning to end. • Use NVivo software to store, collect and retrieve data from one place.
Transferability	• Clear thick, rich description of the behaviours, experiences of participants. • Inclusion of the context in the rich descriptions to enable outsiders to assess whether the findings are transferable to their own setting.
Confirmability	• Researcher reflexivity which entailed deep reflection and memo writing. Examining researchers own explicit and implicit assumptions and preconceptions. • Peer review and debriefing with supervisors.

This qualitative research used an ethnographic toolkit which involved the researcher being involved in the data gathering process. Consequently, confirmability in the form of peer review and debriefing with the researcher's supervisors was essential. Peer review provides an external check of the process involved in the research (Creswell, 2013, 2014; Ely et al., 1991; Erlandson et al., 1993; Glesne & Peshkin, 1992; Lincoln & Guba 1985). The research process checking involved consideration of the process as it relates to positions of power, the position of the researcher and the intersubjective construction of knowledge (Thorne et al., 2004).

Weekly debriefing sessions were conducted throughout the study during the data collection and analysis phase with the researcher's supervisors as a 'thoughtful clinician test' (Thorne et al., 2004). As experts in the field, the researcher's supervisors were able to provide confirmation and plausibility for the interpretations of the relationships and understandings and also to overcome researcher bias.

4.5.1 Bias

Researcher bias can affect the development of the research and the outcomes (Creswell, 2014). Personal judgements, favouritism and distortions in the data introduced will bias the study (Payne & Payne, 2004). Therefore, the researcher was aware of potential biases from preconceived values and beliefs. Strategies to minimise bias were managed using reflexivity, journal reflection, and regular discussions with supervisors during the research process.

Reflexivity has been used by academics to convince readers of the assumptive concepts, values and practices of the field (Smith, 2006). Epistemological reflexivity argues that assumptions contained in any body of knowledge can become the focus of critical attention (Smith, 2006). By the same token, research is considered of good quality when the researcher makes their position explicit about what values, biases, and experiences they bring to the study (Creswell, 2013; 2014; Hammersley & Atkinson, 2019). In this study, the researcher is educated in nursing and law and is currently working in the healthcare industry. These factors were taken into consideration during the study with particular attention to the researcher's thoughts and reflections which were discussed with the researcher's supervisors. In addition, recording of field notes and journal writing of the researcher's opinions were distinguished from those of the participants.

4.5.2 Context and time-bound

The research is also limited as a result of it being context and time-bound. This means that the research is a conceptualisation of reputation situated in a particular context and a moment in time. As a result, applying the methodology again or in a different location, such as a different Hospital and Health Service, may generate different findings. For example, at another time there may be different staff present or different community members who may have different views on the perception of

reputation and its value. In addition, another Hospital and Health Service may have different contextual factors to those in south-east Queensland and their perception of reputation may vary from the participants in this study.

In addition, the priorities for Hospital and Health Services change, particularly with changes in the political environment. Accordingly, the relevance of the research findings from this study will begin to diminish directly upon the completion of the research as culture and society change and healthcare advances. However, reputation is a construct built over time and, therefore, the context and time-specific nature of reputation is relevant to qualitative inquiry and does not necessarily diminish the credibility and value of the research findings.

4.6 ETHICAL CONSIDERATIONS

Ethical approval was obtained through the Australian Public Hospitals Human Research Ethics Committee (HREC) and Griffith University HREC. This research is considered negligible risk; however, the following key ethical issues have been identified: informed consent and power dynamics; and confidentiality (Shank, 2006). Informed consent and power dynamic were provided by the participants in the study where they signed the purposefully designed consent form prior to the commencement of the interviews. The consent form was contextualised to prevent participants from feeling threatened by the format of a standard consent form.

In addition, a participant information letter (Appendix B: Research information sheet for senior managers; and Appendix C: Information sheet for frontline participants) was provided to the participants and the participating organisations, outlining the purpose of the study, financial implications, confidentiality, consent implications and support network. Confidentiality was established to protect the privacy of the individual participant and participating organisations. By using aggregated results in published work, and de-identification of organisations and participants, confidentiality was maintained.

All data was securely stored and will be disposed of after a five-year period following the end of the year of the last refereed publication (Griffith University, 2020). The researcher abides by the Australian Code for Responsible Conduct of Research

(2007) and Griffith University's Best Practice Guidelines for Researchers: Managing Research Data and Primary Materials (2014).

4.7 CHAPTER SUMMARY

This chapter served three purposes. Firstly, as a logical extension to what is known and not known on the topic of reputation the research aims, objectives and questions guiding this study were provided and rationalised. Broadly summarising, the aim of the study was to explore how reputation is conceptualised and formed in the minds of public healthcare stakeholders and how the value of reputation is perceived by the different stakeholders. Secondly, the study was positioned within the broader context of the philosophy of science, with an introduction and justification for the approach and perspective guiding the study – interpretivism/constructivism. Interpretivism was chosen as a subjective approach, using a constructivist lens, orientated toward real-life scenarios. Thirdly, the interpretivist/constructivist method relied on to undertake this study was thoroughly outlined. This involved detailing the qualitative steps involved in the thematic analysis alongside the principles of a subjectivist ontology and epistemology. Consistent with this approach, the devised method was modified throughout the research process, offering methodological insights and allowing the researcher to gain a rich in-depth understanding of the perceptional value of reputation in the public healthcare setting.

The next two chapters of this thesis report on the findings and the theoretical interpretations regarding their meaning and significance. Chapter 5 Internal Stakeholders explores the perceptions of senior managers and frontline staff of the public healthcare organisation under study. In other words, chapter 5 begins to address the questions of how reputation is conceptualised and formed in the minds of internal stakeholders. In particular the dimensions of reputation are developed through the unfolding of the events and experiences of the stakeholders. Chapter 6 External Stakeholders explores the external stakeholders' perceptions of reputation, which included consumers and potential consumers of the public healthcare organisation under study. This chapter examines the extent to which consumers were able to perceive and be influenced by reputational dimensions.

Chapter 5: Findings – Internal Stakeholders

Phase 1 of this research was an exploratory qualitative study aimed at establishing an overall picture of reputation based on the perceptions of internal stakeholders, which included senior managers and frontline staff working in public healthcare organisations. The external stakeholder findings will be described in the next chapter. This chapter focuses on the internal stakeholder perspective to provide an overall picture of how internal stakeholders conceptualise reputation, and how reputation is formed, to provide a clear understanding of the dimensions of reputation and its value for public healthcare organisations. More specifically, how the dimensions of reputation are formed, how these dimensions influence the perceptions of internal stakeholders, and how these perceptions influence the prevailing organisational culture. Understanding how reputational dimensions influence perceptions provides a platform to develop and modify reputational measurement instruments to build and manage reputation. Additionally, understanding the role of organisational culture and its relationship to reputation has implications for Health Service Managers to improve culture and reputation and provide the organisation with a competitive advantage and contestability, over industry peers.

Therefore, the sub-questions specifically developed for Phase 1 were:

1. *How is the perceptional value of reputation conceptualised within public healthcare organisations?*
2. *How do senior managers and frontline staff form their attitudes and beliefs about the reputation of public healthcare organisations?*

As outlined in Chapter 2 of this thesis, the context of this research is public healthcare organisations, and the two key constructs are reputation and organisational culture. Highlighted in Chapter 2, this research examined the relationship between reputation and organisational culture. Outlined was the potential influence that organisational culture may have on reputation. Therefore, this study adopted the multi-perspective cultural lens advanced by Martin (1992): integration perspective,

differentiation perspective, and fragmentation perspective (Martin, 2002; Rosenthal et al., 2017; Weerts et al., 2018).

Additionally, the underlying theory that frames this research includes the Resource-Based View (RBV) of the firm (Barney, 1991). Resource-based view theory examines how reputation is a valuable, rare, inimitable and non-substitutable (VRIN) intangible resource that leads to a competitive advantage (Deephouse, 2000; Roberts & Dowling, 2002). Please refer back to Chapter 2 for further detail on this theory.

This chapter starts with how internal stakeholders conceptualise reputation. Findings from senior managers and frontline staff perspectives on key topics is presented, highlighting the perceptional value of reputation for public healthcare organisations. The focus then shifts towards the internal environment commencing with an exploration of how internal stakeholders perceive the organisational goals and values are designed to achieve the objectives of the organisation. This is followed by presenting the links drawn between the key reputational dimensions identified in this research in order to show how reputational value is shaped by organisational culture in public healthcare organisations.

5.1 CONCEPTUALISING REPUTATIONAL VALUE

5.1.1 How senior managers conceptualise reputation.

The interpretation of 'reputation' can vary among industries, stakeholders and disciplines (Cian & Cervai, 2014). For the purpose of this research, participants were provided with the definition of reputation adopted for this research at the commencement of the interview:

> "A relatively stable, issue-specific aggregate perceptual representation of an organisations past actions and future prospects compared against some standard" (Walker, 2010. p.370).

Reputation was defined by a number of the senior managers as a concept that aligned with the objectives and performance of the organisation. For example: a participant said:

> "I think there's a number of things that are important that is excellent care, timely care and access, and good food and whatever, it is that we would think we should be able to deliver". (SM1)

Another senior manager stated:

> "It is a balanced scorecard. Things that you learn through Magnet and Pathways to excellence is that there are always pockets where the culture or the outcomes aren't great but it's the sum of the parts. Also recognising that sometimes those parts can damage the reputation. I consider it is like a balanced scorecard and has to be more than one dimension and has to be in balance. Its things like those practical outcomes and also the feel within an organisation and those sort of things". (SM3)

Of note, here a senior manager describes two programs ('Magnet' and 'Pathways to excellence') that are organisational culture shaping programs designed to demonstrate the organisations commitment to a positive culture (American Nurses Credentialing Centre, 2020). A functional view of organisational culture is promoted, providing senior managers with practical overarching solutions to organisational problems. This is a functional view of organisational culture and reflects the integration perspective of culture that comes from higher levels in the organisation.

The importance of reputation was expressed from all the senior managers including a board member who concluded, "To me reputation is critical. But at the same time potential risks must be recognised and if necessary, handled with great care so that professional efficient and effective reputation management is realised" (SM15).

The finding that reputation is considered important by senior managers is consistent with Vancheswar et al., (2015) examined the perceptions and sentiments of corporate executives at various levels across industry sectors in India. Their study found that reputation is an important intangible asset that needs to be nurtured especially by top managers and leaders. In healthcare terms, research has demonstrated that reputation consistently ranks as one of the most important factors that consumers use in selecting health services (Dijs-Elsinga et al., 2010; Jung et al., 2011; Yahanda et al., 2016; Ziemba et al., 2017; Ziemba et al., 2019). On this note, some of the senior managers

felt that reputation was a strategic asset that provided value to the organisation. For example, a senior manager stated that "reputation is a strategic asset that as an executive we are very aware of". (SM2). Another senior manager said:

> "I think what you will see is an emerging trend for public hospitals to invest much more heavily into reputation as a strategic asset because the evidence is becoming quite clear from a performance and value perspective" (SM 1).

Reputation conceptualised here by senior managers, describes an asset for the organisation. Consistent with other studies on reputation, that have focused on the outcome of reputation, by examining how reputation is a valuable and rare resource that leads to a sustainable competitive advantage (Fombrun, 1996; Fombrun & van Riel, 2003; Gatzert, 2015; Roberts & Dowling, 2002; Walker, 2010). From a resource-based view theory perspective, reputation is a valuable and rare intangible resource because it is difficult to replicate and highly ambiguous, which leads to a sustained competitive advantage (Deephouse, 2000; Flanagan & O'Shaughnessy, 2005; Roberts & Dowling, 2002; Walker, 2010). This concept of reputation having value was also recognised by a participant who stated:

> "When you have a good reputation, you own a rare and valuable asset that can assist with the performance of the organisation". (SM6)

That participant also highlighted a common link in the senior manager participants, which revealed that senior managers also considered reputation as something that is determined by the public organisations' performance. While, performance is determined by government performance measures, which includes emergency department waiting times, hospital activity, elective surgery waiting lists, specialist outpatient waiting lists, immunisation rates and nurse to patient ratios (State of Queensland [Queensland Health], 2020a) most of the senior managers felt that these performance measures were what was conceptualised when considering the reputation of public healthcare organisations. In addition, the performance reporting has major implications for senior managers as the 'government set' performance measures are linked to public healthcare organisations' budgetary allocation. As a result, all of the senior managers were focused on performance as a basis for conceptualising reputation.

While there is a steady stream of research exploring the reputation-performance relationship, uncertainty exists on the nature of the relationship and the direction of its influence (Boyd, et al. 2010; Kaur & Singh, 2020). In this study, senior managers are clear that there is a link between reputation and performance and that the performance of the organisation, influences the reputation. The senior managers clearly distinguish reputation from contextual perplexities and see performance as a driver of reputation. However, also identified is reputation as a driver of factors influencing performance. For example, a senior manager stated:

> "I think a good reputation influences the decision to provide additional funding. To the core business stuff. So, I think if you have a good reputation as doing your best to deliver on whatever you've promised, you probably get higher up in the queue of people who are waiting for extra funding to do something". (SM6)

Senior managers were mindful of the socio-political environment and the influence and financial benefits of achieving government performance targets set for public healthcare organisations. While the public healthcare sector in Australia has been influenced by efficiency and competitive advantage methods used by private healthcare sector managers (Dedman et al., 2011; Duckett & Wilcox, 2015; Richardson, 2002), it was evident in this study that senior managers felt that good performance was influenced by efficiency and this formed the basis of how they described reputation. Interestingly, frontline staff held a different view of their perception of reputation, which is discussed in the next section.

5.1.2 How frontline staff conceptualise reputation.

In contrast to the senior manager perspective, frontline staff were either not aware of the government mandated performance targets or did not really consider them as important factors in their understanding of reputation. For example, a frontline staff member who works at a regional public healthcare organisation stated:

> "The executive look at the performance targets but we look at the care we provide the patients and the doctors and the nurses work with the families and we give a good service". (FL1)

Another participant said:

> "Executives are very eagle eyed on the money side of things and we do get regular emails from executives saying we've got a great system here and a great hospital and you're all fantastic workers and what have you, but I don't know how much they think about the outside. So, I think what we do as frontline staff is very important in terms of reputation" (FL5).

This finding of service delivery being at the forefront of how reputation is conceptualised, for frontline staff, is consistent with some of the literature which provides that service delivery employees play a crucial role in creating and sustaining the reputation of the organisation (Babić-Hodovića & Arslanagić-Kalajdžić, 2019). The frontline staff were consistent in their perception of the importance of their role in forming the reputation of the organisation. In other words, reputation in the mind of frontline staff was based on the healthcare quality they provided to consumers. Also evident from the frontline staff was the different perspectives of reputation that were perceived by the different levels (senior managers and frontline staff). Frontline staff participants felt that their attitudes and commitment to the public healthcare organisation are reflected in consumer's perception of healthcare quality which in turn formed the basis of the organisation's reputation. For example, a participant said:

> "I think reputation is about the quality of the care that we provide to the patients. If they are happy with the delivery of care and the interactions, they have with us, then that has positive effects on the reputation of the organisation". (FL12)

Frontline staff perceived reputation to be based on the healthcare quality that was delivered to the patient by them and their ability to deliver a high standard of care reflected positively on reputation. However, some frontline staff expressed that their ability to deliver high-quality healthcare was affected by the sometimes constraining decisions of senior managers. For example, a frontline staff member stated:

> "The executive put a system in place without talking to the staff, and it didn't work. If they had spoken to us first, we would have been able to explain to them why it wouldn't work and would end up costing more money rather than saving money". (FL11)

While frontline staff perceived healthcare quality as an important dimension of reputation, most did not consider the effect of their role on reputation. Organisational culture at this level of the organisation is fragmented. There is ambiguity that has developed from unawareness or confusion from the organisation as well as from the complications that arise from divided opinions and tensions between senior managers and frontline staff. This is an important finding as employee's perception of positive reputation has been shown to contribute to positive behavioural patterns and intentions by employees (Fu et al., 2014). Therefore, the importance of creating a positive reputation to ensure aligned behavioural intentions, highlights the significance of reputation management and reputation building in public healthcare organisations.

In summary, senior managers and frontline staffs understanding of the concept of reputation formed the basis of their responses to the interview questions. The findings show that the conceptualisation of reputation aligns directly with where the focus of the feedback, interactions and accountability lies. For example, senior managers receive feedback on, and are accountable for the performance of the organisation, to government agencies and a wider range of stakeholders. Therefore, it makes sense that their perception of reputation is based on aggregate data and reflects an integrated culture perspective, assuming an organisation-wide sharing of beliefs and assumptions that make up culture. Frontline staff receive feedback from and interact with consumers of healthcare services mostly and managers occasionally. Hence it makes sense that their perception of reputation is based on the lens they see. Table 5 below summarises the how senior managers and frontline staff conceptualise reputation in public healthcare organisations.

Table 5

How senior managers and frontline staff conceptualise reputation.

	Senior managers	**Frontline staff**
Conceptualising reputation	Reputation based on the performance of the organisation as a whole. Reputation provides public organisations with a competitive advantage with positive performance implications such as, additional resources, attracting quality staff, philanthropic donations.	Reputation based on the quality of the care provided to the consumer. High quality of care delivered by frontline staff provides a positive experience for the patient which forms the basis of reputation for the organisation. Believe they play a crucial role in shaping the reputation of the organisation.
Organisational culture perspective	Integrated culture	Fragmentation culture

As shown in Table 5 the findings suggest that senior managers' perception of reputation was mostly centred on the organisation as a whole and its performance against targets set by the government. Reputation was considered by senior managers to be a valuable asset for the organisation that could provide it with a competitive advantage for other resources such as additional funding, philanthropic donations and attracting quality staff. This finding is consistent with other studies on reputation that suggest reputation is thought to differentiate organisations and is an intangible asset that is composed of complementary and reinforcing relationships that have positive performance implications (Boyd et al., 2010). In contrast, frontline staff perception of reputation was based on the standard and quality of care delivered to the consumer. When the quality of the care delivered is high then it is likely to result in a positive experience, which in turn creates a positive reputation for the organisation. This finding is consistent with the literature which suggests that favourable perceptions about consumer experience is positively correlated with consumers' perception of reputation (Al-Amin et al., 2018; Nguyen, 2010).

The first research question asks: in what way is the perceptual value of reputation conceptualised about public healthcare organisations? This section of the chapter has partially addressed this question by presenting an examination of the prominent factors that seem to be associated with the conceptualisation of reputation. These factors are

presented at senior management level as a set of shared values and attitudes and cultural practices that reflect an integrated culture of shared values for performance and improvement of the organisation. At the frontline level the prominent factors associated with the conceptualisation of reputation are presented as a distinguishable set of values, beliefs and attitudes that are often inconsistent and unpredictable. The meanings constructed by different members, to aspects of culture (i.e. language, patterns of behaviour, rituals) explains the varying perceptions of the value of reputation and the conflicts that exist between hierarchical groups.

Interestingly, the underlying structural and cultural differences that appear to have influenced the perception of reputation, suggest that culture is a likely predictor of reputation for the organisation, largely due to the internal culture and the perceived reputational factors interlinking and informing each other. Thereby, suggesting that culture would potentially support reputation building activities. However, this is only part of the potential reputation – culture relationship. To fully explore the reputation-cultural link requires understanding how reputation is formed by stakeholders.

5.2 FORMING REPUTATIONAL VALUE

Now that it is clear how senior managers and frontline staff conceptualise reputational value of public healthcare organisations, this chapter will move forward to presenting the results on the perceptions of senior managers and frontline staff on how reputational value is formed. The participants were asked a series of questions about their perception of the value of reputation for public healthcare organisations and what influenced their perceptions. The next section describes the themes that emerged from the interviews and observations noted during the data gathering phase of this study. It explores how senior managers and frontline staff form their attitudes and beliefs about the reputation of public healthcare organisations and their perceived role in shaping reputation.

Three dimensions of reputation that emerged from the interviews and observations were: 1. *Consumer satisfaction,* which included the sub-categories of communication and reputation management. 2. *Healthcare quality,* which includes the sub-category of organisational goals and objectives, which were identified as components of this dimension that influenced the formation of reputational value of public healthcare

organisations. 3. *Organisational culture* as identified through the values of the organisation. These identified dimensions of reputation provided an in-depth understanding of how senior managers and frontline staff formed their opinion, and how they saw their role in shaping public hospital reputation. Of note, the three dimensions are not mutually exclusive, a relationship exists between all of them in relation to forming reputational value for public healthcare organisations.

5.2.1 Dimension 1: Consumer satisfaction

Consumer satisfaction was highlighted by all participants as the most important aim for delivery of public healthcare services and was a key dimension of reputational value for the organisation. All participants outlined the importance of delivering healthcare that was safe and met the safety and quality standards set by the government (Australian Commission, 2017). Participants comments related to consumer satisfaction were subcategorised into reputation management and communication.

Reputation management

When asked about whether participants felt that reputation should be managed by the organisation to ensure consumer satisfaction, all participants agreed that it should be managed. A senior manager recognised the importance of managing the organisations reputation to attract and retain the best staff:

> "Staff want to work in an organisation that has a positive reputation and know that in the next 5 years that our workforce demands are going to be a major challenge for us. The national workforce literature would suggest that in the next 10 years there is going to be over 150,000 registered nurses short of what is required in this country so it is a competition in a way so that if we can develop a little cocoon, and I don't mean work in an insular way, you have to be broader than that but essentially if we want to attract people to the organisation, if we want to do that then the staff have got to see that it's a positive place to work. And that reputation is also about how we look after our staff, not just paying them but how we look after them and develop them and have that very close link

between the staff and the patients. I think if we lose that link then we are in trouble". (SM1)

This finding is consistent with findings by other researchers who conclude that organisations that deliberately manage their reputations enjoy significantly enhanced relationships with their stakeholders (Vancheswar et al., 2015; Fombrun & Rindova, 1996; Tetrault et al., 2019). While the importance of reputation management was understood by the senior manager group of participants, how to actually do this was not clear. Some participants felt that reputation management was linked to good communication. For example, a participant said:

> "I think its constant key messaging out to the community. Celebrate the successes, transparency, and the failures. It's about building the confidence and sometimes acknowledging when things have gone wrong and not brushing them under the carpet but taking full responsibility for them. For example, our care was substandard, and we need to learn from that and to never let that happen again. That's a very strong message. Most families want to hear the truth and know that you are not going to let that happen again. Celebrating the successes – our outcomes are really good given our resources and things like that are outcomes are stellar". (SM8)

Another senior manager said:

> "I think the biggest element is communication. The patients need to know who is looking after them, they need to know where they are up to, they need results of tests that they have had, and they need to know what their plan of care is and when they might be likely to go home. For my particular cohort they also need to know that they will or won't go home, whether they need to be placed or whether they need to have the family come in and have those conversations, but it is all about communication. By far the most complaints I get, are based on communication and if you don't communication those see that as poor care". (SM12)

This finding is consistent with the literature, which suggests that reputation should be based on strategic commitments of the organisation and communicated well

(Dowling & Moran, 2012). In addition, organisations that respond positively to stakeholder expectations will improve reputational resources, which can lead to a sustainable competitive advantage by a continuous investment in 'doing good' to be viewed by stakeholders as 'looking good' and over time 'looking even better' (Tetrault et al., 2019). By managing communication and customer relationships, a good reputation is seen as a hygiene factor rather than a real motivator (Wiedmann, 2017). In the context of this study, communication was highlighted by participants as an important factor in their perception of reputation. Both frontline staff and senior managers described reputation in terms of the importance of communicating a positive message to the general public. For example, a senior manager stated:

> "Having a positive media strategy to get on the front foot is also a very important part of developing the organisations reputation". (SM1)

This finding is consistent with the literature, which suggests that an organisations reputation is influence by the effectiveness of the communication strategy (Forman & Argenti, 2005) and that communication of good behaviour is as important as doing good (Chun et al., 2019). However, in this study it was important to ascertain what participants felt that consumers wanted from public healthcare services and whether they were influenced by the reputation of the organisation. Most of the senior managers felt that the media was very influential on the consumers' perception of the reputation of public healthcare organisations. For example, a senior manager of a large tertiary hospital stated:

> "They [consumers] are definitely influenced by the media in a negative way and I think we have to put it into context. If you look at this hospital a great hospital that is being massively challenged by the ability to supply what the demands of the community are. There is way more positive feedback from our consumers than there is negative feedback but like everything the negative feedback gets the press". (SM1)

Senior managers were mindful of local media publishing stories that may reflect poorly on the reputation of the hospital. This was largely due to the reactiveness that resulted from negative media stories, as stated by a senior manager:

> "For the Minister, the media is unbelievably influential, when an item appears in the Courier Mail, the Minister is on the phone to the executive to respond immediately to the negative press". (SM9)

And:

> "We're constantly getting the minister needs this, or the chief executive needs that, and it's always in response to the local media saying something negative. It's not great. And I guess sometimes that's where the money goes, where the focus goes in responding to the media". (SM8)

This finding may explain why senior managers believe that consumers' perception of reputation is influenced by the local media. Senior managers conceptualised the value of reputation on a broader level than Frontline staff. Senior managers are accountable to external stakeholders and it makes sense that they would consider the media as a potential influence on the reputation of the organisation. However, frontline participants felt that consumers' perception of reputation was influenced by the care received in public healthcare organisations, whether experienced personally or heard through word of mouth. For example, a participant stated:

> " I think consumers look at the type of care they receive or the care they hear others have received, this influences them on whether they have trust in that hospital or not". (FL4)

Participants were asked what they thought consumers wanted from public healthcare organisations. Again, senior managers and frontline staff had differing views. Senior managers were more focused on the performance of the organisation, stating that consumers wanted access to services and to know that the organisation would provide quality healthcare. For example, on the one hand a senior manager stated:

> "Consumers want to know that they are going to get their operation on time and that they are going to get access to services when they need them". (SM6)

On the other hand, frontline participants felt that consumers wanted quality healthcare and that they were listened to and communicated with. For example, a frontline staff member stated:

> "Consumers are influenced by who's talking to the patient, and how much the staff knows what's going on in relation to the patient, things like that. Because the most common things that I hear, where I am now, is there's a lot of miscommunication, nobody knows what's happening, their surgery is getting cancelled, or they don't know what time they're going to surgery and stuff like that and so it's just quite stressful for them. And also I think when people have been to hospital quite a few times, and they already understand sort of, a bit of the process, and then somebody else comes along and they do it differently, that kind of freaks them out without people explaining to them what's happening". (FL8)

The findings show that there are differing views on what internal stakeholders perceive as important to consumers in terms of healthcare needs from public healthcare organisations. The findings show that communication is an important factor in forming the perception reputational value. In the context of this study, when participants were asked to describe what reputation management through good communication would look like, most participants stated that it was about sending the right messages throughout the organisation. One senior manager reflected on the values of the organisation being an important message that should be at the forefront of decision making:

> "The aims and values that we have, because we are a health service not an individual hospital, and if you look at the individual hospitals, they in a way mimic, and I don't mean mimic in a punitive sense, they mirror the health service wide aims and values. What we should be doing is recruiting and employing by our aims and values. You know the expectation that we have for people if they want to join our team they have to be caring, they have to be committed to professional self-development, to the values, they have to be working with integrity etc. And of course, we manage our staff that don't, hopefully our processes

won’t allow them in the door because they don’t fit with our aims and values”. (SM10)

This finding highlights the importance of sending a good message out but also relying on the values that are important to the organisation when managing reputation.

Reputation management has been described as a more active, centralised, focused and scientific approach to communicating with stakeholders (Fombrun et al., 2000). In addition, research suggests that communication to stakeholders both internally and externally should be consistent as employees and advocates are the ones forging the organisations reputation, they endorse and expose with their own beliefs and perceptions, a positive reputation. (Tran et al., 2015; Breitinger & Bonardi, 2019). However, while the relevance of reputation management has increased, the application of more sophisticated reputation management approaches and tools has decreased (Wiedmann, 2017). In the context of this study, some participants were unsure about how to manage an organisation’s reputation. For example, one participant said:

“As to how you go about managing a reputation in this kind of field, I would have no idea how you go about that”. (SM4)

Frontline participants stated that managing reputation was the responsibility of everyone in the organisation, but the senior managers should lead the strategy by their actions and the way they communicated with the staff. For example, a frontline staff member stated:

“The way the executive behave has a huge impact because I think it filters down, and even onto sometimes, regrettably, at the patient level. So, if you don't have happy staff, the patients would undoubtedly feel it as well”. (FL13)

This finding highlights the significance of “walking the talk” so that the employees can see that the values and behaviours that are communicated and expected of the staff are demonstrated in the behaviours of the executive. At this level the culture is integrated with the goal of consensus and conformity. The significance of ‘walking the talk’ has been highlighted in the literature as an important component of reputation management for organisations (Fombrun & Rindova 1996; Vancheswaret al., 2015). In

addition, reputation has been described as a perceptual phenomenon and it depends on how attitudes and behaviours are perceived by those individuals who observe the organisation reputation (Seeger et al., 2003). Among those observers, it is the employee stakeholder who is particularly relevant because they are the ones that contribute to the organisation's reputation (Seeger et al., 2003). In turn, the reputation influences the amount and quality of the employee stakeholder contribution and commitment to the organisations service delivery and willingness to defend the organisation against antagonists (Einwiller & Steilen, 2015; Vancheswar et al., 2015). In this study, most participants stated that the attitudes and behaviours of staff were an influencing factor on the organisation's reputation.

However, when participants were asked whose responsibility, it was to manage the reputation of the organisation, all of the senior managers and frontline participants stated that it was the responsibility of everyone in the organisation, regardless of level or profession. This finding is inconsistent with the literature that suggests that reputation should be managed by the senior level of organisations whose field of activity is related to the subject of reputation (Wiedmann, 2017). In addition, problems that need to be solved are linked to the notion that reputation management is considered a top management issue (Wiedmann, 2017). In the context of this study, public healthcare organisations are complex and service delivery of healthcare is managed at every level of the organisation which may explain why participants felt reputation management was everyone's responsibility.

In summary, senior managers and frontline staff described reputation differently. Table 6 encapsulates how senior managers and frontline staff form reputational value in regard to the reputational dimension of consumer satisfaction.

Table 6

How senior managers and frontline staff form reputational value in relation to consumer satisfaction

	Dimension	Senior managers	Frontline staff
Forming reputational value	Consumer satisfaction	Constant key messaging to the community through clear communication strategies. Believe consumers are influenced by local media. Therefore, reputation should be managed, although not clear on how to manage reputation. Reputation was the responsibility of all employees in public healthcare organisations.	Reputational value gained by providing quality safe healthcare services to consumers. Communication centred on healthcare delivery to ensure patients well informed. Believe that consumers are influenced by the level of care delivered and how they were listened to and communicated with. Believe that reputation should be managed. Reputation management is the responsibility of all staff but is driven by the senior managers of the organisation.
Cultural perspective		Integrated culture	Differentiated / fragmented culture.

Senior managers focused on the influence that the local media has on the reputational value of the organisation. On the other hand, frontline staff described reputational value in terms of clear communication with patients on their healthcare needs. Despite the different perceptions of reputational, both senior managers and frontline staff were in agreement over the importance of communication in forming reputation. When forming reputational value both senior managers and frontline staff highlighted the importance of managing reputation which was the responsibility of all employees regardless of level or profession.

5.2.2 Dimension 2: Healthcare quality

This next section turns toward the internal environment of public healthcare organisations in relation to the relationship between reputational value and organisational goals and objectives on healthcare quality. The participants identified

healthcare quality as a dimension of reputation that was influenced by the goals and objectives of the organisation. The organisational goals and objectives were highlighted by senior managers and frontline staff as an important factor in creating reputational value for the organisation.

Organisational goals shaping the perception of reputational value.

Public healthcare organisations in Queensland set their strategic goals based on the Department of Health's strategic plan 2019-2023 (Queensland Government, 2019) and are outlined as follows:

1. Promote and protect the health of Queenslanders where they live, work and play;
2. Drive the safest and highest quality services possible;
3. Improve access to health services for disadvantaged Queenslander;
4. Pursue partnerships with consumers, communities, health and other organisations to help achieve our goals;
5. Empower consumers and health professionals through the availability and use of data and digital innovations;
6. Set the agenda through integrated policy, planning, funding and implementation efforts;
7. Lead a workforce that is excellent and has a vibrant culture and workplace environment.

Interview participants were asked to talk about the organisational objectives of Queensland Health and throughout the public healthcare organisations that they worked for and how they perceived the goals in terms of reputation. The key themes that emerged were: (1) ambiguity around the meaning of the organisational goals, and (2) goal alignment and reputation relationship.

Ambiguity around the meaning of the organisational goals.

Overall, participants had a general awareness of the goals of public healthcare organisations and most senior managers saw them as important in providing an overall direction for the organisation and influential of the organisations perceived reputation. This was because the goals of the organisation outlined the performance targets that formed the basis of the reputation of the organisation in the minds of the senior managers. The main goals that most senior manager participants considered important were providing safe and high quality healthcare services and leading a workforce that is excellent and has a vibrant culture and workplace. One of the main issues that emerged was the ambiguity around some of the terminology used, especially that of "safest and highest quality of services". For example, one senior manager stated:

> "How we set the agenda seems to vary depending on the organisation and while integrating policy should create consistency throughout public healthcare organisations in Queensland, there still seems to be so much variability within organisations and between them". (SM4)

Frontline staff also commented on the ambiguity of some of the terminology used about the goals of the organisation as they felt this was inconsistent between senior managers. For example, one frontline staff member stated:

> "I think there is a problem with how the goals are defined because you get different messages from different people, for the executive it means one thing but to doctors it means something different". (FL7)

Senior managers indicated that ambiguity around the meaning of goals means that some staff do not feel connected to the goals, and some staff are working towards achieving different goals, which makes operationalising the goals of the organisation difficult and this affects the overall reputation of the organisation. This finding is consistent with Otchere-Ankrah et al., (2016) in their study on the impact of organisational reputation on employee attitude, which found that goal alignment was an important factor in building organisational performance and reputation. Similarly, as found by Miah and Berd (2007) and Olmedo-Cifuentes, and Martinez-León (2014) organisational performance and reputation are only achieved through organisational goal congruence.

Goal alignment and reputation relationship

All the senior managers indicated that the strategic goals were aligned with the goals of the Department of Health, and some held that the strategic goals of the organisation were clearly aligned throughout the organisation. As one senior manager explained:

> "We have set the health service strategic plan to align with the Department of Health plan and expectations and then each directorate sets their operational plans to align with the strategic plan of the health service". (SM12)

Findings suggest that the setting of organisational goals cascades down throughout the organisation and according to the senior manager participant's this is done '*with consultation with clinicians at the frontline*' and then the plan is ultimately approved at the top level of the organisation by the Board. The process of planning and setting the objectives of the organisations was described by senior managers as the setting of the goals for each of their directorates that they were responsible for by consulting with other senior managers in their directorate and then having the final plan approved by the Board through the executive directors. The process was designed in a way that provided consideration of the operational needs associated with the health service objectives to ensure that the goals were achievable and were aligned with the goals of Queensland Health. However, while the process was outlined as being consultative in nature, frontline participants indicated that they are not involved in the decision making and felt that this was done without them being involved. For example, one frontline participant stated:

> "It is frustrating when we are given the objectives set by the organisation and we have not been involved in the decision-making. The clinical requirements of carrying out these objectives is often overlooked and then we run into difficulties achieving the goals because due consideration has not been given at every level. I think this ultimately affects the reputation of the organisation". (FL12)

Indeed, this sentiment was also expressed by some of the senior managers who felt that the planning process lacked clinician input, although some felt that the

clinicians were not concerned about performance targets and it was not something that they spent much time considering, as suggested in this quote:

> "The clinicians are concerned with patients and they don't spend a lot of time considering the performance of the organisation as a whole. There is a level of frustration on both sides I think as we would like clinicians to be more responsive to the overall goals of the organisation and I think the clinicians would like the executive to be less focused on performance and the business side of hospital management". (SM4)

The limited clinician involvement in the development of the strategic goals of the organisation, shows that frontline clinicians generally do not feel connected to the goals, this in turn makes it difficult for senior managers to garner support when implementing them at an operational level, particularly when patient care is affected, as one frontline clinician explained:

> "We get that there are targets that the organisation needs to meet but sometimes this is not possible as you cannot always predict the outcomes for your patients and there may be a day when a large portion of patients have to stay greater than four hours in the emergency department or cannot have their surgery in the recommended time. There are clinical reasons for this, but we then have to explain ourselves to executive because we haven't met the target for that day or week, which is frustrating because ultimately how we care for our patients is very important to us as health professionals". (FL9)

This finding is consistent with the literature, which suggests that healthcare organisations are large and complex and have a broad and diverse range of stakeholders, which requires a broad range of professionals to work together, often with competing goals and interests (Glouberman & Mintzberg, 2001a; 2001b). Different groups of professionals at different levels of the organisation have their own professional standards mandated by external professional institutions, such as, the Royal Australian College of Surgeons and the Nursing and Midwifery Board of Australia. These professional bodies provide standards around work practices in relation to ethical standards and quality and safety of practice for professionals (Crusack et al., 2019). This

study extends the knowledge by providing that professional standards are likely to influence the perceptual value of reputation of an organisation, particularly where disparity exists between professional standards and organisational efficiency.

Public healthcare organisations were previously characterised as professional bureaucracies where professionals had complete control over their own work and the role of senior managers and administrators was to coordinate and support their practice (Abernethy & Chua, 1996; Mintzberg, 1989). However, the introduction of New Public Management (NPM) reforms resulted in a dramatic increase in managerial control over the delivery of care by clinicians, which has increased tension between the professional values of health professionals and the demands for improved efficiency, effectiveness, cost control and resource management (Hallier & Forbes, 2005; Fitzgerald & Dufour, 1998; Fitzgerald & Ferlie, 2000; Kippist & Fitzgerald, 2009). It has also highlighted the reluctance of clinical professionals to adopt management values and priorities (Dedman et al. 2011; Hallier & Forbes, 2005; Kippist & Fitzgerald, 2009).

In summary, these findings suggest that different groups may be prioritising different goals, which is causing a lack of goal alignment and conformity between the strategic goals, the operational goals, and the goals of the health professionals. Table 7 summarises how senior managers and frontline staff form reputational value with regard to the reputational dimension of healthcare quality.

Table 7

How senior managers and frontline staff form reputational value in relation to healthcare quality.

	Dimension	Senior Managers	Frontline Staff
Forming reputational value	Healthcare quality	Strategic goals of the organisation are aligned with the goals of the Department of health. Achievement of goals ensures performance and builds reputational value. Believe that organisational goal setting is consultative in nature but clinical willingness to be involved is limited	Frustration with lack of involvement in decision-making around the setting of organisational goals. Clinical requirements of achieving organisational goals often overlooked. Competing professional goals and interests. Healthcare quality forms the basis of reputational value and relies on clinician involvement in goal setting for the organisation.
Cultural perspective		Integrative culture – goal orientated. Members of professional groups (doctors, nurses, allied health) individually aligned to the broader hospital values.	Differentiated / Fragmented counterculture. Divided opinions and irreconcilable tensions between opposites, contradictions. Lack of consensus.

While the restructuring of the Hospital and Health Services within the state of Queensland has provided more autonomy in setting organisational strategic goals, these goals are highly influenced by the political environment and reflects how the organisation is expected to be perceived by key stakeholders, including Queensland Health and the community. This political influence explains why senior managers see healthcare quality in the performance of targets set by the government, as a basis for the reputational value of the organisation. The operational goals are aligned to the way performance of these targets is measured, yet the goals of the frontline clinicians is providing the right care to the right patient at the right time and this forms the basis of healthcare quality and their perception of reputational value. If on the one hand perceptions of the value of organisational reputation are formed through goal alignment and the achievement of organisational goals which in turn enhances the performance of

the organisation, then on the other hand, the reputational value of the organisation relies on clear goal alignment with internal stakeholders as an essential component of reputation management for public healthcare organisations. Therefore, organisational goal alignment is directly linked with culture and forming reputational value.

5.2.3 Dimension 3: Organisational cultural influence on reputational value

As stated earlier, the dimensions of reputation are not mutually exclusive and cultural aspects have already been identified. This section looks more specifically at the cultural influence on reputation. Interview participants were asked to talk about the values of the organisation and how they are shared throughout the organisation. The perspectives of the organisational values from senior managers and frontline staff were considered from three cultural perspectives: integration; differentiation; and fragmentation. For further detail on the three cultural perspectives see chapter 3, literature review. Overall, findings indicate there are three different value systems that drive attitudes and behaviour within the organisation and form the perceptional value of reputation. The different value systems correspond with different cultural perspectives as shown in Table 8.

Table 8

Value systems from three cultural perspectives

	Integration perspective	**Differentiation perspective**	**Fragmentation perspective**
Value system	Organisational values that define how the organisation expects staff to behave. The assumption that by imparting the organisational values among staff they can align staff behaviours and create a desired culture within the organisation (Flamholtz, 2012).	Professional values and standards which defines how professional colleagues expect each other to behave (Freidson, 2001)	Personal values: define how society and the environment have guided behaviours, attitudes and beliefs (Stokes, et al., 2016)
Organisational level	Strategic level: senior managers	Operational level: professional subgroups/teams	Frontline: individual level. Interactions between strategic and operational levels and between professional subgroups of frontline staff.
Key themes	Strong attachment to the organisational goals by senior managers with the values setting the desired culture which builds performance and ultimately the reputation of the organisation	Strong attachment to professional values of professional group which forms the perceptional basis of reputational value. Some disconnect from organisational values	Inconsistent behaviours and attitudes depending on the interaction. Subcultural boundaries uncertain. Issue-specific attention with no consensus forming perceptional basis of reputational value.

As shown in Table 8, different value systems become prominent at different levels of the organisation. At the strategic level of the organisation, the organisational values

operate as the guiding behavioural system which promotes performance as a basis of the perceptional value of reputation. At the operational level, professional values guide the behaviours and forms the basis of reputational value. However, the values that guide attitudes and behaviours of individual staff is not fixed but changes depending on the interaction and the situational influence. The consensus forming perceptional basis of reputational value is in flux and uncertain as it is guided by the situation and the interaction. Therefore, personal values operate as the guiding behavioural system of individuals when staff from different hierarchical levels and professional subgroups interact with each other in specific situations. The paradox of this complex causality of the three sets of values is portrayed in the reflection of a frontline staff member:

> *"I know that the organisation has an expectation of how we adhere to the values of the organisation, however the interpretation of these values is not always the same between the clinicians and management, at the end of the day I have to remain true to myself and my profession and that may not always align with the expectations of the management"*. (FL4)

The following sections present a thematic analysis of senior managers and frontline staff perspectives around organisational values and their influence on reputational value. In the context of this study, it was important to explore the perspectives of organisational values from both senior managers and frontline staff because there were identified differences in their perception of reputational value in relation to consumer satisfaction and healthcare quality. Previous research suggests that to understand the perception of reputation within healthcare organisations it requires a cultural lens (Alsop, 2004; Corfield & Paton, 2016; Dukerich & Carter, 2000; Flatt & Kowaczyk, 2008; Fombrun, 1996; Fombrun & Shanley, 1990). Importantly, organisational culture has been shown to have a significant role in the building and management of an organisation's reputation (Rashid & Ghose, 2015). Therefore, this research explored the perceptional value of reputation three cultural perspectives.

Strategic-level organisational values: An integrated culture

Findings indicate that there is a strong sense of alignment to organisational values among the senior managers who all highlighted the importance of the values in driving a performance culture throughout the organisation. Senior managers felt that

organisational values are well communicated throughout public healthcare organisations as they were a required item at the bottom of all staff email correspondence and were also referred to in meetings, forums and on posters displayed throughout Queensland Health public hospitals. For example, a senior manager stated:

> "The values of the organisation are very important and are central to driving the culture of the organisation. That is why they are communicated so broadly throughout and highlighted in the forums delivered by the CEO". (SM12)

Some senior managers felt that the values set by the organisation need to be not just words on a page and it was important to show that you personally walk and talk the values. These senior managers talked about how staff will observe your behaviour and so it is important to show them that you are reinforcing the values in your behaviour. For example, a senior manager stated:

> "If the CEO walks past rubbish on the ground the staff will see that. If the CEO stops and picks it up that defines a lot of the culture, there is definitely a huge influence from the leadership showing the values in their work every day". (SM10)

Senior managers indicated that the organisational values were influential in the overall performance of the organisation and also in implementing change throughout the organisation. For example, a senior manager stated:

> "When you have congruence with the values of the organisation you have an organisation that can implement change in a positive and successful way. This is why the values are so important in driving a culture of performance and this is particularly important for healthcare organisations that are constantly subjected to change, either from the political environment or through technology or innovation". (SM6)

This finding is consistent with the literature, which highlights organisational values as one of the most powerful forces in driving change (Sullivan et al., 2002). By aligning the values of the people in the organisation, change can be implemented as the values drive the behaviours and attitudes towards successful change (Sullivan et al.,

2002). Senior managers felt that the values of the organisation were important as they affected the overall performance of the organisation and it was the performance that influence the perception of reputational value for the organisation. These findings suggest that senior managers generally demonstrate the organisational values while interacting with other colleagues at the strategic level of the organisation mostly because at this level the values are normalised and expected. Given the consensus around the organisational values at the strategic level of the organisation that is without the professional subcultural and individual influence, the culture at the strategic level of the organisation is considered to be an integrated culture (Martin, 2002). The following section outlines the operational level which has a differentiated culture driving a professional based perception of reputational value.

Operational–level professional values: A differentiated culture driving a professional based perception of reputation.

Findings indicate that at the operational level of the organisation there are a strong set of values that are aligned to professional standards and ultimately patient care delivery. For example, a senior manager stated:

> "I think that the values of the organisation are highlighted by the executive but for clinicians our focus is on the quality of the healthcare that we deliver to our patients". (SM8)

Most of the frontline staff were aware of the values of the organisation but some of them were unable to clearly state what they were, as a frontline staff member stated:

> "I know we have organisational values, but I couldn't tell you what they are, I think maybe respect and integrity are a couple of them. I don't think that they influence me in the way I deliver care to patients, that is influenced by my profession and the expectations of what it means to deliver quality, safe care. That is what guides my behaviour and that is where I think the organisation gets its reputation from. It's how well we deliver care to our patients and how we behave towards our patients". (FL3)

Indeed, professional values and standards that emphasise patient care are deeply entrenched in clinical professions and it is what drives their behaviours and attitudes. This emphasises the difficulty that senior managers can have in trying to override the behaviours and attitudes of the clinicians with the organisational values that emphasise reputation, performance, efficiency and effectiveness of the organisation. For example, a senior manager stated:

> "The clinicians are important in the delivery of quality healthcare, however there is a responsibility to the taxpayer that we are using healthcare resources wisely and that might mean that we don't spend $20,000 on a hip replacement when we can spend $9,000 and have the same outcome. Sometimes it is difficult to get the clinicians to see this as they are assessing individual patients and want to deliver what they determine is the best care for that particular patient". (SM12)

Some of the senior managers felt that clinicians should consider the organisation as a whole when delivering care, rather than on an individual patient level or an individual professional level:

> "We have changed the way healthcare organisations are managed and it's not solely from a clinician point of view anymore. We have to be mindful of the fact that we are responsible for delivering healthcare to the public with a finite amount of resources. So yes, we need to make sure that we deliver quality healthcare but we are also responsible and accountable for delivering the expectations of the government and the expectations of the community that we serve". (SM12)

Another senior manager stated:

> "You really want people for their attitude, rather than skill set. I mean, obviously they've got to have some skills, but you know, somebody who is not perhaps quite up to speed technically, but you can just see that they're engaged in the way they treat patients, the way they have respect for other people and uphold the organisational values. And to me, that is really important, and it took me a long time to realize that, because I mean most doctors are reasonably intelligent, so you can train them, but

> you can't change their attitude towards the values of the organisation if they don't align with them". (SM14)

Reflecting on why some of the professional clinicians have difficulty aligning with the organisational values, senior managers indicated that it is not something that is prominent in the way they think about delivering their care to patients. This notion was highlighted by some of the frontline staff who felt that the senior managers' job was to focus on political expectations of the organisation but for them it was all about the patients. For example, a frontline staff member stated:

> "The executive talk about the values and the culture that they want in the organisation but at the end of the day what's important to us is that patients get good care, that my reputation as a professional is not compromised and that the patient has the best care that can be delivered". (FL3)

Another frontline participant stated:

> "They [senior managers] come around with their clipboards telling you what you need to do and questioning your decisions, yet they do not have clinical expertise but think they can tell us what needs to be done with our patients. I get that they have to see the bigger picture, but healthcare delivery needs to be the number one priority". (FL8)

The findings highlight a disconnection between staff at the operational level and the organisational values and their meaning. Some frontline staff have said they act with 'integrity' and 'respect' in everything that they do, but it may not necessarily be the same interpretation of integrity and respect as held by the senior managers of the organisation. For example, a frontline participant said:

> "Integrity and respect are organisational values but my interpretation of them is probably different to that of senior executive. I think of it in terms of delivering good quality healthcare, whereas I think the executive think about it in terms of how they want staff to adhere to the organisational goals which may not align with my expectations of delivering quality care". (FL2)

It is clear from this finding that there is ambiguity around the meaning of the values and differences in value systems between frontline professionals and senior managers. However, differences in values between professional groups was also identified, as a frontline staff member stated:

> "We have to work with a number of different professional groups and sometimes they have different values and expectations than you have, and this can cause behaviours and attitudes to become conflicting and the way this is dealt with is usually by reporting each other to executive". (FL11).

These findings suggest that at the operational level there is a disconnection between how public healthcare organisations want staff to behave and how they are actually behaving. In other words, a disconnection between the organisational values espoused by the senior managers and the existing organisational culture and shared values. Therefore, while the strategic level of the organisation is characteristic of an integrated culture that perceives reputation value as defined by the performance of the organisation, the operational level of the organisation consists of professional sub-cultures that is characteristic of a differentiated culture (Mathew, 2019; Martin, 2002), where the value of reputation is professionally driven by the delivery of quality healthcare. Findings also suggest that the relationship between subgroups can also be conflicted.

Interactions between subgroups: A fragmented culture driving an individual perceptional basis of reputational value.

Some of the participants from both the senior manager group and the frontline group suggested that some of the senior managers in the organisation do not consistently behave in a manner that reflects the values of the organisation when interacting with staff at the operational level. For example, one frontline staff member stated:

> "The new top-level didn't walk and talk the values, they were more focused on performance targets and if staff weren't in line with that

> vision, then they were not treated in a way that would have aligned with the values of the organisation". (FL5)

Findings also indicate that the behaviour of staff can be inconsistent depending on the situation and that inappropriate behaviours and attitudes may arise in times of stress and workload pressures. For example, one frontline participant stated:

> "When you are pressured by the amount of patients we have and the severity of their condition, and then executive come around and say you are not approved for additional staff or to give out overtime. We forget about respect and integrity and often our behaviours reflect the frustration we are feeling. It makes you feel that the executive are out of touch with what difficulties are faced by operational staff". (FL5)

These finding suggest that behaviours and attitudes are highly contextual and at the frontline individual level a fragmentation (Latta, 2019; Martin, 2002) cultural perspective exists in which there is no consensus forming the perceptional basis of reputational value. Results demonstrate the importance of considering organisational sub-cultures when exploring the effects of organisational culture on reputation. Extending the analysis to a fragmentation perspective has revealed new insights that add to the understanding of the complex relationships that exist within cultures and subcultures and how this influences the perception of reputation. Particularly because people in organisations can vary in their viewpoints and often shift their behaviours and attitudes to fit changing interactional contexts (Gioia et al., 2000) which, in turn can alter their perception of reputation.

According to Martin (2002) informal practices, which can become social rules, are often inconsistent with the formal practices expressed as rules and policies and procedures. These informal and possibly inappropriate practices can become normalised and passed on to others within the organisation and create countercultures (Drotz & Poksinska, 2014; Latta 2019). These subcultures represent the context for organisational reputation and help workers make sense of what they do because this sense-making is made in the context of cultural norms and artefacts (Flatt & Kowalczyk, 2008; Ravasi & Schultz, 2006). As such, culture can affect the perceptional value of reputation from an internal perspective. This is because the

attractiveness of the workplace is important to workers in terms of being part of the healthcare organisation that has a good culture.

5.3 VALUES LINKING REPUTATION AND CULTURE

This section draws links between the key dimensions identified in this research in order to understand how reputational value is shaped by organisational culture in public healthcare organisations. Findings from this Phase 1 study indicate that organisational culture has a strong influence over the internal organisational environment. In addition, findings indicate that organisational goals and values are the critical link between the perceptional value of reputation and the prevailing culture, as shown in Table 9.

Table 9

Values linking reputation and culture.

Organisational level	Dominant value system	Dominant culture	Perceptional value of reputation
Strategic	Organisational values – wide consensus on basic beliefs and appropriateness of behaviours, often assumed by senior management.	Integrated	Based on organisational performance
Operational middle management	Professional values	Differentiated	Based on professional values and professional reputation
Frontline individual	Individual and professional values – cross-organisational consensus and norms are mostly absent.	Fragmentation	Based on individual and professional values

As shown in Table 9, findings from Phase 1 of this study indicate that there are differences in both the perceptional value of reputation and the type of culture. This difference corresponds with different levels of the organisation and are linked by different value systems. At the strategic level of the organisation, the dominant value system is the organisational values, and the culture is an integrated culture which has a

perceptional value of reputation based on the organisations performance against targets set by the government. This finding is consistent with integrated cultures that occur when there is a wide consensus on the basic beliefs and appropriateness of behaviours within an organisation (Davies et al., 2000). Although, as found in the context of this study, an integrated culture existed at senior management level, in a broad aggregate perception that is more wishful thinking than practically realised at the lower levels in public healthcare organisations. In contrast, at the operational and middle management level, the dominant value system is largely based on professional values and the type of culture at this level of the organisation is differentiated, with the perceptional value of reputation based on professional values and professional reputation.

The differentiated culture has emerged due to multiple groups within public healthcare organisations (medical, nursing, professions allied to medicine, administrative and managerial) possessing diverse and often incompatible views and norms (Davies et al., 2000). The development of these subcultures potentiates misunderstandings and conflicts (Martin, 2002). At the frontline individual level of the organisation, the dominant value system is based on individual and professional values and a culture that is fragmented. At this level, there is ambiguity around the organisational values and the perceptional value of reputation is based on both individual and professional values that can be inconsistent and fluctuating depending on the situation. At this level differences are more marked than commonality and agreements that are seen are often fleeting and tied to specific issues (Davies et al., 2000). Thus, the organisation is characterised by shifting alliances, uncertainty, ambiguity and unpredictability (Richter & Koch, 2004). Findings from this study also indicate that interactions between different hierarchical and professional levels are influenced by individual values, which can result in inconsistent and interchanging behaviours and attitudes.

According to Bromley (2001) there are many levels of culture that influence organisational, group and individual behaviours. This subculture is a local, social framework which incorporated the established norms, rules, shared meanings, feelings and values that constrain individual behaviour and status relationships within an organisation and influence the perceptional value of reputation of the organisation (Bromley, 2001). Cultural differences between hierarchical and professional groups can

lead to culture clashes, ambiguity and conflict, making it difficult for organisations to coordinate activities, implement change and create a consensus of reputational value for the organisation. This is because each subgroup has its own perspective and its own set of values which drives the perceptional value of reputation. Indeed, findings from this study support this idea and suggest that superimposing a set of organisational values over pre-existing deeply entrenched professional and individual values leads to cultural clashes between strategic, operational middle management and frontline levels of the organisation. In turn, this leads to differences in the perceptional value of reputation in the public healthcare organisation.

Excellence in the delivery of healthcare was the primary focus of participants, particularly at the operational middle management and frontline levels of the organisation. However, at the senior management level of the organisation, reputational value was aligned with the performance of the organisation together with the industry's reputation. That is, the reputation of public healthcare sector as a whole as well as the reputation of individual public healthcare organisations. This finding is consistent with the literature which suggests that at senior manager level sector reputation is more likely to be taken into account along with the performance and credibility of the organisation (Cakir et al., 2014; Luoma-aho, 2007).

The operational level of the organisation the perceptual value of reputation was influenced by professional as well as individual values. At this level clinicians highlighted the importance of the delivery of high-quality healthcare motivated by their professional values rather than the values of the organisation. The powerful influence that the professional value system has over staff behaviours and attitudes at the operational level can be explained by Wynia et al., (2014) who highlight that medical professionalism is more than a list of desirable values and behaviours. It is the motivational force of the belief system that leads clinicians to come together, in groups often across multi-disciplinary divides, to create and keep shared promises about how best to organise and deliver care to patients, and its legitimacy relies on fulfilling its promise of ensuring ethical and trustworthy healthcare. Comparatively, Stokes et al., (2016) found that individual embedded values, beliefs and attitudes can be either subversive or conducive to the espoused values of the organisation and either way represents a hidden but persuasive contribution to the overall culture of an organisation.

In the context of this study, the findings suggest that culture has a direct and indirect effect on the perceptional value of reputation.

In summary, these findings highlight that healthcare delivery to patients was the primary focus of all participants but particularly so for the operational middle managers and frontline levels of the organisation. At the senior level, reputational value was aligned with the performance of the organisation which is underpinned by the values of the organisation. For the frontline participants, the perceptional value of reputation was influence by professional values as well as individual values. In answering research question 2, Table 10 summarises how senior managers and frontline staff form reputational value in regards to the reputational dimension of organisational culture.

Table 10

How senior managers and frontline staff form reputational value in relation to organisational culture.

	Dimension	**Senior managers**	**Frontline staff**
Forming reputational value	Organisational culture	Organisational values are an important driver of reputation because the values drive the behaviours that are expected from employees. Demonstrate organisational values while interacting with other colleagues at the strategic level where the values are normalised.	A differentiated and fragmented culture which exists at middle management and frontline levels. Behaviours and attitudes are highly contextual. Counter cultures created which represent the context for reputational value of the organisation. Disconnect between how public healthcare organisations want staff to behave and how they are actually behaving.
Cultural perspective		Integrated view	Fragmented view

5.4 SUMMARY

This chapter presented the findings from Phase 1 of this research, which was an exploratory study aimed at establishing an overall view of the perceptional value of

reputation from senior managers and frontline staff. The focus of the findings was on two topics: (1) Conceptualising reputational value; and (2) Perceptional influence of organisational goals, values and culture on reputational value. It also identified the effect of organisational culture on internal stakeholders at different hierarchical and professional levels in the organisation and drew links between organisational culture and reputation. Importantly, the findings from this study highlighted the different perceptions that senior managers and frontline staff have of what forms the value of reputation in the mind of the public healthcare consumer. Now we know what is going on within the organisation it is clear that in order to gather a complete understanding of the perceptional value of reputation this study needed to also ask similar questions to the consumers. As a consequence, Phase 2 was added to the design of this study to explore the value of reputation from the perspective of the consumer and is discussed in the next chapter.

Chapter 6: Findings – External Stakeholders

In Phase 1 of this study, we looked at how reputation is conceptualised and formed by internal stakeholders of public healthcare organisations. We now turn to the external stakeholder (Phase 2) of this exploratory qualitative study, to establish an overall picture of reputation based on the perspective of external stakeholders, which included consumers and potential consumers of public healthcare organisations. This chapter focuses on the external stakeholder perspective on the dimensions of reputation for public healthcare organisations and builds on the previous chapter, which focused on the internal perspective of reputation. Exploring both the internal and external perspective of reputation for public healthcare organisations provides an overall picture of the dimensions of reputation and a clear understanding of the complexities of reputation and its value for public healthcare organisations.

This chapter presents the findings from Phase 2 of this research, which included qualitative interviews that examined community attitudes and beliefs on the Australian public healthcare system, the dimensions of reputation and its influence on decision making. Therefore, the sub-questions specifically developed for Phase 2 were:

1. *How do consumers conceptualise value of reputation of public healthcare organisations?*
2. *How do consumers form their attitudes and beliefs about the reputation of public healthcare organisations?*

The chapter starts with a description of the findings organised by the research questions and themes identified in the coding process. The results are then evaluated, compared to previous studies, and discussed in relation to the contribution to the field of reputation theory. First, the chapter discusses what participants say about reputation. Consumer perception of reputation was important to understand as it was likely to influence their responses to the interview questions. The focus then shifts towards understanding how consumers and potential consumers form their attitudes and beliefs about public healthcare reputation. This includes exploring the relationship between consumer satisfaction and consumer-based reputation. This is followed by an exploration of healthcare quality and consumer-based reputation and explores the links between organisational culture and external stakeholder perception of reputation. Next,

a thematic model is presented that depicts the how reputation of public healthcare organisations is formed by the participants. Finally, the chapter concludes by exploring the links between consumer experiences measured against the expectation communicated by public healthcare organisations and the influence on consumer-based reputation.

6.1 CONCEPTUALISING REPUTATION

The first research question was: *How do consumers conceptualise value of reputation of public healthcare organisations?* The answer to this question was found in the themes that emerged from the 17 face-to-face semi-structured interviews with consumers. When undertaking the community interviews, it was not known to the researcher whether the participant was a consumer of public healthcare services or was a potential consumer. Regardless, given that 73 per cent of Australians use public hospital services every year and this rate is increasing on average 3.8 per cent per year (Australian Institute of Health and Welfare, 2020), it is highly likely that the interviewees either have accessed these services or will do in the future. For the purposes of this study, a consumer is considered someone who has used public healthcare services, either as an inpatient or an outpatient. A potential consumer is considered someone who has not used public healthcare services yet but may use them in the future.

Participants were initially asked: *"what do you think about when considering reputation in relation to public healthcare organisations?"* This question was asked to understand how the participants perceived the concept of reputation, which could influence their responses to the questions that followed. In summary, the participants indicated in their responses that a reputation could be either good or bad; is based on their personal experience or the experience of others by word of mouth; can change over time; is largely heard about in a negative way through the media; should be managed and has consequences.

The participants identified the potential positive and negative components of reputation and mostly used the terms of *good* or *bad.* The participants also indicated that reputation was tied up with good or bad care and that an organisation could be good

with some components of care and bad with others. One of the participant responses to the question about reputation was:

> "What the hospital does good and is, or how bad it is, the reputation is determined by how good or bad they are at caring for you as a patient". (CPC3)

This statement reflects both the positive and negative aspects of reputation as well as the notion that reputation is based on the service that is provided. This idea was supported by the numerous participant statements about how reputation perception is based on people's experiences, either by personal experience or from word-of-mouth stories. The consumer participants said that personal experiences influenced what people think and ultimately forms their opinion about an organisation. According to one participant who had recently been a patient in a public hospital:

> "My experience has affected how I feel about the hospital, and that's what forms my opinion when people ask me what I think about a certain hospital". (CPC7)

The participants talked about how they share their experiences with others, mostly by word of mouth in person and online through social media. Social media platforms are highly interactive platforms that enable individuals, consumers and communities to share, co-create, discuss and modify user-generated content and share it with friends and followers (Kietzmann et al., 2011). This is an important finding as social media has empowered the public and weakened the position of organisations by exposing them to negative publicity and reputation damage (Horn et al., 2015). Previous research suggests that reputation damage arises mostly from an internal perspective of the employee angle and from unintentional damage occurring when managing an organisation's social media account (Coombs & Holladay, 2009; Cravens et al., 2014; DiStaso et al., 2011; Heng et al., 2007; Kassing, 2002; Miles & Mangold, 2014; Miles & Muuka, 2011). The findings from this study suggest that reputational risk for organisations from social media platforms also arises from an external perspective and is influential on how reputation is formed in the mind of consumers and potential consumers.

Some participants pointed out that their perception was influenced mostly by their own experience but also by word of mouth, observing others during their experience or as a visitor to a health service. One participant with personal experience in a public hospital stated:

> "I know what my experience was like, but I am also interested in what has happened to others, particularly if I am about to go back into hospital soon, because things may have gotten better, or worse since I was there last". (CPC12)

The importance of word of mouth was supported by most of the participants who recognised how the reputation of an organisation can change and can change very quickly. One participant said that reputation is easily ruined:

> "You can have a few good experiences and then one really bad one and it's the bad one that you talk about". (CPC9)

Other participants said that reputation was something that could be built, albeit slowly. The participants described reputation as something that influences their opinion about whether a public hospital was safe or unsafe, with one participant stating:

> "Reputation is important because a bad reputation usually means the hospital is not safe". (CPC 12)

The consequences of reputation were acknowledged by participants, who commented:

> "The emotion tied up in word-of-mouth opinions about a hospital experience can influence how far and to what extent the reputation is shared". (CPC 4)

And:

> "The reputation of a public hospital is important because if the reputation is poor then you lose trust as reputation generally reflects the quality of the care". (CPC 10)

These findings show that personal experience shared through word of mouth is an influential factor in forming reputation in the mind of the external stakeholder. This is

consistent with the literature that suggests that patient experience is an important factor in shaping the reputation of public healthcare organisations (Luxford et al., 2011) and reputation is an important factor for external stakeholders when determining healthcare organisation choice. For example, Dijs-Elsinga et al., (2010) highlight in their cross-sectional study across three Dutch hospitals that the reputation of the hospital was frequently chosen by patients as information they used in their hospital choice. This was because the reputation was closely aligned with the quality of the care delivered. One participant described what a public hospital with a good reputation would look like:

> "I think that a good reputation for a public hospital would be happy patients and good communication between the staff and the patients, as well as how they are treating the patients". (CPC 3)

This finding highlights the importance of consumer satisfaction and healthcare quality on conceptualising reputation for consumers and potential consumers. This is a significant finding for managers of public healthcare organisations as it emphasises the importance of the patient care experience on the reputation of public healthcare organisations. Luxford et al., (2011) reported in their study of eight healthcare organisations across the United States of America the importance of providing frontline staff, management and governance with regular reports of patient care experience data to actively identify areas for improving patient-centred care. As such, the improvement of patient care is likely to impact positively on the reputation of the healthcare organisation.

In summary, the consumer and potential consumer's understanding of the concept of reputation formed the basis of their responses to the interview questions. Overall, the findings suggest that participant's perception of reputation were mostly centred around the operational capability of the organisation, with the safety and provision of good care as important factors in building reputation for public healthcare organisations. This is consistent with other studies on reputation that suggest consumers tended to believe that if a company is providing a good service, then other factors such as quality, appeal, believability and value will follow (Fombrun et al., 2000; Rindova et al., 2005). In the context of this study, participants felt that when public healthcare organisations provided good safe services, then other factors such as caring, good communication and trust followed. Therefore, external stakeholders conceptualise reputation based on the

provision of healthcare quality and the level of consumer satisfaction received. It is these components that form the reputational value of public healthcare organisations.

6.2 FORMING REPUTATIONAL VALUE

Now that it is clear how consumers conceptualise reputational value of healthcare organisations, the research moved forward to unpacking the perceptions of consumers on how reputational value is formed. The participants were asked a series of questions about their perception of the value of reputation for public healthcare organisations and what influenced their perceptions. The next section describes the themes that emerged from the interviews, mostly through participants own experiences but also influenced by word of mouth and observation of others' experiences. It explores how consumers and potential consumers form their attitudes and beliefs about the reputation of public healthcare organisations. Using the most frequently mentioned driver of reputation as a measure of importance, the most important dimension was consumer satisfaction, which included the sub-categories of communication both personal and public.

The second dimension is healthcare quality and the sub-categories of clinical care; health workforce, which includes staff behaviours, attitudes, skills and shortages; and trust that were identified as components of this dimension that influenced the formation of reputational value of public healthcare organisations. The third dimension is organisational cultural influence on reputation. These identified dimensions of reputation provided an in-depth understanding of how consumers and potential consumers formed their opinions about public hospital reputation. Interestingly the three dimensions are not mutually exclusive; a relationship exists between all of them in relation to forming reputational value.

6.2.1 Dimension 1: Consumer satisfaction

Participants comments related to consumer satisfaction were subcategorised into communication, which included personal communication and public communication. The relationship between consumer satisfaction and consumer-based reputation has been identified as a key dimension of organisational reputation (e.g. Davies, et al. 2000; Fombrun & Shanley, 1990; Gheorghe et al., 2018; Jung et al., 2011; Walsh et al. 2009).

Communication

Communication was believed to be a major component of a public hospital's reputation. Participant comments related to communication were subcategorised as either personal communication or public communication. Personal communication was considered that which was between the consumer and the public healthcare organisation or the staff of that public healthcare organisation. Public communication was considered that which was communicated to the public as a whole (e.g. advertising, public relations, hospital website).

Personal communication

Overall participants felt that personal communication was major factor in how they perceived the reputation of a given hospital. Personal communication related to how the consumer (patient) was communicated with regarding their treatment or medical condition and whether they were listened to, or whether they were provided with the information they were seeking. The participants shared stories that included communication with various hospital staff, including administrative, clinical, medical, nursing and environmental. Some participants said that the communication they received regarding their own care, or the care of a loved one, was not at a level acceptable to them. For example, a participant who was recently visiting a relative in hospital said:

> "I visited my aunt who had a stroke. It was a weekend but there were not many nursing staff around and we found it hard to have questions answered. When we did manage to get hold of a nurse, they didn't tell us what was happening and said we needed to wait for the doctor to come tomorrow. It wasn't very helpful". (CPC6)

There were a number of comments that were specific to the doctor-patient or nurse-patient communication. One participant summed up the view about being informed this way:

> "The doctors need to communicate better with their patients, so they know what is going on". (CPC7)

Consumers stated that more explanation is needed from the medical staff to the patients and their carers/relatives. Several participants discussed experiences they had

when they did not understand what the doctor was saying, acknowledging that culture and language barriers make communication challenging:

> "…I couldn't understand what the doctor was saying, English was not his first language, but he should have has someone there to help him with the information because I was confused when he left". (CPC 11)

Consumers also argued that,

> "Nurses often are the ones that make sense of what the doctor has just said to you". (CPC 12)

From a consumer perspective it was stated by a few participants that the communications from the doctor back to the general practitioner (GP) was lacking at times, with one participant saying:

> "My GP never received my discharge letter from the hospital, I had to ask them for it more than once". (CPC 12)

According to some participants, there was often a lack of communication from emergency departments in public hospitals. An example provided by one participant was when an emergency comes in and the doctor is called away, nobody let the people waiting know that this has happened or how long they might be waiting:

> "…the doctor had to go to an emergency but we weren't told and so we waited and waited for hours. The nurse should have come in and let us know. Then at least we could have decided if we wanted to stay or not". (CPC1)

These findings highlight the importance of communicating with patients at all levels whether it is between the clinician and the patient or to inform the patient of waiting times. Poor communication impacted the patient experience, which in turn impacted consumer satisfaction. This finding is consistent with the literature that suggests consumer satisfaction based on personal experience influences consumer perception of reputational value and has a large impact on future hospital choice (Jung et al., 2011). In addition, high-quality communication with the patient has been highlighted as an essential factor in reaching patient satisfaction (Belasen, & Belasen,

2018). Further, patients and relatives have been shown to experience unnecessary anxiety and reduced confidence in healthcare after negative professional encounters (Belasen, & Belasen, 2018) and that *"how"* a message is conveyed may be as important as "*what*" is said (Ambady et al., 2002). In contrast, some participants had a good experience with communication. For example, one participant who had a recent visit to the emergency department of a public hospital said:

> "…they showed that they wanted me to know the details of what they were doing and what was wrong with me, and not just in general, like 'are you alright. You know they're like 'I wanted to see how you were and let you know what your results showed'. It was just that sort of communication and the regular occurrence, where they would come by every 15 minutes or so just to see how I was". (CPC 1)

In this case, the individualised communication approach from staff was much appreciated by this consumer, enhancing their hospital experience, thereby forming reputational value.

Only one participant said that waiting times affected the reputation of the hospital. Most of the participants said it was ineffective or inadequate communication that had the biggest effect on public hospital reputation. Participants based their opinion about their experience and about the hospital overall on the personal communication they received. Participants seemed to have an expectation that the personal communication they received from the hospital staff should be at an optimum level because it was dealing with their health. Participants felt that they should not only be communicated with but also listened to and that the communication should be timely. While studies examining the role of personal communication in forming perceptions of reputational value were not found in the literature, there are a number of studies that highlight the importance of consumer-centred communication in consumer satisfaction (Beyari & Abareshi. 2016; Guan et al., 2018; Ruberton et al., 2016; Schram et al., 2017). In addition, effective communication between patients and healthcare professions has been shown to facilitate patient-centred care delivery and promote better quality health services (Brown, 2020; Ozaras & Abaan, 2018; Tzeng et al., 2019; Tzeng et al., 2018) which in turn improves consumer satisfaction (Ausserhofer et al., 2013; Ozaras & Abaan, 2018; Pehrson et al., 2016; Wittenberg-Lyles et al.,2013). Consumer

satisfaction has been highlighted in this study as an important dimension of reputation that influences healthcare decision making, particularly with personal communication. Thereby highlighting the importance of personal communication in forming reputational value for the consumer.

Public communication

Participants discussed what was defined as public communication (i.e. communication from public hospitals to the general public). Comments about public communication covered advertising, public relations and public hospital websites. In general, participants felt that public hospitals should do more to improve their reputation by telling good news stories. A participant said:

> "They should do what the police force does by going out to schools and the community and talking about what they do and what challenges they face, it would help the public to understand and to trust them. It worked well for the police force". (CPC 4)

All participants stated that public hospitals should manage their reputation and felt this was something that public hospitals did not do well. Reputation literature argues that organisational communication has a strategic role when it deals with the gap between, what an organisation really does, and how the organisation is perceived by its stakeholders (Castellano & Dutot, 2017; Grunig & Hunt, 1984; Romenti, 2010; Van Riel & Fombrun, 2007). Several types of advertising were mentioned including public hospital websites, social media cites such as Reddit, Facebook, and local media, such as newspaper and local news. Participants used the hospital website to find out information about the services and the location of services but none of the participants used the website as a basis to forming their perception of reputation.

The one advertisement that was mentioned by the majority of participants was, what was said in local newspapers. Many participants did not place any credibility in the local newspaper stories. For example, a participant in response to being asked about the influence of local news stories said:

> "It might have some truth, but I understand how the media takes only the critically bad stories to air and they don't always tell you in an unbiased way". (CPC 4)

The most common response to public communication was that they mostly heard bad news stories about the problems with access to care, not enough beds in hospitals, and long waiting lists. However, when asked whether these stories in the news influence their opinion of the reputation of the public hospital, most participants said *"no", "not at all",* and a participant said:

> "I might look into a story further if I was heading to that hospital as a patient, but I still don't think it would change my opinion about that hospital". (CPC 13)

Participants were influenced mostly either by their own experience or the experience of others heard by word of mouth and what they expected of the organisation when considering the reputation of public hospitals. Social expectation is frequently used as a basis for distinguishing organisations (Boateng & Okoe, 2015; Christensen, & Lodge, 2018; Ghosh, 2017; Kim, 2019; Roach & Wherry, 1972). That is, most organisations derive their reputation by doing exactly what society expects of them, such as providing quality health services in the case of public healthcare organisations. Consumers and potential consumers with favourable attitudes towards public hospitals were more likely to take actions that reflected that attitude; however this was influence by their own experiences and the experiences of others, and not through local news stories.

Consumer satisfaction from personal experience or from word-of-mouth communication was an important theme of reputation that influenced decision making for the consumer and potential consumer participants. This finding is supported by other studies which have demonstrated that consumers select their healthcare based on referrals and recommendations (Chao et al., 2016; Dijis-Elsinga et al., 2010; Hibbard et al., 2005; Jung, et al., 2011; ; Yahanda, et al., 2016; Ziemba, et al., 2017; Ziemba, et al., 2019). Previous research has demonstrated that reputation formation is heavily influenced by market strategies, such as social media and word of mouth, primarily in

the form of physician recommendations, family or friend recommendation or patient testimonials (Ziemba et al., 2019; Ziemba et al., 2017).

The word-of-mouth behaviour is important because it is an experience-delivery mechanism (Walsh et al., 2009) that satisfies what consumers are seeking. That is, information from individuals who are similar to them in terms of health status or have had similar experiences (Lubalin & Harris-Kojetin, 1999; Ziemba, et al., 2019). However, previous research has suggested that the general public are highly influenced by newspaper media and advertising (Jung et al.,2011; Shamma & Hassan, 2013; Ziemba et al., 2017; Ziemba et al., 2019). In the context of this study, participants were critical of these media sources and were unlikely to use them to form an opinion of public hospital reputation. Specifically, the participants rely on word-of-mouth recommendations and some social media sources. The participants are aware of public healthcare organisations actions, and activities through different media sources and word of mouth communications are very important sources for gathering and disseminating information about organisations (Boatang & Okoe, 2015; Shamma & Hassan, 2013). As such, public communication is an important consideration for hospital administrators and managers who may consider local news and print media as factors influencing the organisations' reputation and fail to recognise other sources that are influencing consumers and potential consumers' perception of the organisations' reputation, such as word of mouth and some social media sources.

In summary, consumer satisfaction was an important dimension of reputation that influenced healthcare decision making for participants, particularly with personal communication and word of mouth. Previous research has demonstrated that reputation formation is heavily influenced by market strategies, such as social media and word of mouth, primarily in the form of physician recommendation, family or friend recommendation or patient testimonials (Ziemba, et al., 2017; Ziemba, et al., 2019). The word-of-mouth behaviour is important because it is an experience-delivery mechanism (Walsh, et al., 2009), which satisfies what consumers are seeking. That is information from individuals who are similar to them in terms of health status or have had similar experiences (Lubalin & Harris-Kojetin, 1999; Ziemba, et al., 2019). This finding is supported by other studies which have demonstrated that consumers select their healthcare on reputation that is based on referrals and recommendations (Djis_Elsinga, et al., 2010; Hibbard, et al., 2005; Jung, et al., 2011; Yahanda, et al.,

2016; Ziemba, et al., 2017; Ziemba, et al., 2019). The following section moves on to the second dimension of reputation found in this study which is healthcare quality.

6.2.2 Dimension 2: Healthcare quality as determined by consumers.

The relationship between healthcare quality and consumer-based reputation has been shown to exist because consumers strongly associate reputation with hospital performance quality data, such as hospital activity and median wait times (Ziemba, et al., 2019). When choosing what is important for consumer stakeholder participants, the reputation of the public healthcare service was identified as the main driver of healthcare decision making. However, in the context of this study, objective quality indicators that are used to define public hospital performance on healthcare performance websites, such as *myHospitals* website, were disregarded by participants as factors that influence their perception of reputation.

Consumer participants consistently relied upon their indicators of healthcare quality that were categorised as quality care and staff, as factors that informed their perception of public hospital reputation. This finding is not surprising as reputation can vary and organisations can have several different reputations depending on the stakeholder quality dimension (Dowling, 2016; Herbig & Milewicz, 1997; Nguyen & Leblanc, 2001; Walsh et al., 2009). For example, one consumer may relate reputation to excellent clinical care, but to another consumer, it is the efficiency of administrative care. In the context of this study the varying dimensions of hospital reputation between consumers at the individual level are explained by the level of personal experience informing the elements of reputation. In other words, reputation can be formed by direct interactions with a public healthcare organisation, such as a hospital stay or treatment, or by word of mouth or social media, which is based on the quality of the healthcare received.

The next section discusses the perception of reputational value that involves clinical care and the quality of care provided by public healthcare organisations.

Perception of reputational value involving clinical care.

Participants indicated that the quality of the care provided by public healthcare organisations is one of the major influences on reputation. A consumer participant said:

> "Efficiency, safety and good care, for me it's about quality care where you know that you are going to get the care you need at the time you need it. You also want to know that the care is of a good standard, so you feel safe and you have trust that you are getting the care you need". (CPC5)

In healthcare terms, quality of care is delivering health services for individuals that increase the likelihood of desired health outcomes that are consistent with current professional health knowledge (Spath, 2012). Increasing consumer information on the quality of care delivered by public health services requires clarification of what quality aspects consumers consider relevant and useful for their healthcare choices (Feldman et al., 2018; Harris & Buntin, 2008; Jung et al., 2011). A large portion of the comments about quality of care were about the accident and emergency departments or elective surgery waiting times. There were both positive and negative comments associated with the accident and emergency department, but all of the comments relating to elective surgery waiting times were negative. One patient described a positive reflection on the emergency department at one public hospital as:

> "This place looked like a war zone, there were people in stretchers everywhere, people crying, people yelling, people vomiting, but the staff were so quick they move people into places out the back and kept everyone in the waiting room up-to-date with what they were doing. I thought we were going to have to wait for hours but we were seen really quickly, I couldn't believe it". (CPC 17)

In contrast, another consumer who had recently experienced a visit to a public hospital emergency department had a very different experience:

> "There was no one around and my wife was in a lot of pain, I kept asking the person at the desk to please get someone, but they kept saying please just wait. It took 3 hours before she was seen". (CPC 7)

When describing waiting for elective surgery, consumers related how frustrating it was to be kept waiting when needing surgery. In one case, a consumer was supposed to have his surgery done within three months, but he had waited longer:

> "I was supposed to have a knee replacement within 3 months because my arthritis was that bad that I couldn't walk and that meant that I couldn't work. They kept me waiting for over 6 months and if effected my job". (CPC 6)

While there is information in the public domain on the performance of hospitals, which includes emergency department waiting times and elective surgery waiting times, participants rarely searched for this information and did not understand it, or trust it, and as such, this information did not impact on their decision making in respect to public hospital choice. This finding is consistent with the literature which has shown that hospital performance data is rarely searched or understood at a level that would influence consumer choice (Al-Amin et al., 2018; Dijs-Elsinga et al., 2010). While there is an increasing amount of information available to consumers, there is little evidence about the effectiveness of quality information and its influence on consumer healthcare choice (Al-Amin et al., 2018; Faber et al., 2009). As such, the recognition of what is important to consumers in terms of public hospital information requires clarification. The reputation of public hospitals in terms of clinical care delivery and the friendly atmosphere were frequently expressed by consumers as the information that they considered when forming reputational value.

Perception of reputational value involving healthcare workers.

Most of the consumer participants talked about public hospital staff and these comments were further separated into two categories: 1) staff behaviours, attitudes and skills, which related to the way staff acted towards patients, and the ability of the staff to perform in a way that was expected by the consumer; and 2) staff shortages, which referred to comments relating to not enough staff available to deliver the care expected.

Staff behaviours, attitudes and skills

Staff behaviours, attitudes and skills were described by participants as actions by staff that consumers had either experienced or observed. One participant described a positive experience with hospital staff that was observed during a hospital stay:

> "I saw this nurse that comes to give this little kid an injection, and she gave him a cuddle, and she was like this big lady and she was giving him this big squeeze, and then she did this injection in the other arm, and she was like 'no, look this way and cuddle me' and then gave him the injection. And he was like 'I didn't even feel it! I didn't even notice! And he was so proud of himself, but it was really her that had distracted him. But she made him feel like that, and I just thought that was really amazing that people like that are in that job". (CPC 9)

Another staff member who had bypass surgery and had to spend time in the intensive care unit said:

> "The staff gave excellent care and were always communicating with me and allowing me to be part of the decision making, the whole team of doctors, nurses and others were very friendly and happy. It makes you feel so much better when the staff that are caring for you look like they really like what they are doing". (CPC 3)

Evidence shows healthcare workers are central to consumers forming their perceptions about reputational value. While the above comments indicate healthcare workers went beyond their call of duty or displayed high levels of skill, it also raises expectations for next visits, which could end up being disappointing. However, positive opinions about hospital experience were influenced by hospital staff members or clinicians with positive attitudes and behaviours. The relationship found between staff attitudes and behaviours and participants opinions about reputational value is consistent with Nguyen (2010) finding that consumers favourable perceptions of the competence and kindness of consumer-based staff were positively correlated with their perception of reputation.

Unlike the positive staff behaviours experienced in these examples, one participant shared a negative experience. While in a public hospital as a patient in an area with three other patients, one of the patients was very confused and the nurse caring for this patient was rude and uncaring:

> "I was in hospital for a couple of days after having minor surgery and I was in a bay with other patients. An elderly man was confused and kept

> calling out and trying to get out of bed. The nurse came in and pushed him back into bed and told him if he got up he would fall and the nurse wouldn't be there to help him. The nurse was so rude I felt sorry for the man". (CPC 8)

While there were positive comments about staff behaviours and attitudes, most of the comments were negative. A common term associated with the negative comments were about staff being rude. For example, one participant said:

> "Most of the staff were nice and friendly but one night we had an agency nurse and she was so rude, if you asked her to do something she would roll her eyes. I was frightened to ask her for anything". (CPC 5)

There were a number of comments about staff behaviours towards patients that were negative with some of the terms describing the staff as *nasty; uncaring* and *unhappy.* It was evident that the staff attitude toward patients influence participant opinions about public hospitals in both a positive and negative way depending on the experience. One participant summed up the importance of staff behaviours this way:

> "I think it's the most important part of a hospital stay is how you are treated by the staff and how they behave towards you. When they are kind, caring and happy it makes you feel so much better about asking for help and it is only going to help you get better when it's a pleasant environment". (CPC 7)

There were a number of comments that related to the skills and qualification of staff. Comments relating to staff skills were identified as views such as "*the staff knew exactly what they were doing*" (CPC 8); "*I'm not sure they were adequately trained*" (CPC 2) and "*some of the staff had no idea*" (CPC 11) which reflected participants perceptions regarding staff skills. Some of the participants felt that the skills of the staff reflected on the healthcare quality that was experienced. These findings suggest that the behaviour, attitudes and skills of staff influenced consumers' perception of the reputation of public healthcare organisations. Importantly, the extent to which staff interact with consumers affects the formation of reputational value. Reputation seems to be based on experience or from others who have had experiences within the organisation. This potentially means that future experiences are likely to follow a

'confirmation bias'. Therefore, reputation management strategies by Health Service Managers may need to focus on setting up strategies aimed at providing positive experiences going forward.

Staff shortages

Participants thought that the reputation of a public hospital was heavily influenced by the management of the hospital. All participants felt that a public health service should manage its reputation. One participant suggested:

> "Reputation is encouraged and developed by staff striving for optimal delivery of care. This requires communication and engagement on multiple levels". (CPC 2)

The importance of management communicating with staff to ensure that optimal service delivery is being achieved, was highlighted by participants as a reputation building mechanism. For example, a participant said:

> "Management needs to establish the processes for creating a culture that strives for honest assessment of patient needs and outcomes. Without this reputation remains unremarkable and only "on paper." (CPC 16)

A participant who recently visited a friend in hospital said:

> "Short staffing of trained staff is a problem. Hearing that they have a lot of managers but are cutting the staff at the bedside doesn't make sense to me. They talk about saving money, but they seem to cut in the wrong areas. I see how many of the public hospitals now have such a high percentage of administrative staff, if you look at efficient private business the percentage of administrative staff is a lot lower, the focus of staff should be at the bedside providing the care that is needed". (CPC7)

It appears that consumers believe understaffing does not allow for patient's needs to be met, or care to be optimal. Participants thought that shortages of nurses meant that there is not enough care provided to the patients that need them and this, in turn, affected the quality of the healthcare provided. Staffing resource was considered by external stakeholders to be an important component of reputational value.

In summary, the findings from this study show that staffing levels, behaviours, skill levels and culture are a predictor of forming reputational value. Previous studies provide substantial evidence to support a strong association between staffing levels and healthcare quality (Al-min et al., 2018; Kane et al., 2007; Lang et al., 2004; Ma et al., 2015). When discussing staffing shortages, most of the consumers were referring to nursing staff. In a cost-containment era when public organisations are exploring options to improve efficiency, administrators and managers may need to realise the importance of adequate staffing levels, particularly with nursing levels. Hospitals with higher nurse-patient ratios, have improved patient safety and quality of care, safer workloads and improved retention and employee satisfaction rates (Lang, et al., 2004; Al-Amin et al., 2018) which influences the trust associated with the organisation and the overall value of reputation. Highlighted here is the value of reputation as a resource. Reputation being valuable, rare, inimitable and non-substitutable makes it a resource capable of building the organisations livelihood (Boyd et al., 2010). Understanding this value will assist Health Service Managers to strategically develop, alter and manage reputation to its full potential in order to gain a competitive advantage in the form of value (i.e. quality staff, funding, donations) against industry peers.

Perception of reputational value in relation to trust

Most participants talked about healthcare quality in terms of trust. That is, depending on the exchange or the observation experienced, it influenced the level of trust held for that public healthcare organisation. For example, one participant stated:

> "I could see the nurses and doctors really cared about me, and that made me trust them". (CPC 4)

The relationship between trust and organisational reputation has been emphasised in the literature (Roberts & Dowling, 2002; Rose & Thomsen, 2004), although rarely empirically established (MacIntosh & Doherty, 2010; Walsh, et al., 2009; Zheng, 2018). Trust is seen in terms of willingness to rely on an exchange partner in whom one has confidence (Anderson & Weitz, 1989; Moorman et al., 2018; Walsh et al., 2009). An important aspect of this is that trust is seen as a belief or an expectation about the exchange partner (public healthcare organisation) that results from the partner's expertise, reliability, and intentionality (Walsh et al., 2009). By trusting an

organisation, consumers or potential consumers are likely to think the organisation is acting fairly, being reliable and showing concern for its consumers. If consumers trust public healthcare organisations, this will positively affect their feelings and evaluations of the organisation and its reputation will improve.

In the context of this study, consumer satisfaction and trust influenced participant's perception of reputation, this is because consumers of healthcare services derive their sense of the organisation's reputation from their interactions with its staff. In addition, public healthcare organisations that provide quality services and reliability will gain a favourable reputation, which in turn will have an impact on the linkage between the consumers and the organisation, based on trust. Therefore, staff behaviours are directly linked with forming reputational value.

6.2.3 Dimension 3: Organisational cultural influence on reputational value

Of particular interest in the context of this study was the extent to which core organisational culture values enacted by staff or public healthcare organisations are picked up by external stakeholders/consumers as cues or references by the consumers and potential consumers of public healthcare organisations. These cues help to produce a certain perception of what public healthcare organisations are all about or "how things are done around here". Rindova and Fombrun (1999) argue that staff relationships with consumers and potential consumers are not just exchanges but sustained social interactions in which past impressions affect future behaviours. These impressions can imprint on a consumer or potential consumers mind and consequently generate either positive or negative feelings towards the organisation. Thus, 'how things are done around here' is becoming increasingly transparent to outsiders and indeed may be manipulated by senior management because of that (Hatch & Schulz, 2004). Davis, et al., (2014) suggest that organisations should attempt to align the positive internal views in order to create a positive external image for their clients. According to Schulz and De Chernatony (2002) culture provides a platform for an organisation to develop and express its distinctiveness through a consistent relationship with all of its stakeholders. It would seem that the internal phenomenon of organisational culture has the potential for a larger and more intricate web of influence than traditionally expected. Thus, it was of interest in this current study to examine both consumers and potential

consumers' perception of reputational value and the dimensions that influence organisational reputation.

Organisational culture was explored through the attitudes and behaviours that described the core cultural value system of public healthcare organisation within south-east Queensland, see Table 11 for an outline of the core values for Queensland public healthcare organisations.

Table 11

Queensland Health Core Values

Core values Queensland Health	Definition
Care	Attentive to individual needs and circumstance
Integrity	Consistently true, act diligently and lead by example
Respect	Behave with courtesy, dignity and fairness in all that is done
Commitment	Do the best we can all of the time

(State of Queensland [Queensland Health], 2020).

The core cultural values outlined by the public healthcare organisations under study were aligned with the values perceived by the external participants. Consumers and potential consumers in the study perceived that public healthcare organisations were mostly characterised by their commitment to care, commitment to quality service delivery, integrity and respect. In addition, they perceived the dimensions of trust and communication as large components associated with these values.

Consumer and potential consumer participant's perception of public organisational culture revealed that the core cultural values held by public healthcare organisations of care, integrity, respect and commitment were readily apparent in "how things are" in public healthcare organisations. The participants perceived that the organisation was mostly characterised by its commitment to providing good quality care. In contrast they perceived the values of integrity and trust as less readily apparent in public healthcare organisations. For example, there were some participants with less

of a sense of confidence in staff member's ability and level of knowledge, that the organisation does what it says it will do, and that information is clearly communicated. Participants did not perceive these things to be valued by public healthcare organisations. However, these views can be expected to shape participants perception of the organisation's reputation (Dowling, 2016; Hatch & Schultz, 2000; Kowalczyk & Pawlish, 2002; MacIntosh & Doherty, 2010; Rindova & Fombrun, 1999; Schultz & de Chernatony, 2002). As the participants perception of organisational culture shaped their perception of the components of reputation of public healthcare organisations, it can be summarized that organisational culture was detected, at least in part, through contract and exchanges with employees and as heard through word-of-mouth stories.

In addition, although the findings are not directly comparable because of different methodologies, it is interesting to note that Ziemba et al., (2019) found, in the context of the healthcare industry, that staff in healthcare organisations also perceived quality care to be the predominant organisational core value, while integrity in terms of timely diligent service delivery was one of the least evident aspects. Some parallels in consumer and potential consumer perceptions of organisational culture are apparent and may be expected (Hatch & Schulz, 2004). As such, the role of staff is an important influencing component in the formation of reputational value by consumers and potential consumers.

Although care and commitment were perceived to be the most dominant values in public healthcare organisations, and were the most meaningful to consumers, the organisational values of respect and integrity were the most important values to this external participant group. This was evidenced by comments such as, "It's important that I feel respected" (CPC 3) and "You want the type of care they say they are going to deliver" (CPC 7). The values of respect and integrity significantly influenced participant's satisfaction with public healthcare organisations and formed the basis of their intention to remain loyal, trust or use the services of the organisation.

In essence, integrity means that an organisation will do what it says it will do for the consumer when using their services. In other words, when someone is a patient in hospital, they have certain expectations of the organisation in regards to healthcare quality. Whether the staff and the organisation are accountable and promises kept (such as following up on test results) can influence the consumers' perception of the

organisations reputational value. Certainly, integrity was a key component regarding consumer and potential consumer attitudes and future behaviour in this study.

While organisational culture is predominately thought of as an internal organisational phenomenon, impacting staff attitudes and behaviour as well as other organisational performance measures, it is purported to influence the external environment as well (Hatch & Schultz, 2004; Kowalczyk & Pawlish, 2002; MacIntosh & Doherty, 2010). The findings of this study revealed that organisational culture was associated with quality care and staff, thus supporting the notion that the scope of culture extends beyond an organisations' boundaries. The findings also extend the understanding of factors that influence consumers and the general public's perception of public healthcare organisations reputation and highlight the role of perceived organisational values in shaping consumers and potential consumers attitudes and future behaviour.

6.3 CONCEPTUALISING AND FORMING REPUTATIONAL VALUE

This chapter presented the findings from Phase 2 of this research, which was an exploratory study aimed at establishing an overall view from consumer and potential consumers perception of public healthcare reputation. The focus of the findings was on two topics: (1) Conceptualising reputational value; and (2) Forming reputational value. It also identified the effect of organisational culture on the external stakeholder and drew links between the consumer satisfaction, healthcare quality and organisational reputation. This section presents a discussion of the findings in response to the Phase 2 sub-questions.

6.3.1 Phase 2 sub-question 1.

How do consumers conceptualise value of reputation of public healthcare organisations?

Findings indicate a number of assumptions around reputation awareness and understanding. However, reputation was determined as either good or bad and was mostly based on personal experiences or the experience of others. On one hand, the quality-enhancing effect of reputation can be explained by the fact that organisations providing poor care delivery will be penalised by customers who will engage in word of

mouth that is likely to be negative. On the other hand, consumers who perceive the organisation to have a good reputation would be expected to be more willing to engage in positive word of mouth than those who do not perceive the organisation has a good reputation. This means that public healthcare organisations with very good reputations are likely to stimulate positive word of mouth (Walsh et al., 2009; Sundaram et al., 1998).

From the consumer and potential consumer perspective, the perception of reputation was influenced by the quality of care delivery experienced by self or by others, as important drivers of reputation. The consumer and potential consumer's understanding of the concept of reputation formed the basis of their perception of drivers of reputation. The operational capability of the organisation, with the safety and provision of good care were identified as important factors in building reputation for public healthcare organisations. Consumers that were positive about public healthcare organisations providing a good service were confident that other factors such as quality, caring good communication and trust were also present.

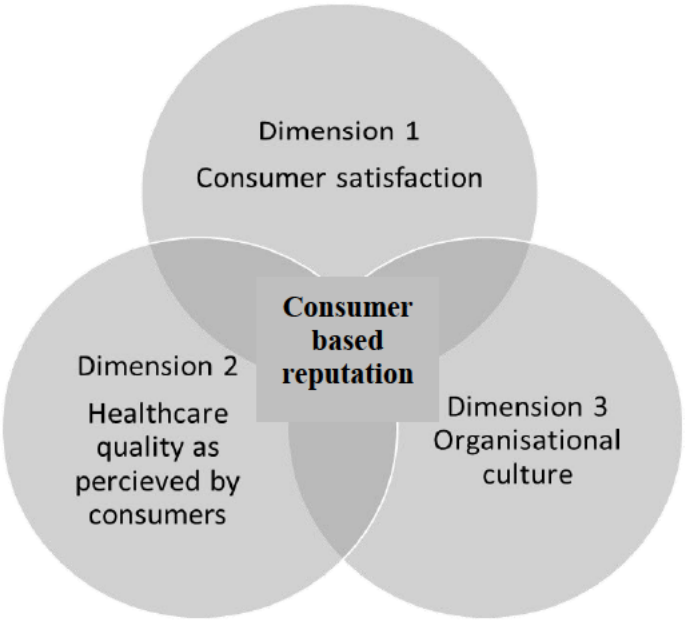
6.3.2 Phase 2 sub-question 2.

How do consumers form their attitudes and beliefs about the reputation of public healthcare organisations?

Findings in response to this question are considered from the perspective of consumer satisfaction and healthcare quality. A model of how consumers and potential consumers formed their perception of reputation for public healthcare organisations is shown in figure 1 below. The formation process flows from left to right beginning with factors identified as affecting the perception of reputation, such as experience, behaviours and attitudes that resulted in consumer responses representing the drivers of consumer and potential consumer-based reputation among study participants. The experiences represent a persons' inclination or intention toward the organisation (Romenti, 2010). As modelled in Figure 1, the staff attitude, behaviours and overall organisational culture and staff shortages influenced the perception of healthcare quality which was a driver of reputation for participants in the study. The responses of trust and safety in the provision of healthcare services were important to participants in the outcome of overall reputation for public healthcare organisations.

Figure 6

Model of how consumers formed their perception of reputation for public healthcare organisations.



The findings from this study show that the consumer experiences or the experiences of others measured against the expectation or image communicated by the hospital, influenced external stakeholder opinion of the public hospital and its reputation. This supports the notion outlined by Foreman et al., (2012) that organisational reputation is an assessment of the organisation's nature and behaviour. The nature and behaviour of the organisation is driven by the quality of its intended service delivery (Foreman et al., 2012).

Previous studies on reputation have purported that reputation is not created through crafted communication but earned through the service that the organisation provides (Al-Amin, et al., 2018; Adeosun & Ganiyu, 2013; Bergh, et al., 2010; Iwu-Egwuonwu, 2011; Luxford et al., 2011). The perceptions and attitudes of individuals in a stakeholder group toward an organisation forms that organisations reputation (Burke et al., 2011). The results of this study suggested that the attitudes formed from patient experiences are the primary determinants of public hospital reputation among the participants. The results also indicated that participants believe that reputation is based primarily on experiences, perceptions and opinions. Beyond describing the general

concept of reputation, consumers described their perceptions of public healthcare organisations and how they arrived at these perceptions.

The overwhelming influence on the formation of perceptions about public healthcare organisation among the consumers and potential consumers was their personal experience or the experience of others that they had heard about. The stories of experiences revealed the components that formed their opinions of public healthcare organisations that collectively formed the consumer-based reputation among this group of participants. The potential consumers relied on word of mouth and observation of others' experiences to form their opinions. The experiences, either personal or observed, generated the perceptional view of reputation.

6.4 SUMMARY

The findings from this Phase 2 qualitative study suggest there are a number of factors that influence the perception of reputational value for public healthcare organisations, according to consumers. Although the most influential is obtained through personal experience with the organisation or through word of mouth from others' experiences. These findings support the idea that in order to view consumer and potential consumer-based reputation of public healthcare organisations, consumer satisfaction and perceived healthcare quality are driving factors of reputation. Therefore, communication through word-of-mouth and through organisational culture through staff behaviours and attitudes are important dimensions for building reputation. These findings suggest that in order to build reputation hospital administrators need to collectively manage reputation through these dimensions.

Chapter 5 and 6 have provided the findings from this research. The next chapter considers the value of these findings, in light of existing scholarly research and in relation to their capability for theoretical generalisation to other contexts and practice settings.

Chapter 7: Conclusion

This research explores the perceptual value of reputation and the influence it has on the organisation's internal and external environment. In doing so, it examined how reputation is conceptualised and formed by both internal and external stakeholders of public healthcare organisations. This study drew upon resource-based view theory and examined reputation as a valuable, rare, inimitable and non-substitutable resource in public healthcare organisations in South East Queensland. In addition, this research used a three-perspective cultural lens to shed light on the organisational cultural patterns that exist when examining views on reputational values. For example, this research found that the normative view held by managers in an organisation differs from the ambiguity perspective from front line staff.

In order to develop a complete cultural picture, this research used an ethnographic toolkit to explore the perceptual value of reputation. Therefore, this research was conducted in two phases. Phase 1 explored the internal stakeholder view of reputation at different hierarchal and professional levels within public healthcare organisations. In that Phase, the perceptual value of reputation of internal organisational stakeholders was explored. This was a multi-perspective examination involving diverse hierarchical levels within the organisation (i.e. managerial staff and frontline staff) from three cultural perspectives: integration; differentiation and fragmentation perspectives (Martin, 2002). In Phase 2, the perceptual value of reputation as held by external stakeholders (consumers and potential consumers of public healthcare organisations) were explored. These qualitative steps provided a platform for the meticulous exploration of the meaning of reputation and its key dimensions as perceived by internal and external stakeholder groups.

This study addresses the following research questions:

1. *In what way is the perceptual value of reputation conceptualised about public healthcare organisations?*
2. *In what way is the perceptual value of reputation formed about public healthcare organisations?*

3. *How do internal and external stakeholders perceive the value of reputation in public healthcare organisations?*

In this concluding chapter, the findings are discussed in response to the overarching research question and, in light of, current literature. The significance of this research is presented in terms of its contributions to theory, implications for practice, and methodological contributions. The chapter concludes with recommendations for future research and concluding remarks.

7.1 ANSWERING THE RESEARCH QUESTIONS

The next section provides a discussion of the findings in relation to each of the research questions. The first research question explores how reputation is conceptualised by stakeholders of public healthcare organisations. Organisational reputation has been conceptualised as constructed from market signals (Basdeo, et al., 2006; Fombrun & Shanley, 1990) or through strategic level communication (Rindova & Fombrun, 1999; Prabhu & Stewart, 2001), where the beliefs about the sender form the basis of the organisation's reputation. However, organisational communications, intentions and abilities do not always align with stakeholder perceptions and may not reflect a true perception of reputation. Without a clear understanding of how reputation is conceptualised and defined by stakeholders, managers are unable to build and manage organisation reputation. Therefore, this study explored how reputation is conceptualised and understood by stakeholders of public healthcare organisations.

7.2 RQ. 1: *IN WHAT WAY IS THE PERCEPTUAL VALUE OF REPUTATION CONCEPTUALISED ABOUT PUBLIC HEALTHCARE ORGANISATIONS?*

As discussed in Chapters, 5 and 6, this study found that there are three dominant attributes that exist when conceptualising reputation in public healthcare organisations namely, *reputation as consciousness; reputation as resource*; and *reputation as appraisement*. *Reputation as consciousness* is a collective perceptual representation reflecting broad visibility of the organisation. In other words, reputation as consciousness represents the prominence of the organisation within the healthcare industry. *Reputation as resource* is a judgement or evaluation of characteristics of public healthcare organisations and likely reflects the performance of the organisation against set targets, as well as, the perceived quality of service delivered. *Reputation as*

appraisement is an overall summary judgement of the favourability and appeal of the organisation that goes beyond certain aspects of the organisations past or future. That is, public healthcare organisations are viewed as having desirable healthcare practices that conform to locally appropriate and culturally desirable quality.

7.2.1 Reputation as consciousness

From the perspective of reputation as consciousness, the organisation is characterised as having not only prominence but understanding within the healthcare industry. For example, from an organisational level perspective, reputation as consciousness is reflected as the organisation 'being known' to exist in the industry as a healthcare provider. This notion of 'being known' highlights how well recognised the organisation is by stakeholders, including professional streams within the industry. From an external perspective, reputation as consciousness highlights a strong awareness and understanding of public healthcare organisations being known to exist and, particularly that they are known to provide free access to healthcare which make them stand out amongst private healthcare providers.

Findings from this study indicate that organisational reputation was deemed stronger if internal and external stakeholders had a more distinctive perceptual view of the organisation, irrespective of judgment or evaluation. These findings align with previous research in this area, where the extent to which an organisation is widely recognised among stakeholders in its industry, and the extent to which it stands out relative to its competitors, may be an important component of reputation (Rindova et al. 2005). Barnett et al. (2006) describe this component as observer or stakeholder awareness of the organisation without judgement. They include awareness as comprising of "aggregate perceptions, latent perceptions, net perceptions, global perceptions, perceptual representations and collective representations" (p. 32). In addition, reputation as consciousness has been somewhat described in the literature as *being known* (Agarwal et al., 2018; Lange et al., 2011; Scott & Walsham, 2005). Shamsie (2003) describe being known as the level of awareness that the organisation has been able to develop for itself. Indeed, the level of familiarity with or knowledge of the organisation by stakeholders, regardless of stakeholders' judgement of the organisation provides the basis for reputation (Fombrun, 2001). Rindova et al., (2005) describe this viewpoint as 'prominence' which is the extent to which the organisation is

known and recognised by its stakeholders. However, the notion that reputation encompasses awareness of the organisation is not universally accepted. For example, Boyd et al., (2010) distinguish between reputation and prominence, with prominence as something that logically follows reputation.

This research extends the knowledge in this area by finding that there is a deeper level of consciousness or being known, captioned. Thus, reputation as consciousness is more complex and more about experiencing the existence of reputation. The consciousness results in awareness and is associated with an innate understanding that brings about awareness and a perception of that awareness (Rosen, & Swann, 2018). For example, when an organisation is observed for its prominence in the industry, it is the consciousness of the information that brings about awareness. That is, the innate intelligence which is a result of the consciousness that provides the sense of awareness.

Accordingly, reputation as consciousness contributes to the literature by reflecting a deeper more complex experiencing of the existence of reputation and as one of the dominant attributes of stakeholder's conceptualisation of reputation. When public healthcare organisations are well known, observers have a strong sense and understanding of what is central and distinctive about its attributes, especially relative to other organisations in the industry. Given that other studies have focused more on reputation measurement (Brown & Perry, 1994; Fryxell & Wang, 1994; Lewellyn, 2002; Walker, 2010). This study focuses on how reputation is conceptualised and formed by stakeholders as well as the value of reputation as perceived by stakeholders. Hence, this study provides useful guidance and understanding to public healthcare organisations by providing that when defining reputation, it is more than just an awareness of the organisation in the industry, it is an experienced existence.

For public healthcare managers these findings highlight the importance of reputation management and reputation building strategies to influence stakeholder perceptions of the organisation's reputation. Stakeholder definition of reputation for public healthcare organisations includes reputation as consciousness as one of the dominant attributes. For example, as shown in Table 9, from a normative point of view, perceptions of the value of reputation as consciousness were characterised by organisational performance against government-set targets. At the same time, from a differentiation perspective, this research found that reputation as consciousness was

characterised by the organisational goals and values of the organisation and by the healthcare quality experienced. The ambiguity perspective of the organisational culture indicated reputation as consciousness was characterised by healthcare quality experienced. Reputation as resource is another dominant attribute conceptualised by stakeholders to define reputation.

7.2.2 Reputation as resource

From the perspective of reputation as a resource, findings from this study highlight that when conceptualising reputation, there is a judgement or an evaluation of the quality of service delivered and of the achievement of organisational objectives. The organisation has particular attributes of interest or value that it is known for. Specifically, an organisation can be known for specific healthcare quality that the organisation can be trusted to provide. Hence, reputation as resource constitutes an assessment of an attribute or characteristic, specific to that organisation, that assists that organisation in meeting objectives.

In contrast to the *reputation as consciousness* attribute, judgement is a central feature of *reputation as resource.* This means that organisational reputation is closely coupled with consequences and tangible organisational outputs of the organisation to meet stakeholder needs and expectations. Therefore, when conceptualising or defining organisational reputation the perception includes the result of judgement with respect to the organisations demonstrated ability to create value. The subjective perceptions are in respect of the likelihood of seeing desired quality outputs and behaviours from the organisation in the future. This finding aligns with previous research in this area, where the conceptualisation of reputation is reflected as a perception that the organisation has an attribute or asset of interest or value to the stakeholder (Deutsch & Ross, 2003; Fischer & Reuber, 2007; Sánchez & Sotorrío, 2007). Rindova et al., (2005) describe this notion of judgement as '*being known for something',* component of organisational reputation and is determined as the perceived quality of products or services. This means the degree to which stakeholders evaluate an organisation positively on an identified attribute or characteristic (Rindova et al., 2005), such as the quality of healthcare delivery. Similarly, Lange et al., (2011) describe the notion of being known for something as a judgement or evaluation of a particular attribute or asset of the

organisation with respect to the organisations' ability to create value based on past behaviour.

Consequently, findings for this study extend the knowledge in this area by highlighting that reputation as resource is a judgement of *more* than an asset of value for public organisations, but rather an asset that has value in achieving the objectives of the organisation. In this way reputation is a valuable, rare, inimitable and non-substitutable (VRIN) resource. Given that most studies on reputation examine reputation from the private organisation perspective (Barney, 1991; Klein et al., 2010; Szymaniec-Mlicka, 2014), the findings from this study differ by extending reputation as a VRIN resource for public healthcare organisations, where reputation as resource can be used to achieve the objectives of the organisation. This study also highlights that stakeholder experience with an organisations services is an important driver of subjective perceptions of reputation. Estimates of the likelihood of certain types of actions or patterns of organisational behaviour are based on past experience or word of mouth and are likely to be consistent with consumer expectations. Accordingly, this study provides guidance to public healthcare organisations and health services managers that by understanding, managing and building reputation, as a resource it can provide value to organisations in terms of competitive advantage, contestability and choice.

In an effort to answer the research question '*In what way is the perceptual value of reputation conceptualised about public healthcare organisations?'* thus far the findings indicate that consciousness (being known) as well as resource characteristics (being known for something) is how organisational reputation is conceptualised. As shown in Table 12 (p. 177), from a normative point of view, perceptions of the value of reputation as a resource were characterised by achievement of organisational objectives. At the same time, from a differentiation perspective, this research found reputation as a resource is characterised by attributes of the organisation that are of interest and value to the stakeholder. Similarly, the ambiguity perspective of organisational culture indicated reputation as resource is characterised by attributes of the organisation that are of interest and value specific to stakeholder group and issue. The third dominant attribute of how an organisation's reputation is conceptualised is through evaluation and judgement of those resource characteristics: appraisement.

7.2.3 *Reputation as appraisement*

Findings from this study provide that when conceptualising organisational reputation, the perception includes a general appraisement, where the organisation is characterised by an overall judgement. That is, an overall generalised assessment of the organisation in ways specific to stakeholder expectations. As shown in Table 12 (p. 175), at an organisational level judgement is based on the performance of the organisation on a variety of attributes, such as culture, financial performance, values and goals. From an operational level, the general evaluation of the organisation is based on a number of characteristics such as, workplace culture, good leadership, education and training, and quality of care delivered. From an external level, findings suggest the importance of a general appreciation and regard to which the organisation is held and how attractive the organisation is and the overall capability of the organisation to provide safe quality care. Hence, reputation as appraisement about public healthcare organisations is based on multiple organisational attributes.

These findings differ from previous research in this area through these factors under the *reputation as appraisement* conceptualisation of reputation, where stakeholder's perceived judgements about the organisation are based on the organisations attributes that specific stakeholders choose to investigate. Previous studies have described somewhat similar findings as a 'generalised favourability' which is a nonspecific evaluative impression of the organisation as emanating from observers' collective judgements (Love & Kraatz, 2009; Rao, 1994; Reuber & Fischer, 2005). Judgements about the organisation are based on multiple organisational attributes rather than being dependent on a given stakeholders expectations for specific organisational outcomes (Fischer & Reuber, 2007; Love & Kraatz, 2009; Barnett, et al., 2006; Agarwal, et al., 2018). Hence, organisations are viewed as coherent and conscious actors and the stakeholders find attractive those organisations that have desirable attributes that "conform to practices that are locally appropriate and culturally desirable" (Agarwal, et al., 2018).

Nevertheless, findings from this study differ from a generalised favourability in two ways. Firstly, reputation as appraisement is stakeholder group specific, which means that different stakeholder groups have different issues and perspectives in terms of conceptualising and defining reputation. Therefore, it cannot be seen as a generalised

favourability but more of an appraisement, a valued judgement, specific to issue and stakeholder group. Secondly, given that previous research has mostly focused on reputation measurement in private organisations, the findings in this study uniquely provide a public organisation perspective resource as appraisement is immersed in cultural systems from which standards for judging and appraising organisational attributes and characteristics are socially constructed.

In the context of this study, the overall assessment by stakeholders builds on, and transcends, particular aspects of the public healthcare organisations' past or future resulting in assessments that are comparatively made with judgements of particular characteristics or attributes of similar organisations. For example, senior managers compare the performance results against government targets with other similar organisations in their judgement of the organisations value. Stakeholders find attractive those organisations that appear to have the desirable attributes or character traits (i.e., trustworthiness, integrity) that they consider important in their judgement. Understanding that when defining reputation, stakeholders include a general appraisement of the attributes or characteristics that are desirable is important. Firstly, it has implications for reputation management in public healthcare organisations as managers need to strategically consider reputation building strategies that consider all aspects of the organisations characteristics and attributes to facilitate an overall positive appraisement by stakeholders. Secondly, implementing reputation building strategies based on the perceptions of stakeholders can reduce the effect that negative experiences can have on stakeholder perceptions.

Integrating the three conceptual perspectives of reputation (consciousness, resource, and appraisement) provides a clear understanding of how reputation is understood and defined by its stakeholders (See Table 12 below).

Table 12

Dominant attributes defining reputation.

Multilevel perspective		Reputation as consciousness	Reputation as resource	Reputation as appraisement
Organisational level – normative/integrative perspective		Individual organisational performance. Prominence of the organisation in the industry.	Achievement of organisational objectives.	Judgement influenced by socio-political environment and organisational targets. Comparative organisational performance
Operational level – differentiation / fragmentation perspective	Group / Individual	Organisational goals and values experienced. Healthcare quality	Attributes of interest and value	Workplace culture, leadership, integrity, trust, education, training, quality and safety of care delivery.
External level – fragmentation / ambiguity perspective		Healthcare quality experience	Attributes of interest and value	Healthcare capability, quality and safety of care delivery.

The dominant attributes conceptualised by public healthcare organisation stakeholders holds some similarity with expectations from existing research on organisational reputation (Agarwal, et al., 2018; Barnett, et al., 2006; Fischer & Reuber, 2007; Lange, et al., 2011; Love & Kraatz, 2009; Rindova, et al., 2005). However, this study differs in several important ways. Firstly, this study is the first in Australia to define how reputation is conceptualised in public healthcare organisations. Operational stakeholders and external stakeholders were similar in defining reputation. The similarity was not expected as research has shown that external stakeholders are not

able to view the workings of an organisation which are often opaque and first-hand information about organisational capabilities and intentions is limited (Rindova, et al, 2005). However, for public healthcare organisations the capability of the service delivered is often directly opaque and transparent to consumers. The similarity between the operational and the external levels of public healthcare organisations in defining reputation is an important finding with significant implications for reputation management strategies. Highlighting the importance of organisational level managers seeking to understand operational level values and goals, in order to manage reputation from all stakeholder perspectives to ensure a complete strategic picture is developed and understood.

Secondly, this study is among the first to explore the perceptions of reputation from multiple levels, groups and individuals, both internal and external to public healthcare organisations. By doing this, a complete picture of how reputation is conceptualised from key stakeholders could be explored. The benefit of looking at multiple levels, groups and individuals provided a deeper level of understanding and the ability to draw the conclusion that organisational reputation defined by stakeholders is issue and stakeholder specific and as requires specific measurement tools in order to provide an accurate picture of reputational issues. Understanding how reputation is conceptualised enables reputation measurement instruments to be developed that are organisation specific. Previous reputation measurement instruments have been developed with private organisations in mind (see discussion in chapter 2. on reputation measurement) and therefore, are unlikely to be effective in obtaining a complete picture of a public healthcare organisation's reputation measure, unless adapted to specific reputation attributes and dimensions identified for public healthcare organisations from this and future studies. The findings in this study provide a basis for adapting reputation measurement instruments that are specific for public healthcare organisations to assist with planning and implementation of reputation management strategies.

Thirdly, understanding how public healthcare organisation stakeholders conceptualise reputation further emphasises the importance of organisational learning through knowledge of both internal stakeholders and external stakeholders (Agarwal, et al., 2018; Jaworski & Kohli, 1993). By knowing how reputation is conceptualised, reputation management strategies can be steered in line with the definition and make reputation building strategies specific to public healthcare organisations. Improving the

perceptual reputation of public healthcare organisations is important because a good reputation provides an organisation with a number of strategic benefits such as, attracting skilled professionals (Fombrun, 1996; Fombrun, et al., 2000) and a significant competitive advantage (Deephouse, 2000; Eckert, 2017), which are essential for public healthcare organisations that are competing for finite resources.

In summary, in answering the question: "In what way is the perceptual value of reputation conceptualised about public healthcare organisations?" this research provides a deeper understanding of how reputation is defined by stakeholders of public healthcare organisations. This information will assist managers with understanding how the value of reputation is conceptualised and how they can capitalise on this increase knowledge by managing their organisation's reputation. Understanding the complexities by tapping into the organisational cultural patterns will assist managers in influencing the perception of reputation as well as providing a platform for short- and long-term reputation building strategies.

7.3 RQ. 2: *IN WHAT WAY IS THE PERCEPTUAL VALUE OF REPUTATION FORMED ABOUT PUBLIC HEALTHCARE ORGANISATIONS?*

This research found that the perceptual value of reputation formation is critical for understanding and managing reputation in public healthcare organisations. Findings show that reputational value is formed from three dominant dimensions: consumer satisfaction; healthcare quality; and organisational culture. These dimensions are found across both internal and external stakeholder groups. While each domain is specific to the stakeholder group there is some overlap of perceptions across each domain, which suggests that reputation is rooted in stakeholder perceptions of the organisation's actions and behaviours. Understanding the dimensions of reputation specific for public healthcare organisations provides a basis for measuring reputation as well as allowing for conceptual and contextual transferability and generalisability of studies and for researchers to meaningfully build and integrate their findings.

As discussed in Chapters 5 and 6, this study found that there are three dimensions of reputation that are specific to public healthcare organisations namely, consumer satisfaction, healthcare quality and organisational culture. These dimensions of reputation provide an important guide towards reputation measurement and reputation building strategies and are discussed in detail in the next section.

7.3.1 Reputation measurement of public healthcare organisation

The dominant dimensions identified in this study confirm previous research, which suggests reputation is a multidimensional construct that can be accurately estimated through its individual measurable dimensions (Lange, et al., 2011). This study highlights that reputation is a reflective construct derived from stakeholder perceptions that share some commonality. However, this study also highlights the specificity of the dimensions (consumer satisfaction; healthcare quality; and organisational culture) and their importance for public healthcare organisations. For example, the dimension of consumer satisfaction was largely focused on communication with senior managers under the misconception that consumers were influenced by local media, when essentially consumers were more influenced by experience or word of mouth, where the importance of communication was centred on healthcare delivery. Therefore, a clear understanding of the specificity of the dimensions from all stakeholder perspectives will assist in building and managing reputation. The reputation dimensions identified are specific to healthcare organisations and each dimension is a different manifestation of the multi-dimensional construct. Consequently, reputation measurement tools need to measure the specific aspects of reputation to ensure a complete picture of the reputational issue being explored.

As discussed in Chapter 2, the operationalisation of reputation measurement tools requires close alignment to the definition and dimensions of reputation as constructed by stakeholders. Existing reputation measurement tools mostly examine market performance of organisations (E.g. Brammer & Pavelin, 2006; Roberts & Dowling, 2002), social responsiveness (E.g. Turban & Greening, 1997) and management techniques (E.g. Staw & Epstein, 2000; Zyglidopoulos, 2005), using quantitative measures for organisations that were largely private industries. However, while previous studies focused largely on private industries using quantitative measures, without precise conceptualisation and accurate measurable dimensions of reputation, the ability to meaningfully measure, build and manage reputation is flawed. Certainly, management research is in its infancy with regard to conceptualising and identifying the dimensions of reputation, mostly in part because of the multidimensional, nature of the construct has been underexplored (Agarwal & Osiyevskyy, 2019). In addition, findings from this study show that reputation is also industry-specific and issue-specific, which adds to the confusion and lack of systematic conceptualisations and exploring of

alternative reputation dimension. Clear understanding of these factors of organisational reputation will allow for drawing of conclusions regarding building, managing and sustaining this valuable intangible asset.

One of the significant problems identified in the reputation literature is lack of an agreed method of reputation measurement (Walker, 2010). As reputation is based on perceptions, reputation measurement tools can be adapted to measure the dimensions identified for organisations, thereby providing a more complete picture of reputation. Reputation should measure stakeholder's perceptions not factual representation (Mahon, 2002; Wartick, 2002). For example, measuring factual components such as, market share (Fang, 2005) or target performance (Fombrun, 1996) are objective measures and not consistent with the perceptual nature of reputation (Walker, 2010). Embracing the dimensions captured in existing research studies using existing reputational measurement tools (see chapter 2 for more discussion on reputation measurement) is far from constructive as some dimensions might be overlapping theoretically and empirically and are not stakeholder specific (Agarwal, et al., 2018). With the specificity of stakeholder, industry and issue requirements for accurately measuring reputation, it makes sense that reputation measurement for public healthcare organisations should be based on the perceptions of stakeholders and informed by the dimensions of reputation specific to healthcare organisations.

The dimensions of reputation are important as they provide the basis for reputation measurement (Eckert, 2017). After defining reputation (research question one), measuring reputation is an important step in strategic reputation management (Doorley & Garcia, 2020). Without measuring, strategies to build and improve reputation are unable to be adequately evaluated (Eckert, 2017). However, as outlined in chapter 2, measuring reputation is challenging as it is often defined by the perceptions of stakeholders (Gatzert et al., 2016) and as found in this study reputation is also industry and issue specific. Hence, there is currently no 'uncontroversial measurement' method existing that can adequately measure reputation (Eckert, 2017).

Although many measurement methods, distinguish between previously identified reputational domains, most do not distinguish between stakeholder groups (or recognise the domains specific to public healthcare organisations). This research suggests that different stakeholder perceptions of reputation influence numerous outcomes, including

an organisations performance (Deephouse, 2000; Rindova et al., 2005) competitive advantage (Boyd et al., 2010; Fombrun, 1996; Fombrun & Rindova, 1996) and perceived quality (Rindova et al., 2005). While assessing a public healthcare organisation's quality is inherent with difficulties and uncertainties, whereas reputations are influential because they represent a collective judgement.

This research highlights stakeholder perceptions of the dimensions of reputation that are specific to public healthcare organisations. The knowledge of the specific dimensions can be used in future research to modify existing or develop new reputation measurement tools that measure reputation with respect to a certain issue, from the perspective of a specific stakeholder group. The stakeholder group-issue specific combination is likely to provide a useful measure of reputation and a more complete picture for reputation risk management strategies (Eckert, 2017). Without a qualitative approach, looking at the issues that are deeply seeded within the organisational stakeholders, reputation of an organisation is not fully discovered by managers. Listening to different levels of staff within the organisation will assist with painting a fuller picture of perceptional reputation, which can then be managed in an effective and timely manner and assist the organisation with competing for future funding opportunities, philanthropic donations and experienced quality staff.

In summary, this study provides that the dimensions of reputation drive the overall reputation and as such, influencing any dimension would change the reputation. Therefore, measuring reputation through an understanding of how reputation is formed (i.e. dimensions driving reputation) will provide a clearer picture for managers to accurately measure reputation. The precise dimensions of reputation for public healthcare organisations are essential for the progress of this crucial research stream and the integration of its findings in the broader body of knowledge. Moreover, an understanding of the dimensions of reputation will allow for conceptual and contextual transferability and generalisability of studies and for researchers to build and integrate their findings. From a practical point of view, understanding the dimensions of reputation specific to public healthcare organisations will assist managers in developing strategies for short- and long-term reputation management by maximising valued relationships with stakeholders to advance common goals of the organisation. However, stakeholder group issue-specific reputations can have competing interests

within the organisation, as outlined in the preamble for this study. The next section discusses issue-specific reputations.

7.3.2 Perceptual value of competing reputations

Findings in this research highlight that reputation is issue and stakeholder specific. As a result of different issues and stakeholders within public healthcare organisations, it makes sense that there are multiple perceptions of issue-specific reputations, as perceived by different stakeholder groups. For example, when considering healthcare, a consumer may consider the reputation of the healthcare organisation as a whole, the reputation of the healthcare quality provided and even the reputation of the workforce. Alternatively, a professional when choosing employment opportunities may consider the reputation of the organisation through its performance, the reputation of healthcare provided, and the reputation of the organisation as an employer. Multiple reputations can influence outcomes and these reputations often interact and compete with each other when determining particular outcomes (Boivie et al., 2016). The findings from this study add to the body of knowledge on reputation by providing that multiple reputations are considered through the dominant reputational dimensions and that the specifics of each dimension and relatedness to a particular stakeholder group is important when considering which type of reputation will be more influential. For example, if the organisation wants to improve their reputation as a valued employer for certain stakeholder groups, then managers will need to explore the perceptual value of reputation held by those stakeholders in regard to that specific issue. By understanding that reputation is issue-specific and stakeholder specific, managers are able to target strategies for building and managing particular reputational issues.

The multidimensional construct of reputation identified in this study is consistent with and confirms the definition used in this study which provides that reputation is 'issue-specific' (Walker, 2010). Examining issue-specific reputation can be particularly useful for reputation risk management strategies which need to consider all reputation risk (Tuck, 2012). For example, the risk that the organisational reputation deteriorates, i.e. the perceptions of the stakeholders deteriorates, and the risk that the behaviour of stakeholders will change for the worse due to deteriorated organisational reputation.

Hence, distinguishing between different stakeholder groups and different reputations has various advantages in organisational reputation risk management by providing organisation with a full understanding of how stakeholders perceive reputational issues and, allows the organisation to distinguish between reputations. By distinguishing between different stakeholder groups, it is possible to garner a clear weighting for stakeholder groups that risk management strategies should focus on (Wartick, 2002). For example, the weighting assigned to stakeholder groups could be higher for groups that are more important for the organisation, or weighting could be assigned equally between groups. To do this, managers need to determine the reputational issues in terms of importance for the organisation and then seek to understand the mechanisms affecting perception of reputation in the minds of stakeholders. With identified dimensions of reputation provided by this study managers will have the ability to develop and build specific reputational aspects of the organisation and have the ability to use the competitive advantage achieved through the reputation to maintain, develop and influence within the industry, possibly to the detriment of others, particularly other healthcare service providers seeking similar opportunities.

Another advantage of distinguishing between different stakeholder groups and different reputations is that the organisation has a full understanding of how stakeholder groups perceive the organisation for different issues. The organisation can evaluate its situation and use purposefully aligned strategies to improve the reputation for certain stakeholder group-issue reputation combinations (Eckert, 2017; Tuck, 2012). The different reputation stakeholder group issues have varying importance for the organisation and distinguishing between these reputations through an understanding and measurement of the identified reputation dimensions, allows the organisation to focus on the reputations that are considered more important to the organisation.

So far in this chapter the research has answered how reputation is conceptualised and formed by stakeholders of public healthcare organisations. These two questions were essential to answer in order to address the third research question which explores the perceived value of reputation in public healthcare organisations.

7.4 RQ. 3: *How do internal and external stakeholders perceive the value of reputation in public healthcare organisations?*

The perceptual value of reputation in public healthcare organisations is variable depending on the stakeholder group and the reputational issue. In addition, reputation is based on the perceptions of stakeholders with competing interests and therefore, is not directly under anyone's control (Cian & Cervai, 2014). Reputations develop based on aggregated information and give observers a means by which to classify the organisation or aspects of the organisation. This study found that organisational reputation is informed by the stakeholders' familiarity (experience) with the organisation and the beliefs about what can be expected from the organisation in the future. Importantly, findings indicate that the relationship between organisational reputation and value is established by relationships with stakeholders. Thereby, raising the importance of understanding and developing the dimensions of reputation that hold value to stakeholders.

Consequently, findings from this study indicate that internal stakeholders working at the frontline of the organisation are more closely aligned with consumers when conceptualising and forming reputational value. This is an important finding with implications for managers. By seeking to understand frontline staff perceptual value, managers are likely to understand the perceptual value held by external stakeholders. Therefore, measuring reputation the dimensions found in this study from the frontline perspective will give managers an important insight on how to build their organisations reputation from the external perspective. This finding raises implications for future research which needs to look at developing or modifying reputation measurement tools towards measuring the dimensions from aspects of reputation that the organisation is interested in building and managing. Particularly, because the attributes on which the reputation is built, and the expectations of stakeholders determine that reputation's influence on a given outcome. For example, external stakeholders having a positive experience in a public healthcare organisation are likely to be influenced by that experience when choosing future healthcare needs and are likely to reflect positively on the reputation of that organisation through word-of-mouth communication.

Importantly, the close alignment of the perceptual value of reputation between consumers and clinicians is a significant finding relevant to public healthcare organisation reputation management. While reputation management literature

highlights the importance of aligning employees' behaviours and performance in support of the organisations goals (Doorley & Garcia, 2020) findings in this study challenge this assumption and suggest that reputation management strategies, particularly organisational communication, need to be developed in collaboration with all stakeholders to ensure the dimensions of reputation are considered from both internal and external perspectives. These findings support Davies and Chun (2009) who suggest adopting a hybrid approach where factors that align with both staff members and consumers should be aligned in the organisation's communication strategy. However, what is important is how well all of the reputation management strategies support the achievement of the organisational goals, and how well management aligns with informal values associated with professional subcultures and the external environment (Stokes, et al., 2016). Therefore, in terms of how internal and external stakeholders perceive the value of reputation, it can be said that reputational value is both stakeholder specific and issue-specific and requires clear reputation management strategies that consider aspects of different stakeholder group issues. While previous research has mostly focused on private organisations using quantitative reputation measurement tools, it is clear from this research that reputation is stakeholder group-specific and issue-specific and future practice must take into account all reputational issues in order to mitigate reputational risk.

7.5 RESEARCH CONTRIBUTIONS AND IMPLICATIONS

Organisation reputation requires knowledge of industry-specific dimensions and clear management strategies, which in the end will bolster competitive advantage for organisations. This next section outlines the contribution this research makes to theory and outlines the research implications for practice and health administrators.

7.6 RESEARCH CONTRIBUTIONS TO THEORY

This research contributes to theory in three ways. First, from a theoretical perspective, reputation is viewed as an aggregate perception of all stakeholders. Findings in this research acknowledge that it is an aggregate perception, however what is important is that reputation is both issue and stakeholder specific and can only be measured by specifying which stakeholders and which issues are being analysed. This study uniquely provides evidence that an organisation can have many reputations and it

is important to note which issue and which stakeholder group is being measured. Without identifying the issue and the stakeholder, managers will have difficulty in planning and implementing strategies to build and manage reputation. The expansive organisational reputation literature has not so far acknowledged the value of issue and stakeholder specific reputation in measurement. While there is some degree of recognition of the different issues that are specific to certain stakeholder reputations within an organisation within Walker's (2010) definition, this study showcased the immense importance of these differences being included explicitly within accepted definitions of reputation going forward.

The basic assumption of reputation is that it is an aggregate perception of the organisation. This study has shown the distinct stakeholder issues of reputation that exist and that issue-specific reputation counts to a significant degree for stakeholder evaluation of organisational reputation. Reputation measurement instruments have been evaluated and measured from the perspective of social responsibility, vision and leadership, emotional appeal, financial performance, workplace environment, product and services (Fombrun et al., 2000). However, this study has determined that the existing reputation measurement tools need to be aligned to the stakeholder dimensions of reputation in order to ensure a clear picture of the organisation's reputation from a stakeholder's perspective. Hence, the very conceptualisation of industry-specific organisational reputation measurement requires further investigation.

For public healthcare organisations, reputation is a multi-dimensional construct that is driven by the dimensions of consumer satisfaction, healthcare quality and organisational culture. Research on reputation in healthcare organisations has been largely focused in the private sector and has used reputation measurement instruments designed for private sector organisations (Brown & Perry, 1994; Fryxell & Wang, 1994; Lewellyn, 2002; Walker, 2010). However, findings in this research have identified the reputational dimensions specific to public healthcare organisations (consumer satisfaction; healthcare quality; and organisational culture) and suggest an alternative reputation measurement protocol for public healthcare organisations specifically designed to measure the reputation dimensions identified in this research to ensure a complete picture of public healthcare reputation is obtained.

Second, findings from this research suggest that resource-based view theory is a useful framework for examining reputation in public healthcare organisations, in part. The application of RBV theory in examining reputation has been mostly used within private sector organisations (Barney & Arikan, 2001; Boyd, et al., 2010; Deephouse, 2000; Hoflinger, et al., 2018; Newbert, 2007; Powell & Dent-Micallef, 1997; Raithel & Schwaiger, 2015; Rindova, et al., 2010; Roberts & Dowling, 2002; Schroeder, et al., 2002; Wiklund & Shepherd, 2003). Private sector organisations are focused on valuable resources that provide them with a competitive advantage against industry rivals (Rindova, et al., 2010). However, public sector organisations and, in particular, public healthcare organisations are externally justified with their existence dependent on the provision of services for public purpose (Bryson et al., 2007). Although, to assist public healthcare organisations to meet expectations and create healthcare value and responsiveness, RBV theory is useful as it can assist healthcare managers in understanding resource value and value creation in healthcare as being dependant on the efficient and effective use of resources in delivering quality healthcare. This research addresses the gap identified by extending RBV theory to public organisations and confirms its applicability when examining reputation in public healthcare organisations. This is because public healthcare organisations recognise reputation as a valuable resource and the competitive advantage that a good reputation provides the organisation.

Recognising, developing and strategically managing reputation as a VRIN intangible resource (see Chapter 2) builds organisational livelihood (Tarafdar & Gordan, 2007) and assists public healthcare organisations to meet expectations and create healthcare value and responsiveness. This research added specific public healthcare dimensions to focus on, including understanding the capability of resources that are valuable, rare, inimitable and non-substitutional, such as reputation. As well as understanding the value of reputation as a resource and the dimensions that are specific to public healthcare organisations (consumer satisfaction, healthcare quality, and organisational culture).

In addition, findings from this research provide that RBV theory is closely aligned to the definition of reputation used in this research and specifically to the attributes defining reputation. Those being a relatively stable, issue-specific, aggregate perceptual representation of an organisations actions based on industry standards (Walker, 2010). The attributes identified in the definition of reputation are all relevant when seeking to

understand and measure public healthcare organisation reputation. As Walker (2010) suggests these attributes contribute to the notion that organisations can have multiple reputations on distinct and differing issues. Specifically, findings from this research evidence that when examining reputation in the public healthcare context researchers must determine the reputation for what, and according to which stakeholder.

This research also addresses two specific gaps that were evident in the literature. Firstly, the findings demonstrate that organisational culture is a dimension of reputation and vice versa. The link between reputation and organisational culture found in this study, differs from previous studies by not only providing that all three perspectives of culture coexist (Martin, 2002) and influence the perception of reputation, but that they are interrelated with one another and permeate organisational boundaries. Organisational culture as an identified dimension of reputation has not been presented in prior research and is illustrated in this study by the finding that organisational reputation a multi-dimensional construct of which organisational culture is an important dimension. Secondly, the findings demonstrate that organisational culture is not distinguished as positive or negative by whether it is integrated, differentiated, or fragmented. What is significant are the value systems and the quality of the relationships between the organisational level, operational level and the external level which reflect the perceptual value of reputation. Therefore, reputation equals culture.

7.7 RESEARCH IMPLICATIONS FOR PRACTICE AND MANAGERS

The outcome of management research, which by nature is applied, should provide managers with the evidence to change practice. This research has the potential to influence and build strategies for the management of reputation for public healthcare organisations. The following section outlines the research implications for practice and managers which includes reputation management and reputation building strategies.

7.8 REPUTATION MANAGEMENT FOR PUBLIC HEALTHCARE ORGANISATIONS

Findings from this research suggest reputation management for public healthcare organisations is crucial since improved reputation can reduce the negative effect that poor experiences can have on the perceptions of patients (Mira et al., 2014). A poor reputation can also affect the financial situation of a public hospitals. Since charitable donations are a significant source of income for some public hospitals, a bad reputation

is likely to affect the hospitals' ability to raise funds (Hibbard, et al., 2005). Hence, it is vital to have a reputation management plan in place, however findings from this study highlight that this is an area that is lacking direction. Since healthcare organisations are complex the reputation management in these organisations is complicated. There is no precise and commonly agreed reputation management strategy for healthcare organisations (Leonard, 2017). However, in order to develop reputation management in public healthcare organisations, the findings in this study support the ideas of Waeraas and Byrkjeflot (2012) who argue that reputation should be managed, and that any reputation management plan has to measure, monitor and establish a plan for managing reputation assets, and liabilities.

Importantly, this study found that reputation was vital to organisations and as such, should be managed. However, how to manage reputation was not clearly understood or identified by stakeholders. An important implication for practice highlighted from this study is the need for public healthcare organisations to manage their reputation. Organisations need to develop reputation management plans that are designed to include a reputation audit strategy of internal and external stakeholders. This means one audit that assesses what operational staff believe to be the intrinsic reputation (what the organisation stands for on a particular issue) and compares that with what senior management believes the intrinsic reputation of that specific issue to be. The gap between the two views is then analysed and a plan to converge them is formulated. A second audit measures how external stakeholders view the organisation through the dimensions of reputation identified as unique to public healthcare organisations (consumer satisfaction, healthcare quality, organisational culture). The gap between the external view and internal view is analysed, and a plan to close the gap between the desired reputation and the perceived reputation is created and added to the overall reputation management plan. Public healthcare organisations also need to include in their reputation management plan, a communication strategy, reputation challenges and potential problem areas.

The findings in this study show that the quality of healthcare services is an important dimension of reputation and good hospital reputation can be achieved through a successful management of service quality (Bell & Krivich, 2000; Marakanon & Panjakajornsak, 2017). The importance of communication was also established as critical to reputation. In particular, the way clinicians and all other employees interact

with each other and consumers during, and after, care is crucial for establishing a good reputation because consumers' perceptions of reputation are formed from their own experience or the experience of others, and the experience starts from the moment they first interact with the healthcare organisation (Arpey et al., 2017). Findings from this study show organisational culture as a dimension of reputation which highlights the need for reputation management plans to create and strengthen the culture to align with the organisational goals and values. The reputation management plan then serves as a strategic guide for units of the organisation to follow both in the short and long term (Doorley & Garcia, 2020). The findings from this research can be used by managers and leaders in developing strategies for building reputation. The next section provides strategies for operationalising the findings in this study and provides avenues for further research.

7.9 REPUTATION BUILDING STRATEGIES FOR MANAGERS

Findings from this research advance the understanding of reputation as an intangible resource that is multidimensional. This has important implications for managers who can implement reputation building strategies by ensuring that the dimensions of reputation for public healthcare organisations are understood from both an internal and external perspective. The concept of reputation needs to be understood by considering all perspectives and not in isolation. These findings are consistent with Boivie et al., (2016) who see the importance including all perspectives of reputation when managing and building reputation. Indeed, findings from this study suggest the importance of reputation from an organisation perspective, reputation of professional groups and the reputation of healthcare quality and delivery. Surprisingly and most importantly, this study found that operational staff were closely aligned with consumers in their perceptional value of reputation, which suggests that reputation building strategies should be developed in collaboration with all stakeholders. Thus, including the perceptual value of reputation from an operational perspective will generate a clear understanding of what consumers' value. The understanding from the point of view of operational staff can be used by managers to plan strategies for building organisational reputation.

Public healthcare organisation managers have less room for movement with reputation management than private sector organisations, mostly due to strategies and

practices having to be open and transparent (Luoma-aho, 2007). Findings from this study suggest that senior managers often find their hands tied by government initiatives, targets and bureaucracy. This is because public sector healthcare organisations are required to externally report all of their performance targets which deflects from the important dimensions of reputation. Hence, healthcare managers while mindful of achieving government performance targets, also need to include reputation building strategies by building a positive culture, stakeholder trust and making sure stakeholder experiences of everyday healthcare delivery practices are positive.

7.10 STUDY STRENGTHS AND LIMITATIONS

This research is beneficial to both academia and society in at least four ways: 1) a novel research approach; 2) defining reputation in a public healthcare organisation; 3) providing clarity about perceived reputational domains specific to public healthcare; and, 4) clarifying and unpacking the role of organisational culture in understanding and using perceptual reputation in public healthcare organisations.

Firstly, this research contributes in terms of the qualitative research approach undertaken to explore the concept of reputation in public healthcare organisations. The depth of understanding of reputation that this research has provided is a result of conversations with the participants and field notes of observations which have highlighted the participant's voices and their construction of reputational value in public healthcare organisations. This research has illuminated the complexities of reputation by bringing together careful scholarly reflection and pertinent literature to enrich understanding and provide meaningful contributions to theory (organisational reputation, organisational culture, resource-based view) and to practice (reputation risk, reputation management, building reputation, organisational culture).

Secondly, this research contributes in terms of identifying 'how' reputation is defined by stakeholders of public healthcare organisations. The dominant attributes conceptualised by public healthcare organisation stakeholders confirms expectations from existing research on reputation. However, a surprising find from this study was the similarity between operational stakeholder groups and external stakeholder groups in their conceptualisation of reputation which provides significant insights into the definition of reputation. While there is yet to be an accepted definition, this research

builds on previous work (Walker, 2010) to establish conformity and consistency and alleviate some of the confusion surrounding the definition of reputation.

Thirdly, this research contributes by confirming that reputation for public healthcare organisations is a multidimensional construct that consists of three dominant domains: consumer satisfaction; healthcare quality; and organisational culture. Although previous research has identified reputation as a multidimensional construct, this study provides insights into the domains that are specific to public healthcare organisations. The identified domains are important for the development of reputation measurement and reputation risk management and provides a basis for the development and modification of existing tools and strategies to better assist healthcare organisations in managing and building their reputation.

Fourthly, this research contributes by adding to the gaps in the literature on the relationship between organisational culture and reputation. While previous research has identified a link between organisational culture and reputation. This study has made it clear that organisational culture is actually a dimension of reputation and is a significant factor in the formation of reputational value by stakeholder groups.

The literature on organisational reputation mainly focuses on the use of quantitative research that measures reputation using various reputation measurement instruments. For example, the Reputation Quotient Instrument (Fombrun et al., 2000). This research qualitatively explored the perceptual value of reputation using a cultural lens in order to develop a complete picture and understanding of the value of reputation as constructed by participants. Reputation has been measured in healthcare organisations, mostly through the use of surveys (Hall & Dornan, 1990; Johansson et al., 2002; Kıdak & Aksaraylı, 2008; Önsüz et al., 2008; Şatır, 2006; Shortell et al., 1977) and report cards which rank hospitals by measuring their reputation (Shahian et al., 2011). However, no studies were identified that have qualitatively explored the perceptual value of reputation using broad and open-ended inquiry. The qualitative interviews conducted within Phase 1 set the basis for the research by allowing for exploration of key issues in relation to the healthcare system, reputation and organisational culture. However, the interviews only presented internal stakeholder perspective of reputation and identified a need to explore the perceptual value of reputation from consumers or potential consumers. Phase 2 of this study allowed for

exploration of key issues in relation to healthcare organisations and reputation. This allowed for a complete picture to be understood from key stakeholders of public healthcare organisations which contributed to the richness of the research findings.

7.11 OPPORTUNITIES FOR FUTURE RESEARCH

The research conclusions collated in this thesis provide future research opportunities. Future research opportunities include:

This research has highlighted reputation as a multi-dimensional construct that includes consumer satisfaction, healthcare quality, and organisational culture as important dimensions. However, this study was only undertaken in Southeast Queensland, therefore future studies could be undertaken in other Australian states and other international locations with regard to how the value of reputation is perceived.

This research identified organisational culture as a dimension of reputation for public healthcare organisations. While culture has been linked to reputation in previous studies (Flatt & Kowalczyk, 2008; Yusuf, et al., 2018) further research on exploring the dimension of organisational culture in other contexts will provide further insights into the reputation-culture relationship.

The perceptual value of reputation has been explored and findings suggest that reputation should be managed in the public healthcare context. Further research into reputation management in this context will assist managers in developing strategies for building and maintaining a positive reputation.

This research showed the benefits of examining reputation by using resource-based view as the underlying theoretical principle associated with reputation. However, future research in the healthcare context could apply different theories or theoretical principles when analysing reputation, particularly the stakeholder characteristics of reputation. For example, stakeholder theory could be used to examine the influence of stakeholders on different aspect of an organisation's reputation.

7.12 CONCLUDING REMARKS

This research has explored the perceptual value of reputation from internal and external stakeholders of public healthcare organisations, through a cultural lens. In

doing so, it has identified how stakeholders conceptualise and form reputational value in the healthcare context.

Ongoing healthcare reforms and the introduction of competition into public healthcare sector, has resulted in reputation being recognised as a valuable, rare, inimitable and non-substitutional resource that can provide organisations with a competitive advantage over industry peers. Organisational reputation is an asset in creating a difference within a competitive environment. In order to gain respect from stakeholders, reputation should be well managed, considering all dimensions since it is vulnerable to any threat.

Organisation reputation can be better understood when viewing it through a cultural lens. Using a multi-level (organisational, group, and individual) and multi-perspective (integrated, differentiated, and fragmented) approach enabled this research to paint a complete picture. In addition, the ethnographic multi-phase sequential design combined with iterative and reflexive learning has enabled the ideas and construction of meaning of reputation in public healthcare organisations and greater clarity around the multi-dimensional elements of reputation specific to the healthcare context.

This thesis concludes that research on reputation should continue particularly within public sector organisations that will benefit from a deeper understanding of reputation and reputation management strategies. The complicated nature of public healthcare organisations and the multi-dimensional aspect of reputation presents ongoing opportunities for research into reputation. This research has shown the perceptual value of reputation in the context of public healthcare sector and has provided an opportunity to advance resource-based view theory, particularly within the public healthcare context. Future research needs to capitalise on and progress the knowledge of reputation developed through this research, which involved reconceptualising reputation to reveal that reputational value in public healthcare organisations is a multi-dimensional construct and affects not only consumers in their hospital choices, but also the commitment of employees to the organisation.

7.13 EPILOGUE

Considering such scholarly depths in research, an understanding of the definition and construction of reputation and its relationship to and with organisational culture has

not been seen in researching the concept of reputation for public healthcare organisations. This research greatly enhances the understanding that reputation is an asset to any organisation. Importantly, this research recognises that to build and manage reputation it is important to ensure each reputational issue is guided by clear alignment of the goals by all stakeholders. The reputational issues identified in the preamble were impacted by siloed goals between senior managers and frontline staff. Recognising that reputation is both issue-specific and stakeholder specific provides a unique aid for senior manager and frontline staff who are equally able to influence and improve healthcare service delivery. A good reputation brings with it a sense of trust in the organisation that they are going to do right by the consumers and the employees.

Trust in public healthcare organisations has never been more important than the recent environmental jolt we have experienced by COVID 19. Healthcare organisations are at the forefront of this crisis and how they conduct themselves in this crisis will have significant impact on their reputation. Organisations that have a collaborative culture and engaged their operational staff in preparation are able to build their reputation. For example, in speaking with senior colleagues they reflected on the value of reputation during the impact of COVID 19. Organisations that were well prepared and quickly engaged their operational staff in the planning and preparation were able to build their reputation. The management of this environmental jolt was state-wide and very quickly organisations that prepared well were called upon to advise other healthcare organisations. COVID 19 saw health ministers and governmental staff engage regularly with healthcare services. Those organisations with collaborative cultures quickly became trusted health services that other healthcare organisations and government officials relied on for advice and guidance. Organisations that recognised the value in building reputation during this time were able to access government funding for the required resources and were able to secure these resources early. Securing the resources early was extremely important as a worldwide shortage left a number of healthcare services without the required protective equipment.

Healthcare organisations play a large role in managing health crisis and the public will evaluate crisis responses based on how well organisations prioritise public good and/or serve public interest. At the time of writing this thesis there is no research available to test reputation and its benefits to healthcare organisations or to consumer confidence. However, on reflection, the environmental jolt caused by COVID 19 has

strengthened the findings in this study, that reputation is a valuable resource that provides a competitive advantage for healthcare organisations. Having a cohesive culture can strengthen reputation and healthcare organisations that recognise the importance of organisational culture as a critical dimension of reputation will establish themselves an advantage, whether it is for additional resources, quality staff or innovative opportunities. The cohesion between political leaders and the collaboration with medical experts has been critical to the success so far and highlights the importance of a collaborative culture.

Appendices

APPENDIX A: Healthcare Reform Strategies

Review	Objective	Recommendations for healthcare	Impact	Considered by	Specific
Hilmer 1993	Independent inquiry into a national competition policy	Arrangements that detract form competition should be retained only if they can be shown to be in the public interest.	Review of health-related legislation	CoAG	*Medical Practice Act 1992* (NSW); *Dentist Act 1984* (SA); *Nursing Act 1992* (Qld) *Health Act 1937* (Qld); *Private Health Facilities Act 1999* (Qld); *Nursing Homes Act 1988* (NSW); *Private Hospital and Nursing Homes Act 1981* (NT)).
Productivity Commission 2005	Review of the National Competition Policy arrangements	Noted the challenges facing Australia's ageing population and increasing healthcare costs. Further healthcare reform needed to improve living standards and community wellbeing. Ttackled through separate nationally coordinated initiates	Working group on health and ageing established to imporove health outcomes and sustainabliity of Australias healthcare system	CoAG	Addressed elective surgery waiting times in public hospitals. Assessed investment in aged care and public dental programs. Addressed preventative healthcare programs. Carefully implemented consumer choice policies can encourage the provision of more cost efficient services to meet the individual's needs. Limits on the amount of choice possible requiring policy makers to strike a balance.
NHHRC 2009	Health system reform. Benefit of competition and consumer choice	Greater consumer choice and provider competition will empower consumers through choice of provider. Create the right incentives for health and hospital plans to attact and retain customes and deliver value services. Incentivises health service providers to deliver high quality care and greater efficiency. Hospital and Health Plan Medicare Select	National Health and Hospitals Network established. National Commission of Audit	CoAG	*National Healthcare Agreement 2011* *National Health Reform Agreement 2011* National Commission of Audit suggested a universal health insurance arrangment to inject greater competition and efficiencies into the Australian healthcare system.
Harper review 2015	Review of Australia's competition policy, laws and institutions by the Competition Policy Review Panel	Express recommendation: New set of competition principles that would commit the government to competition reform. Healthcare sector amenable to competition reform to ensure innovative ways to deliver high quality and efficient human services. Establising choice and contestibilty in the provision of human services can improve services. Empowerment of service users. Improve productivity Improve performance Presumption choice can have significant benefits in human service sectors. Putting users in control drives service providers to become more responsive to individual requirements.	National Commision of Audit paper: Efficiency in Health. Recognised need for competition in pharmacy sector.	Australian government.	Australian Government Hearing Services Program - provides consumer choice.
Productivty Commission 2017	Review of Australia's human services with regard to innovative ways to improve outcomes throught introducing the principles of compeition and informed user choice while maintaining quality of service.	Finding: Public hospital services best suited for competition-based reform with consumer choice the basis of service providion and delivery. Although varied between jurisdictions - noted some progress with introducing competition, contestibility and user choice to human services The service delivery frameworks that are inefficient and ineffecitve are causing significant costs to the economy and poor productivity and outcomes	Informed choice will improve outcomes for users because it has intrinsic value by empowering individuals to have greater control over their choices of healthcare decisions that meet their needs. Incentivises healthcare providers to be responsive to user needs. Drives innovation, efficiency and performance in service delivery.	Australian government. Australian Healthcare and Hospitals Association (AHHA)	Affordability and equity cannot be forgotten in the rush to implement competition, choice and contestibility in human services. The importance of integrated healthcare in achieving health outcomes should not be impeded by short-term incentives that work against it.

APPENDIX B: INFORMATION SHEET SENIOR MANAGERS

Hello, my name is Jennifer Kosiol and I am the principal researcher on this project. I am a PhD Candidate from Griffith University Business School.

Study title: So What? The value of Reputation in Public Healthcare Organisations.

Protocol number: HREC/18/QPAH/286
Research Supervisor: Professor Anneke Fitzgerald / Dr Katrina Radford
Research site: South East Queensland Hospital and Health Service

Principal Investigator	**Associate Investigator**
Name: Anneke Fitzgerald **School**: Griffith Business School **Phone**: +615552 7043 **Email**: anneke.fitzgerald@griffith.edu.au	**Name:** Jennifer Kosiol **School:** Griffith Business School Phone: +61481 032 603 Email: Jennifer.kosiol@griffithuni.edu.au

Why is the research being conducted?

This research study is being conducted for research purposes only and is not part of the curriculum or normal school activity of Griffith University. This research is being conducted to provide empirical evidence on the value of reputation within the public healthcare setting. It will provide key information that can be used to provide Australian public healthcare organisations with guidance on the management of reputation. The understanding of reputation and its influence on performance and competitive advantage will be useful for strategic management decision makers and for overall reputation management.

Definition of reputation used in this study: Adapted from Walker (2010) "A relatively stable, issue-specific aggregate perceptual representation of an organisations past actions and future prospects compared against some standard"

What you are being asked to do

You are being asked to voluntarily participate in a face to face interview that will be approximately 45-60 minutes in length.

The basis by which participants will be selected or screened

All participants who are employed at participating organisations as senior managers are being invited to participate in this study.
Senior manager: Defined as senior manager: director / executive / assistant director / administration manager / board member.

The expected benefits of the research

The findings from the research will provide organisations with a better understanding of the value of reputation as an organisational asset. Equally important this research will provide

an understanding of reputation and its influence on performance and competitive advantage will be useful for strategic management decision makers and for overall reputation management.

Risks to you

The risks involved in participating in this research are no greater than that arising from daily living.

Your confidentiality

Any information gathered will be kept strictly confidential with no individual identifiable by anyone other than the researchers, who will use this information only to identify the organisation to which you belong and only for research purposes. Furthermore, access to the data collected will be restricted to the researcher and chief investigator, with the data file containing the information collected being stored away from the organisation and not accessible to anyone other than the primary researcher. Moreover, no information on your participation will be provided to the participating organisation.

Your participation is voluntary

Your participation in this research is completely voluntary, and you are free to withdraw at any point prior to the end of the interview without loss or penalty of any kind, you are not obliged to answer every question unless you wish to do so.

Providing your consent to participate in this study

Prior to the interview taking place the researcher will ask you to complete a form giving your consent to take part in this research. If you would like to ask any additional questions please contact the researcher, Jennifer Kosiol, either by phone (0481032603) or email (jennifer.kosiol@griffithuni.edu.au).

Questions / further information

If you have any questions or wish to obtain further information regarding this study please feel free to contact Jennifer Kosiol by phone (+61481032603) or email (jennifer.kosiol@griffithuni.edu.au).

The ethical conduct of this research

Griffith University conducts research in accordance with the *National Statement on Ethical Conduct in Human Research*. If potential participants have any concerns or complaints about the ethical conduct of the research project they should contact the Manager, Research Ethics on 3735 4375 or **research-ethics@griffith.edu.au** Ethical approval has been obtained for this study.

Privacy statement

Please note that the conduct of this research involves the collection and analysis of data. Any information collected is considered to be confidential and will not be disclosed to anyone else without your expressed consent, except to meet any government, legal or regulatory authority requirements. Your anonymity will be protected at all times. If you have any questions about this privacy statement, you may consult the university's privacy plan at https://www.griffith.edu.au/about-griffith/plans-publications/griffith-university-privacy-plan or telephone +61 7 3735 4375.

APPENDIX C: INFORMATION SHEET FOR FRONTLINE PARTICIPANTS

INFORMATION SHEET – INTERVIEWS – FRONTLINE STAFF

Hello, my name is Jennifer Kosiol and I am the principal researcher on this project. I am a PhD Candidate from Griffith University Business School.

Study title: So What? The value of Reputation in Public Healthcare Organisations.

Protocol number: HREC/18/QPAH/286
Research Supervisor: Professor Anneke Fitzgerald / Dr Katrina Radford
Research site: South East Queensland Hospital and Health Service

Principal Investigator	**Associate Investigator**
Name: Anneke Fitzgerald **School**: Griffith Business School **Phone**: +615552 7043 **Email**: anneke.fitzgerald@griffith.edu.au	**Name:** Jennifer Kosiol **School:** Griffith Business School Phone: +61481 032 603 Email: Jennifer.kosiol@griffithuni.edu.au

Why is the research being conducted?

This research study is being conducted for research purposes only and is not part of the curriculum or normal school activity of Griffith University. This research is being conducted to provide empirical evidence on the value of reputation within the public healthcare setting. It will provide key information that can be used to provide Australian public healthcare organisations with guidance on the management of reputation. The understanding of reputation and its influence on performance and competitive advantage will be useful for strategic management decision makers and for overall reputation management.

Definition of reputation used in this study: Adapted from Walker (2010) "A relatively stable, issue-specific aggregate perceptual representation of an organisations past actions and future prospects compared against some standard"

What you are being asked to do
You are being asked to voluntarily participate in a face to face interview that will be approximately 45-60 minutes in length.
The basis by which participants will be selected or screened
All participants who are employed at participating organisations as frontline operational staff are being invited to participate in this study.
Frontline operational staff: Defined as: Clinical**:** Nursing / medical / Allied Health (physiotherapist, speech pathologist etc).
Non-clinical: environmental / administrative / support (cleaning, catering, etc.).
Management: Nurse Unit Manager / Consultant / Administration lead.

The expected benefits of the research

The findings from the research will provide organisations with a better understanding of the value of reputation as an organisational asset. Equally important this research will provide an understanding of reputation and its influence on performance and competitive advantage will be useful for strategic management decision makers and for overall reputation management.

Risks to you

The risks involved in participating in this research are no greater than that arising from daily living.

Your confidentiality

Any information gathered will be kept strictly confidential with no individual identifiable by anyone other than the researchers, who will use this information only to identify the organisation to which you belong and only for research purposes. Furthermore, access to the data collected will be restricted to the researcher and chief investigator, with the data file containing the information collected being stored away from the organisation and not accessible to anyone other than the primary researcher. Moreover, no information on your participation will be provided to the participating organisation.

Your participation is voluntary

Your participation in this research is completely voluntary, and you are free to withdraw at any point prior to the end of the interview without loss or penalty of any kind, you are not obliged to answer every question unless you wish to do so.

Providing your consent to participate in this study

Prior to the interview taking place the researcher will ask you to complete a form giving your consent to take part in this research. If you would like to ask any additional questions please contact the researcher, Jennifer Kosiol, either by phone (0481032603) or email (jennifer.kosiol@griffithuni.edu.au).

Questions / further information

If you have any questions or wish to obtain further information regarding this study please feel free to contact Jennifer Kosiol by phone (+61481032603) or email (jennifer.kosiol@griffithuni.edu.au).

The ethical conduct of this research

Griffith University conducts research in accordance with the *National Statement on Ethical Conduct in Human Research*. If potential participants have any concerns or complaints about the ethical conduct of the research project they should contact the Manager, Research Ethics on 3735 4375 or **research-ethics@griffith.edu.au** Ethical approval has been obtained for this study.

Privacy statement

Please note that the conduct of this research involves the collection and analysis of data. Any information collected is considered to be confidential and will not be disclosed to anyone else without your expressed consent, except to meet any government, legal or regulatory authority requirements. Your anonymity will be protected at all times. If you have any questions about this privacy statement, you may consult the university's privacy plan at https://www.griffith.edu.au/about-griffith/plans-publications/griffith-university-privacy-plan or telephone +61 7 3735 4375.

APPENDIX D: RESEARCH INTERVIEW QUESTIONS

QUESTIONS – INTERVIEWS

Study title: So What? The value of Reputation in Public Healthcare Organisations.

Protocol number: HREC/18/QPAH/286

Research Supervisor: Professor Anneke Fitzgerald / Dr Katrina Radford

Research site: South East Queensland Hospital and Health Service

Principal Researcher	**Associate Investigator**
Name: Anneke Fitzgerald **School**: Griffith Business School **Phone**: +61 55527043 **Email**: anneke.fitzgerald@griffith.edu.au	**Name:** Jennifer Kosiol **School:** Griffith Business School **Phone:**+61481 032 603 **Email:** Jennifer.kosiol@griffithuni.edu.au

Interviews will be semi-structured with senior managers and will be approximately 45 minutes in length. The questions will consist of open and closed questions with a focus on the participant's view of reputation.

This research is not seeking information about the reputation of the HHS and is not seeking to get an assessment from individuals about their workplace. This research is seeking participant's view of reputation as a concept that might have value as a resource for public healthcare organisations.

In no way will any hospital or health service be disclosed in this research.

.

Each senior manager will be asked the same questions.

Example participant questions are provided below:

1. Can you tell me about your role in the organisation?
2. Can you tell me what you think reputation means for healthcare organisations?
3. What value do you think a good reputation can bring to a healthcare organisation?

4. What do you think best describes a good reputation for healthcare organisations?
5. What do you think best describes a poor reputation for healthcare organisations?
6. What outcomes can be predicted on the basis of reputation?
7. To what extent is reputation being intentionally formed?
8. In what way has the notion of reputation influenced your decision making?
9. How do you think reputation is perceived within different hierarchical (frontline / senior managers) and professional groups (nursing, medical, allied health) within healthcare organisations?
10. What recommendations do you have, or suggestions you could make that would influence the management of reputation?

An invitation to participate in interviews will be sent via email.
An example of the email is submitted with this application.

APPENDIX E: CONSENT FORM FOR STUDY

Consent Form

Project title: So What? The value of Reputation in Public Healthcare Organisations.

Protocol number: HREC/18/QPAH/318

Researcher: Jennifer Kosiol

Please tick:

- ○ I have read and understood the information provided about this research project in the Information Sheet
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ○ I understand that this research is not seeking information about the reputation of any particular Hospital or Health Service or any other Healthcare organisation.
- ○ I agree to take part in this research.
- ○ I wish to receive a copy of the report from the research (please tick one): Yes○ No○

Participant's signature:
.....

Participant's name:
.....

Participant's Contact Details (if appropriate):

……..

……..

……..

……..

Date:

APPENDIX F: CONSUMER ADVERTISEMENT

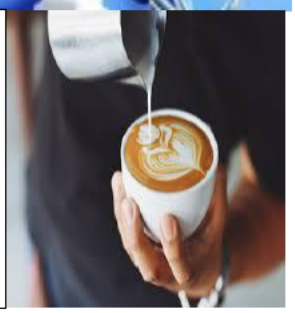
Your opinion matters – healthcare research

My name is Jennifer
I am a PhD candidate who wants to hear your opinion on our public healthcare system

If you are interested in being interviewed
Will only take 15-20mins

Ethics HREC/18/QPAH/318
Mob: [redacted]
j.kosiol@griffith.edu.au

Coffee Vouchers for all participants



Grab my contact info & give me a call!

Contact | Jennifer [redacted] j.kosiol@griffith.edu.au

Contact | Jennifer [redacted] j.kosiol@griffith.edu.au
Contact | Jennifer [redacted] j.kosiol@griffith.edu.au
Contact | Jennifer [redacted] j.kosiol@griffith.edu.au
Contact | Jennifer [redacted] j.kosiol@griffith.edu.au
Contact | Jennifer [redacted] j.kosiol@griffith.edu.au
Contact | Jennifer [redacted] j.kosiol@griffith.edu.au
Contact | Jennifer [redacted]

APPENDIX G: RESEARCH ADVERTISEMENT INTERNAL STAKEHOLDER

Research – Frontline Staff and Senior Managers - Participation Needed

Frontline staff:
Clinical: Nursing / medical / Allied Health (physiotherapist, speech pathologist etc).
Non-clinical: environmental / administrative / support (cleaning, catering, etc.).
Management: Nurse Unit manager / Consultant / Administration lead.

Senior manager: Defined as senior manager: director / executive / assistant director / administration manager / board member.

Study Title: So what? The value of Reputation in Public Healthcare Organisations

Protocol Number: HREC/18/QPAH/318

My name is Jennifer Kosiol and I am a PhD Candidate from Griffith University. I am genuinely interested in the value of reputation in public healthcare organisations.

You are invited to take part in the proposed study. An information sheet is provided to assist you with your decision to participate in this study.

Why do we need your help?
Our research team is interested in understanding your perception of reputation and its value in public healthcare organisations.

The aim
The purpose of this study is to understand the value of reputation as a resource within Australian public healthcare organisations.

What does the study involve?
A face-to-face audiotaped interview, with semi-structured questions, about your experiences and perceptions of reputation.

How much time will the interview take?
It will be approximately 45 minutes

Do I have to take part?
No, participation is purely voluntary and importantly you may opt out of the study at any time. We will ask that you provide consent to participate in the research

Payment?
There are no financial incentives for participating in this research

Dissemination of results
Results from the interviews will be outlined in the PhD thesis for Griffith University Doctor of Philosophy.

What next?
Please contact me if you have any questions and are willing to participate in this research project.

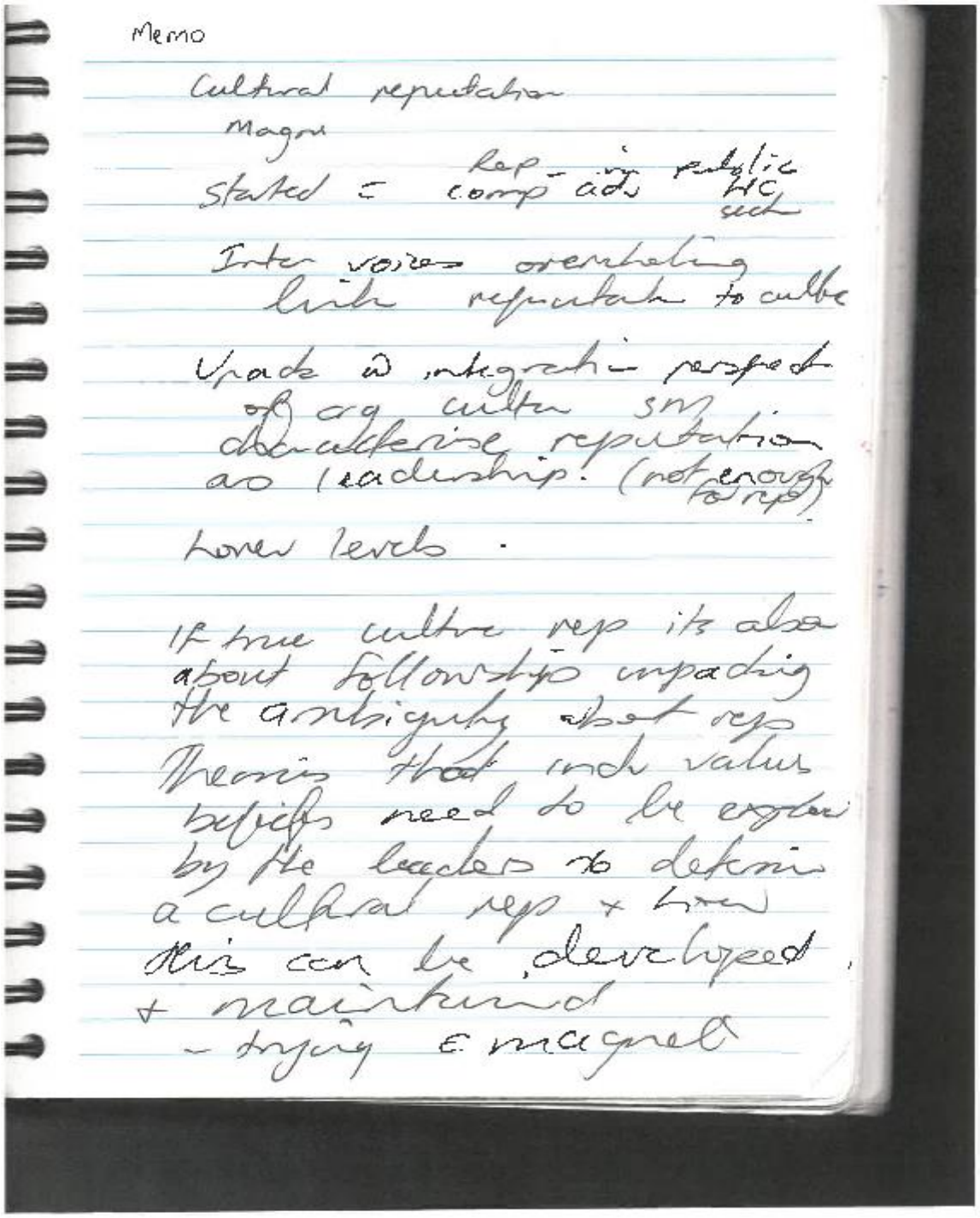
Please contact: J.kosiol@griffith.edu.au or Mob: [redacted]

Supervisor on this project:
Professor Anneke Fitzgerald and Dr Katrina Radford
Griffith University International Business and Asian Studies.

anneke.fitzgerald@griffith.edu.au [redacted]

k.radford@griffith.edu.au

APPENDIX H: RESEARCH MEMO


Memo

Cultural reputation

Magni

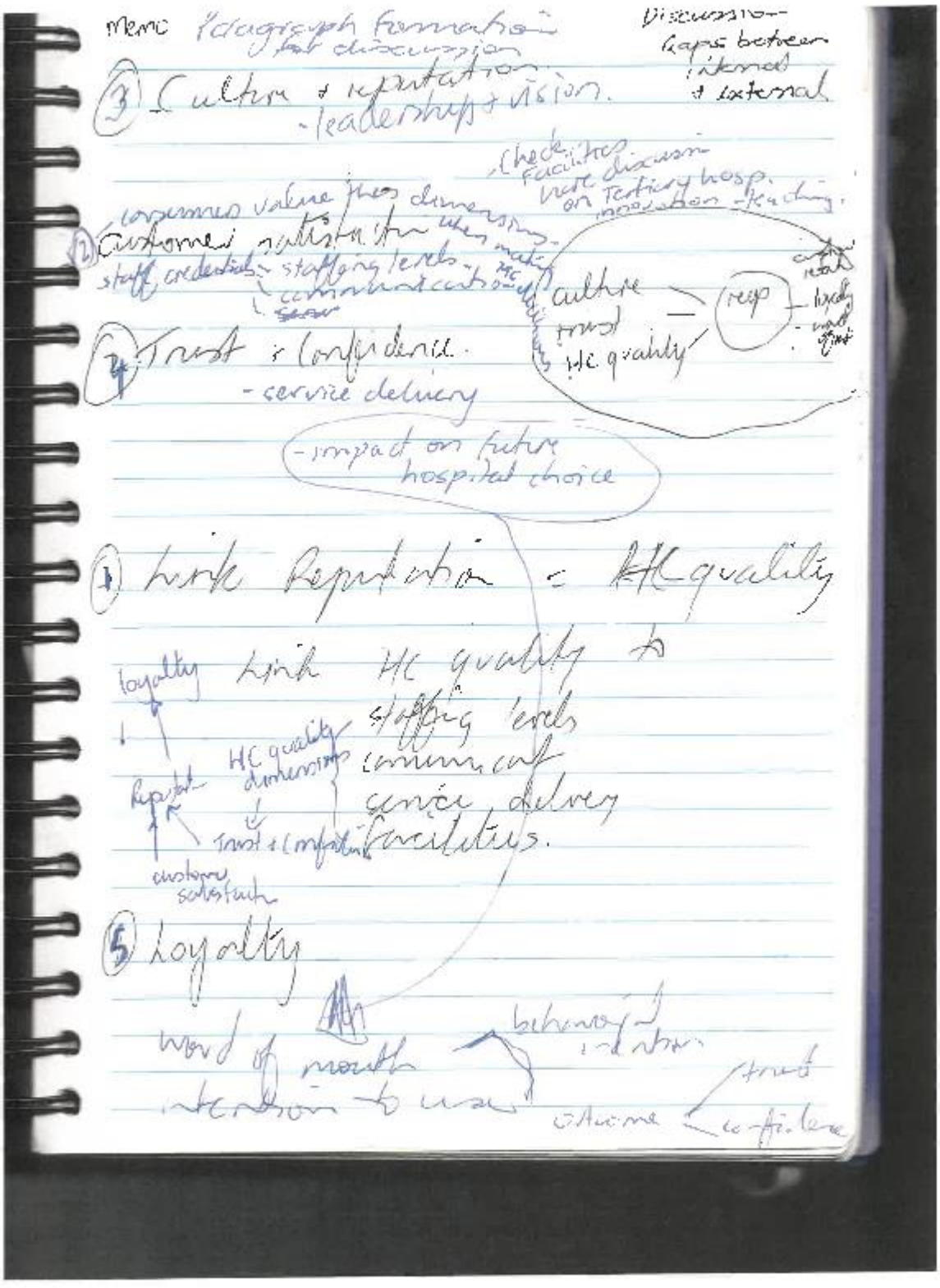
Stated = rep - in public
comp adj HC
such

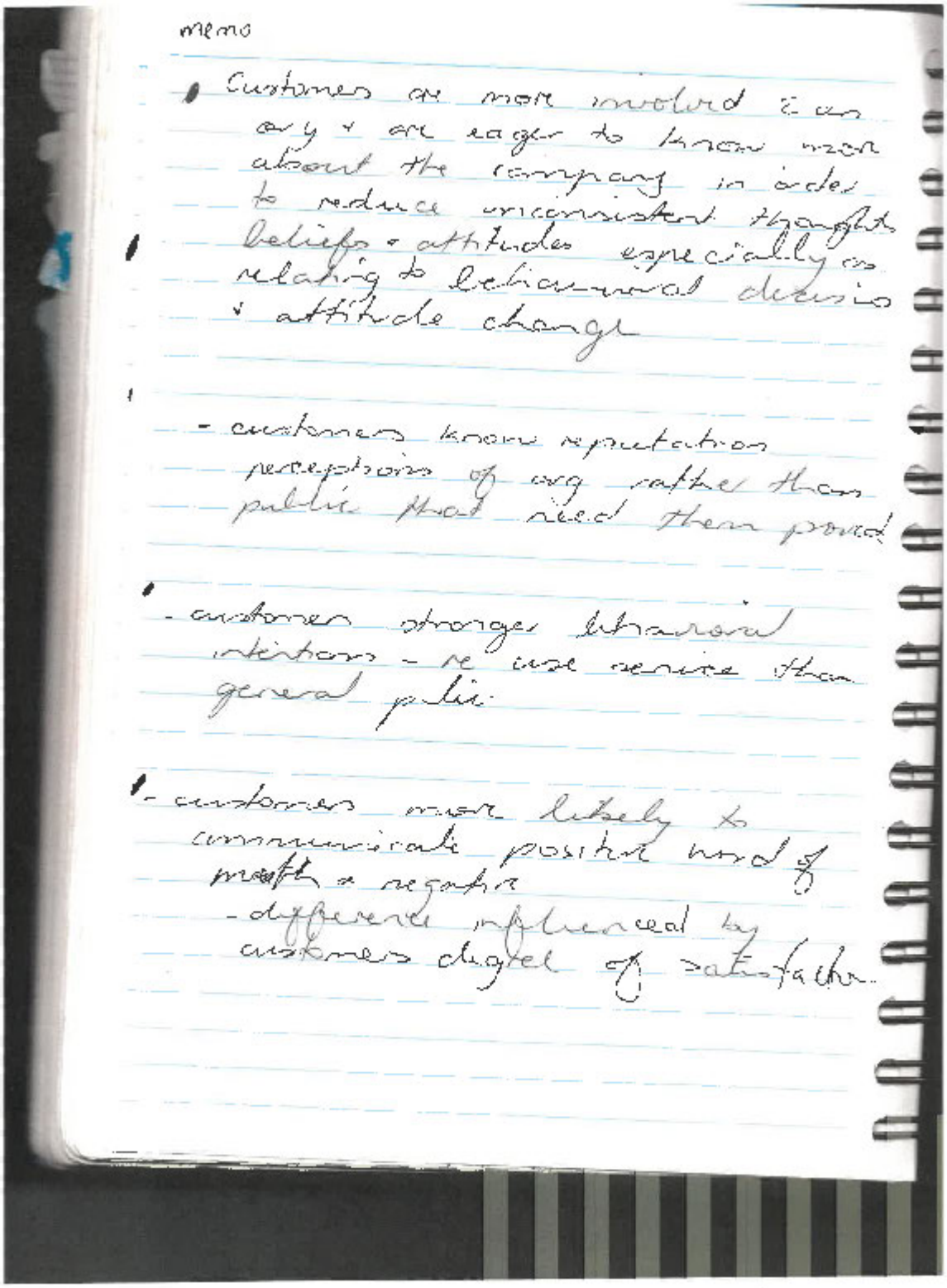
Inter voices overlooking
link reputation to culture

Upside integration perspect
of eg culture SM
develop reputation
as leadership. (not enough
for rep)

Lower levels.

If true culture rep its also
about followship impacting
the ambiguity about rep
Theories that such values
beliefs need to be explored
by the leaders to determine
a cultural rep + how
this can be developed
+ maintained
- trying to magnet


Menc
Discussion-
Gaps between internal & external
(3) Culture & reputation
- leadership + vision.
(2) Customer satisfaction
staff credentials
staffing levels
(4) Trust & confidence
- service delivery
culture
trust
HC quality
rep
- impact on future hospital choice
(1) Link Reputation = HC quality
loyalty
Link HC quality to
staffing levels
communic
service delivery
facilities.
HC quality dimensions
Trust & confidence
customer satisfaction
(5) Loyalty
word of mouth
intention to use
behaviour
attitude
trust
confidence



memo

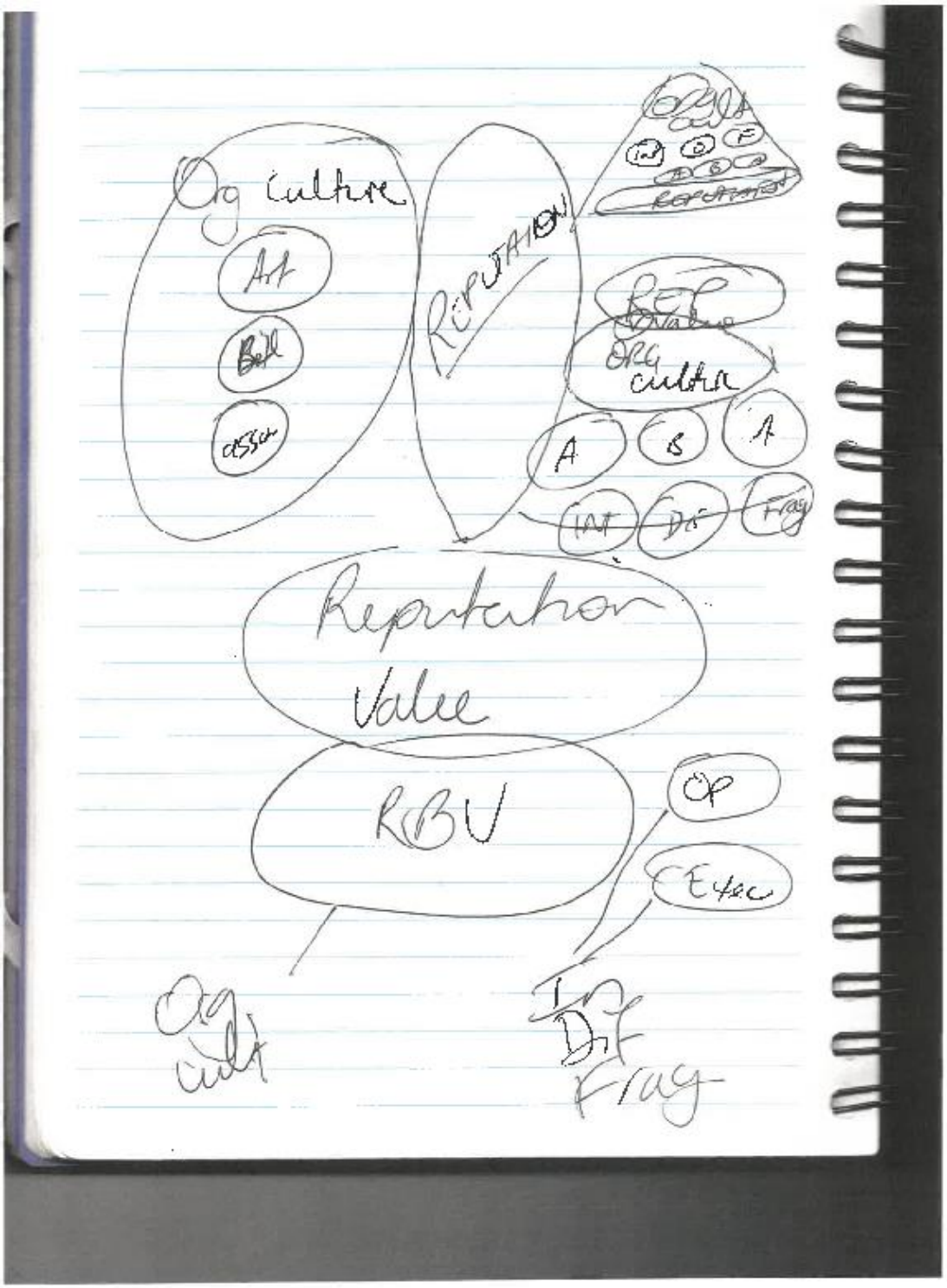
- Customers are more involved i.e. they are eager to know more about the company in order to reduce unconsistent thoughts, beliefs & attitudes especially on relating to behavioural decision & attitude change

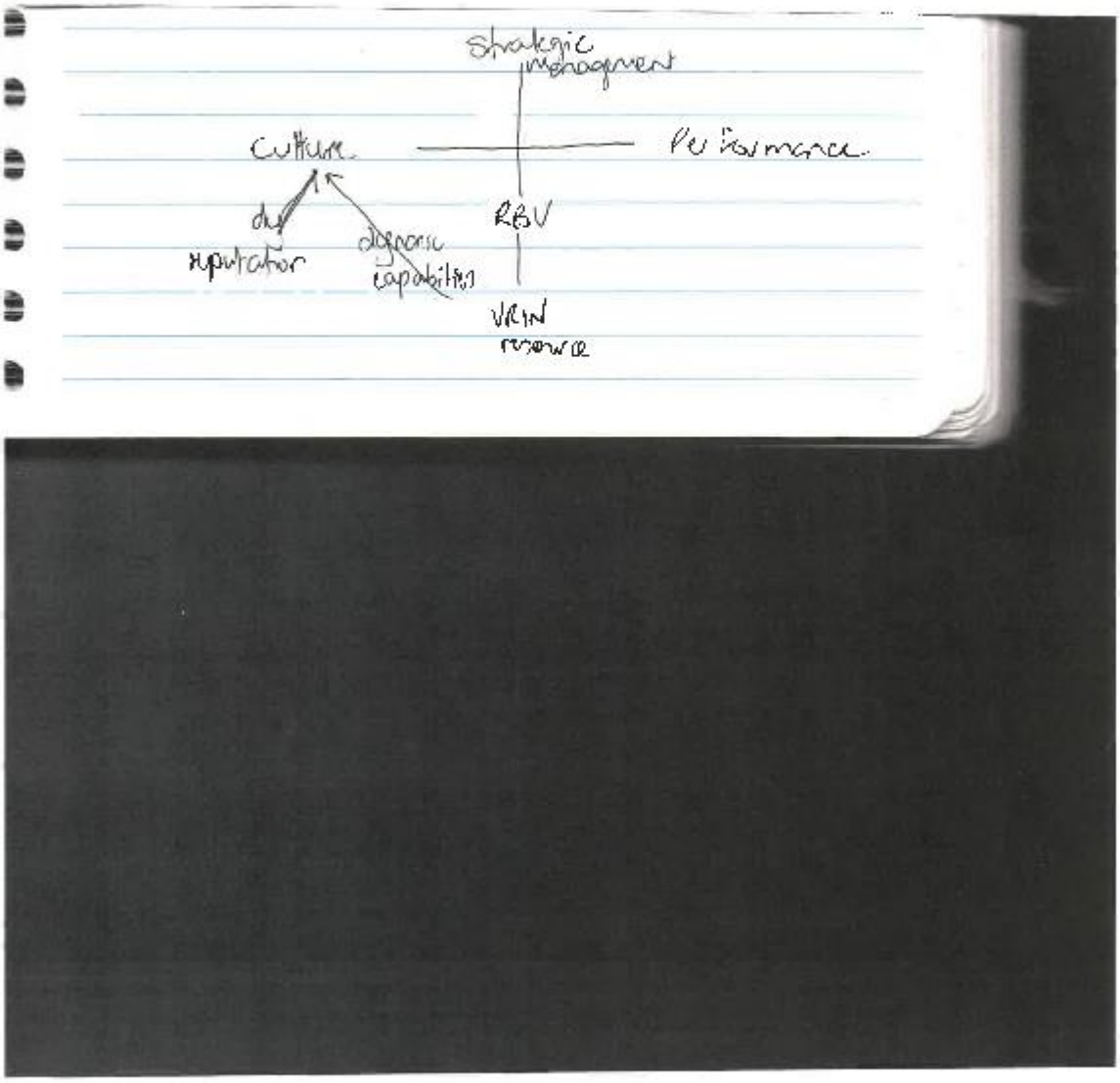
- customers know reputation perceptions of org rather than public that need them most

- customers changes behavioral intentions - re use service than general public

- customers more likely to communicate positive word of mouth & negative
- difference influenced by customers degree of satisfaction

APPENDIX I: CONCEPTUAL DRAWINGS



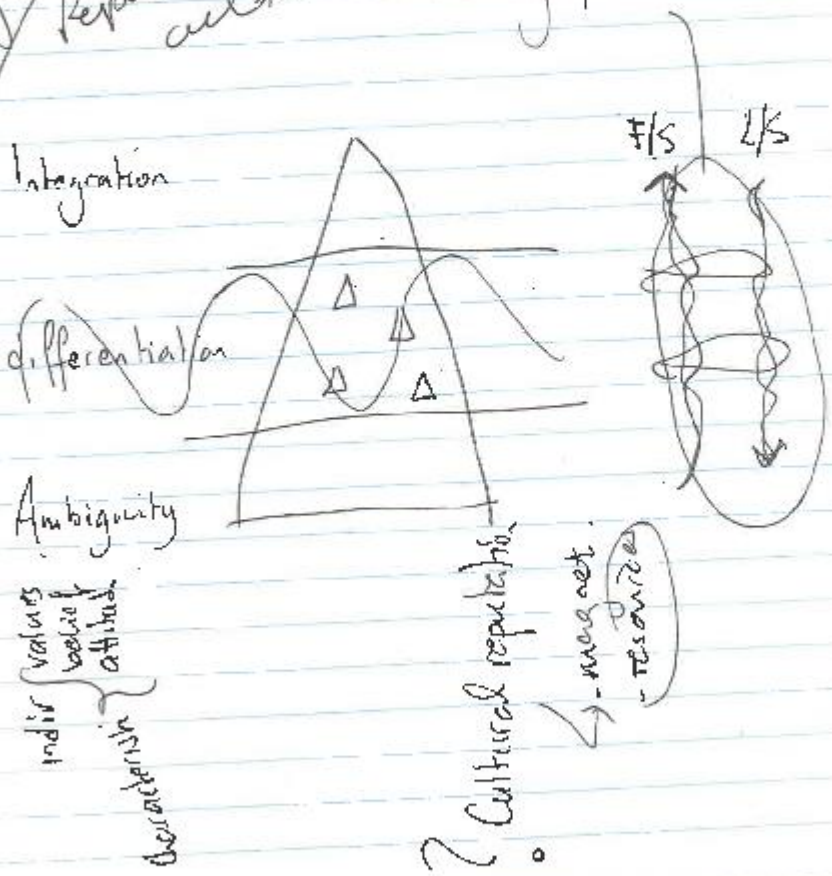

Strategic management
Culture
Performance
RBV
dy
reputation
dynamic capabilities
VRIN resources

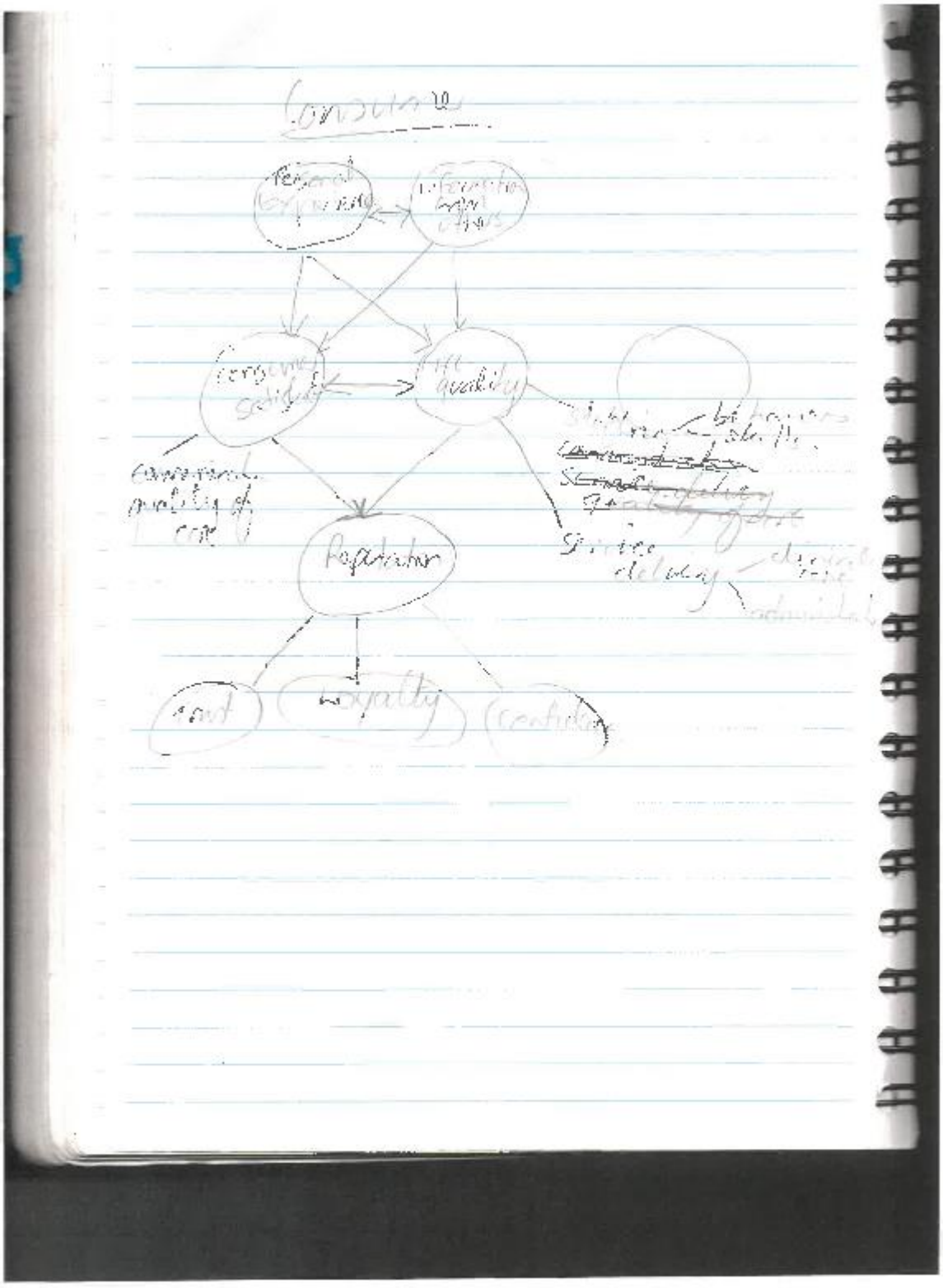
reputation related to behavioral patterns

Rep. → Behavioral patterns

Argument / Reputation is linked to culture.

gap.




Refactoring

APPENDIX J: STUDY ETHICS APPROVAL

Metro South Health

Enquiries to: Metro South Human Research Ethics Committee
Phone: 07 3443 8049
Fax: 07 3443 8003
HREC Ref: HREC/18/QPAH/318
E-mail: MSH-Ethics@health.qld.gov.au

Mrs Jennifer Kosiol
International Business and Asian Studies
Griffith University

Dear Mrs Kosiol,

HREC Reference number: HREC/18/QPAH/318
Protocol title: Perceptions of reputation: An exploratory mixed methods examination of the application of resource-based-view in public hospitals in Australia.

Thank you for submitting the above research protocol to the Metro South Health Human Research Ethics Committee for ethical and scientific review. This protocol was considered by the Low Risk Review Panel and will be ratified at the next Metro South HREC meeting.

You are reminded that this letter constitutes ethical approval only. You must not commence this research protocol at a site until separate authorisation from the Hospital Health Service Chief Executive (CE) or Delegate of that site has been obtained.

A copy of this approval must be submitted to the Research Governance Office(r)/Delegate of the relevant institution with a completed Site Specific Assessment (SSA) Form for authorisation from the CE or Delegate to conduct this research at the Princess Alexandra Hospital, Logan Hospital and Redlands Hospital.

If this study currently receives grant funding, please remember to forward a copy of this approval letter to the relevant Grants Office of the Administering Institution(s) for the grant.

I am pleased to advise that the Low Risk Review Panel of the HREC has granted approval of this research protocol. The documents reviewed and approved include:

Document	Version	Date
Low or Negligible Risk Application AU/10/6CC537		19/04/2018
Cover Sheet		n.d
NHMRC Human Research Ethics Application ID JK00768		08/05/2018
CCS Booking Email		27/04/2018
Information Sheet – Interviews: Metro South Health		n.d
Information Sheet – Survey: Metro South Health		n.d
Research – Frontline Staff Participation Needed: Metro South Health		n.d
Research – Senior Manager Participation Needed: Metro South Health		n.d
Research – Participation Needed: Metro South Health		n.d
Consent Form: Metro South Health		n.d
Protocol (as rec'd)		n.d
CV for Investigators		n.d
Email Correspondence – Support from Metro South Sites		13/07/2018
Formal Letter addressing LRRP Concersns		12/07/2018
Email Correspondence in respect to LRRP concerns		27/07/2018

This HREC approval is valid from 30/07/2018 until 30/07/2021

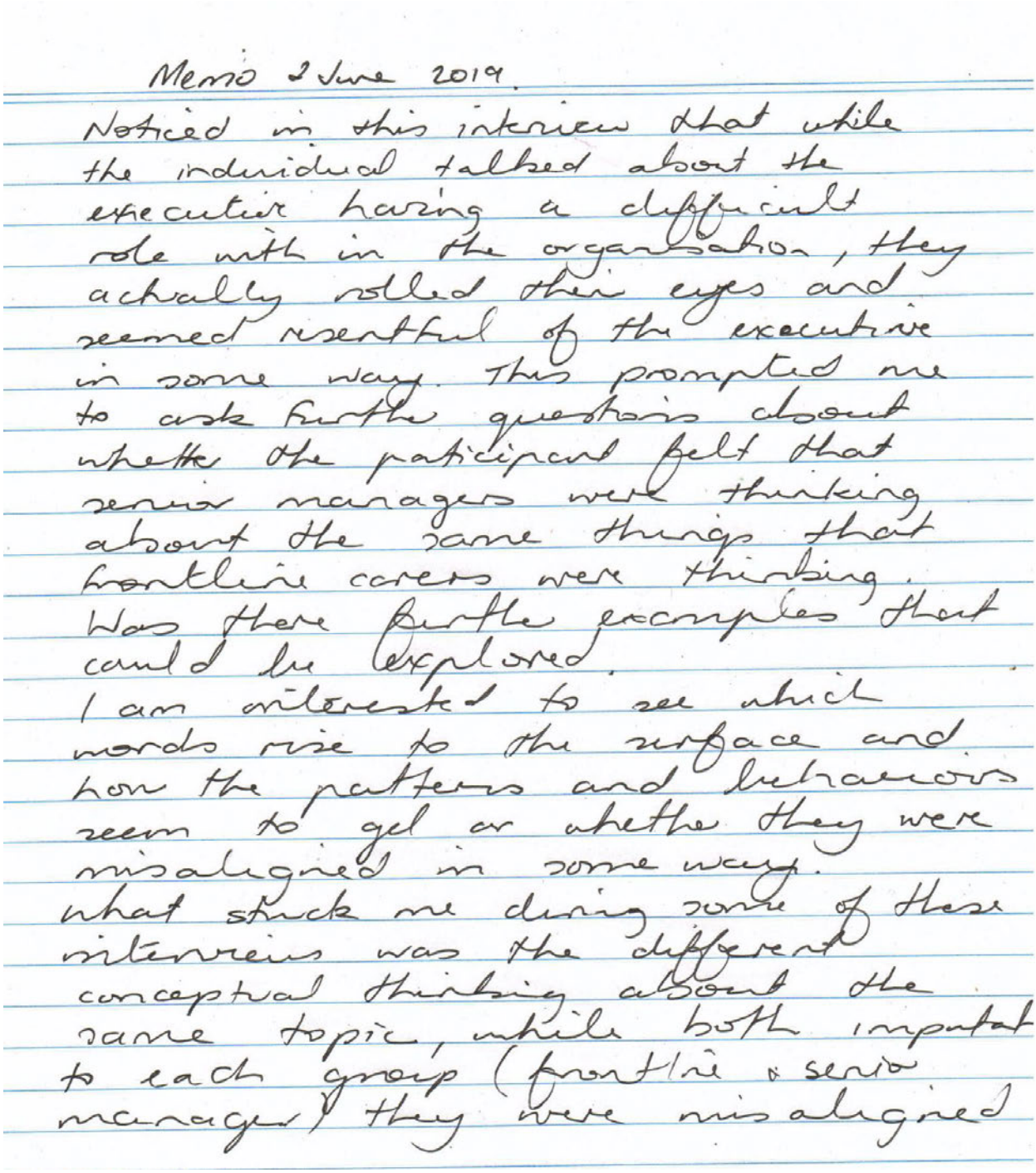
Please note the following conditions of approval:

Queensland Government

APPENDIX K: DOCUMENTS

- **Department of Health Strategic Plan 2019–2023** – outlining the States healthcare strategy and provides information on the alignment of these strategies with local health services. Includes the core values and objectives upheld by the Department of Health.
- **Health Service Strategic Plan 2019–2023** – local health service strategic plan provided information on the strategy of the health service, its alignment with the Department of Health strategy and the values and objectives the health service is seeking to achieve in the future.
- **Health Service Staff Survey 2016-2018** – a cultural stakeholder engagement survey which provides information on the perceived culture of the organisation, the perception of reputation and perceived performance in achieving goals.
- **The Australian Medical Association Queensland 2018 and 2020 Resident Hospital Health Check Survey –** this survey evaluates the state of Junior Medical Officer employment in Queensland, and subsequently compares hospitals across the state.
- **Hospital and Health Service Annual Report 2017-2018 –** provides information on the performance of the health service, the objectives achieved and the recognised areas for improvement.
- **The Queensland Cabinet and Ministerial Directory Media Statement June 13 2017 -** Advancing health service delivery through workforce: A strategy for Queensland 2017-2026 released, providing strategies on workforce improvement.
- **Hospital and Health Service publications 2018 –** media forms from the health service through the health service website and Facebook site. Providing information on reputation building strategies.
- **Australian Institute of Health and Welfare My Hospitals 2019 –** website providing information on Hospital and Health Service performance, benchmarked against other health services across Australia.
- **Local newspapers**, which contributed to reputational value by reporting on Hospital and Health Service issues and provided an opportunity for analysis.

APPENDIX L: MEMO – FIELD OBSERVATIONS



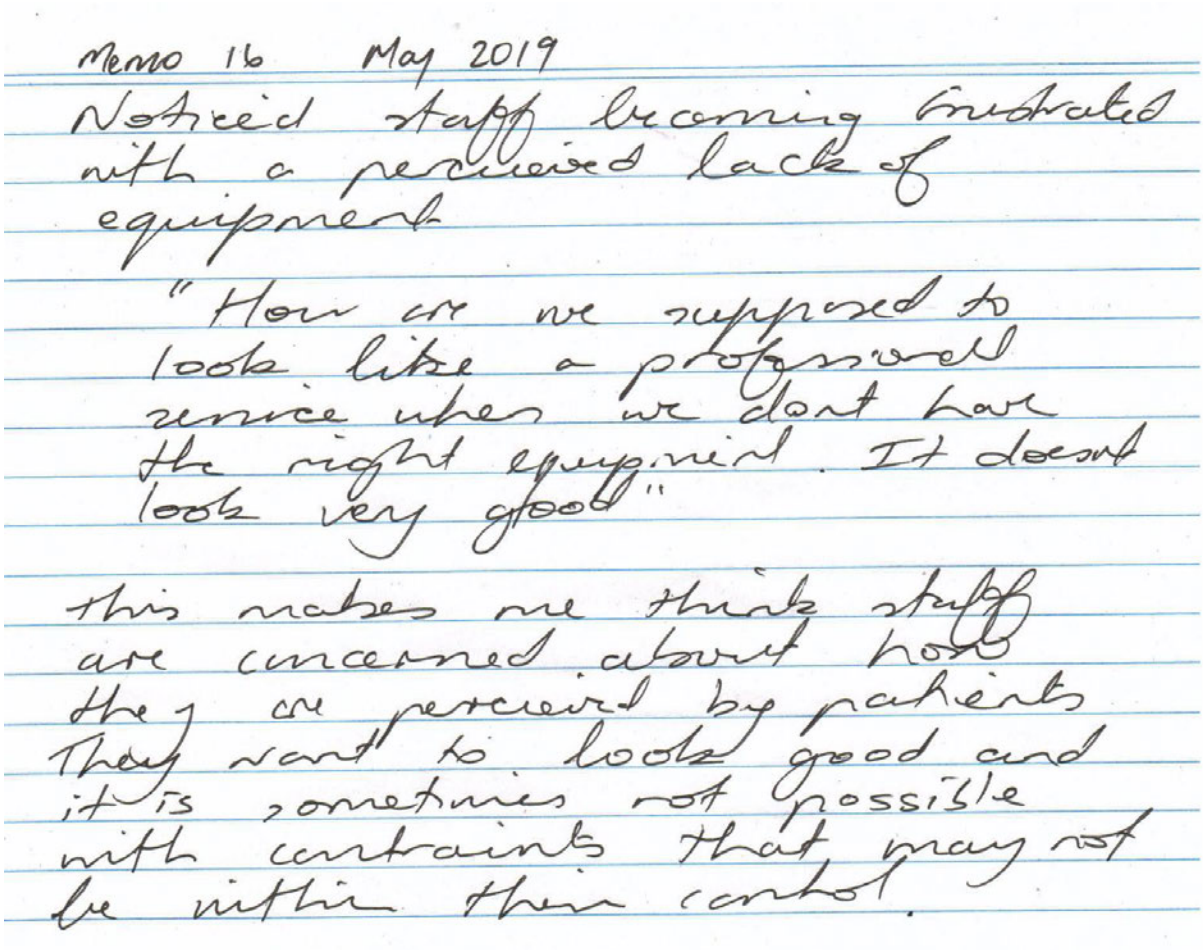
Memo 2 June 2019.

Noticed in this interview that while the individual talked about the executive having a difficult role with in the organisation, they actually rolled their eyes and seemed resentful of the executive in some way. This prompted me to ask further questions about whether the participant felt that senior managers were thinking about the same things that frontline carers were thinking. Was there further examples that could be explored.

I am interested to see which words rise to the surface and how the patterns and behaviours seem to gel or whether they were misaligned in some way.

What struck me during some of these interviews was the different conceptual thinking about the same topic, while both important to each group (frontline & senior managers) they were misaligned

APPENDIX M: JOURNAL REFLECTION MEMO FOLLOWING OBSERVATION



Memo 16 May 2019

Noticed staff becoming frustrated with a perceived lack of equipment

"How are we supposed to look like a professional service when we dont have the right equipment. It doesnt look very good"

this makes me think staff are concerned about how they are perceived by patients They want to look good and it is sometimes not possible with contraints that may not be within their control.

APPENDIX N: LEVEL 6 CODES

Level 6 Refinement Reputational codes	
Culture	Communication
decision making	Culture reputation link
Reputation and consumer choice	Reputation definition
Good leaders	Care
Good will	reputation has value
hierarchical levels	Services offered by facility
How to build reputation	Support
Influence work choice	Team
Leadership	Values
Manage reputation	what consumers want

APPENDIX O: NVIVO SEARCH QUERY

Reputation and culture relationship

In Folder	References	Coverage
Files	3	0.77%
Files\\Community	3	0.68%
Files\\Community	9	0 99%
Files\\Community	2	0.80%
Files\\Community	3	0.78%
Files\\Community	2	0 29%
Files\\Community	7	2.32%
Files\\Community	4	1.61%
Files\\Community	3	1 24%
Files\\Community	3	1.53%
Files\\Community	3	1.44%
Files\\Community	3	1.59%
Files\\Community	2	0 99%
Files\\Community	2	1.05%
Files\\Documents	5	0.12%
Files\\Documents	2	0.05%
Files\\Documents	1	0.02%
Files\\Documents	37	0.03%
Files\\Frontline staff	25	0.84%
Files\\Frontline staff	29	1.58%
Files\\Frontline staff	23	1.56%
Files\\Frontline staff	37	1.53%
Files\\Frontline staff	25	1.54%
Files\\Frontline staff	11	1.13%
Files\\Frontline staff	18	1.31%
Files\\Frontline staff	32	0.76%
Files\\Frontline staff	36	0 92%
Files\\Frontline staff	24	1.53%
Files\\Frontline staff	10	1.03%
Files\\Frontline staff	8	2.55%
Files\\Frontline staff	14	1.47%
Files\\Frontline staff	17	0.79%
Files\\Transcripts Senior Managers	1	0.08%
Files\\Transcripts Senior Managers	42	2.31%
Files\\Transcripts Senior Managers	45	0.86%
Files\\Transcripts Senior Managers	28	2.61%
Files\\Transcripts Senior Managers	36	1.30%

Files\\Transcripts Senior Managers	31	1.70%
Files\\Transcripts Senior Managers	14	0.62%
Files\\Transcripts Senior Managers	40	0.67%
Files\\Transcripts Senior Managers	36	0 92%
Files\\Transcripts Senior Managers	24	1.53%
Files\\Transcripts Senior Managers	35	0.72%
Files\\Transcripts Senior Managers	32	0.76%
Files\\Transcripts Senior Managers	31	1.70%
Files\\Transcripts Senior Managers	37	1.53%
Files\\Transcripts Senior Managers	41	1.16%

References

Abernethy, M. A., & Chua, W. F. (1996). A field study of control system "redesign": the impact of institutional processes on strategic choice. *Contemporary Accounting Research, 13*(2), 569-606. https://doi.org/10.1111/j.1911-3846.1996.tb00515.x

Abito, J. M., Besanko, D., & Diermeier, D. (2019). *Corporate reputation and social activism: Strategic interaction, firm behavior, and social welfare.* Oxford University Press. https://doi:10.1093/oso/9780199386154.001.0001

Adeosun, L. P. K., & Ganiyu, R. A. (2013). Corporate reputation as a strategic asset. International *Journal of Business and Social Science, 4*(2). https://doi:10.30845/jbss

Agarwal, J., & Osiyevskyy, O. (2019). Does country really matter? Exploring the contextual effect of individual self-construal in reaping the relational benefits of customer-based reputation. In D. L. Deephouse, N. A. Gardberg & W. Newburry (Eds.) (pp. 95-125), *Global Aspects of Reputation and Strategic Management*. Emerald Publishing Limited. https://doi:10.1108/S1064-485720190000018005

Agarwal, J., Stackhouse, M., & Osiyevskyy, O. (2018). I love that company: Look how Ethical, Prominent, and Efficacious it Is—A Triadic Organizational Reputation (TOR) Scale. *Journal of Business Ethics, 153*(3), 889-910. https://doi:10.1007/s10551-016-3421-2

Aksak, E., Ferguson, M. A., & Atakan Duman, S. (2016). Corporate social responsibility and CSR fit as predictors of corporate reputation: A global perspective. *Public Relations Review, 42*(1), 79-81. https://doi:10.1016/j.pubrev.2015.11.004

Al-Amin, A. Q., Filho, W. L., & Kabir, M. A. (2018). The challenges of sustainability in business: How governments may ensure sustainability for offshore firms. *Technological and Economic Development of Economy, 24*(1), 108-140. https://doi:10.3846/20294913.2015.1075442

Alexander, J (2001) Context and lead-up to health reform. In A. Bloom (Ed.). *Health Reform in Australia and New Zealand.* (pp. 161-77) Oxford University Press.

Alharahsheh, H., & Pius, A. (2020). A review of key paradigms: Positivism vs Interpretivism. *Global Academic Journal of Humanities and Social Sciences, 2*(3), 39-43. https://gajrc.com/gajhss

Allaire, Y., & Firsirotu, M. E. (1984). Theories of organizational culture. *Organization studies, 5*(3), 193-226. https://doi.org/10.1177/017084068400500301

Alniacik, E., Alniacik, U., & Erdogmus, N. (2012). How do the dimensions of corporate reputation affect employment intentions? *Corporate Reputation Review, 15*(1), 3-http://19. doi:10.1057/crr.2011.25

Alsop, R. J. (2004). Corporate reputation: anything but superficial–the deep but fragile nature of corporate reputation. *Journal of Business Strategy*, *25*(6), 21-29. https://doi:10.1108/02756660410699900

Alvarado-Vargas, M.J. (2013) *The mediating effect of innovation on the relationship between corporate reputation and performance in US firms*. (Doctoral Dissertation) [Florida International University] Florida University Digital Commons. http://digitalcommons.fiu.edu/etd/927

Alvesson, M. (1987). Organizations, Culture, and Ideology. *International Studies of Management & Organization*, *17*(3), 4-18. http://www.jstor.org/stable/40397067

Alvesson, M. (1993). *Cultural perspectives on organizations*. Cambridge University Press.

Alvesson, M. (2002) *Understanding organizational culture.* Sage Publications.

Alvesson, M., & Berg, P., (1992). *Corporate culture and organizational symbolism: An overview.* Walter de Gruyter.

Alvesson, M., & Sandberg, J. (2014). Habitat and habitus: Boxed-in versus box-breaking research. *Organization Studies*, *35*(7), 967-987. https://doi:10.1177/0170840614530916

Alvesson, M., & Sveningsson, S. (2008). *Changing organizational culture: Cultural change work in progress.* Routledge.

Alvesson, M., & Sveningsson, S. (2015). *Changing organizational culture: Cultural change work in progress*. Routledge.

Ambady, N., Koo, J., Rosenthal, R., & Winograd, C. H. (2002). Physical therapists' nonverbal communication predicts geriatric patients' health outcomes. *Psychology and Aging*, *17*(3), 443. https://doi.org/10.1037/0882-7974.17.3.443

American Nurses Credentialing Centre (2020). *ANCC Magnet Recognition Program*. Retrieved January 15, 2020 from https://www.nursingworld.org/organizational-programs/magnet/

Aminu Yusuf, N., Mustaffa, C. S., & Mohamad, B. (2018). External perception of organisational culture and customer based corporate reputation: The mediating role of transparent communication. *The Journal of Social Sciences Research*, (SPI6), 638-645.https:// doi:10.32861/jssr.spi6.638.645

Anderson, J., & Smith, G. (2006*).* A great company can be a great investment. *Financial Analysts Journal*, *62*(4), 86-93.https:// doi:10.2469/faj.v62.n4.4189.

Anderson, E. & Weitz, B. (1989), "Determinants of continuity in conventional industrial channel dyads", *Marketing Science*, *8*(4), 310-323. https://doi/abs/10.1287/mksc.8.4.310

Andrews, R., Beynon, M. J., & McDermott, A. M. (2016). Organizational capability in the public sector: A configurational approach. *Journal of Public Administration Research and Theory*, *26*(2), 239-258. https://doi.org/10.1093/jopart/muv005

Andrews-Speed, P. (2016). Applying institutional theory to the low-carbon energy transition. *Energy Research & Social Science*, *13*, 216-225. https://doi:10.1016/j.erss.2015.12.011

Araujo, R., Santos, G., Costa, J. B. d., & Sá, J. C. (2019). The quality management system as a driver of organizational culture: An empirical study in the Portuguese textile industry. *Quality Innovation Prosperity, 23*(1), 1. https://doi:10.12776/qip.v23i1.1132

Argyris, C. & Schön, D. (1978) *Organizational Learning: A Theory of Action*. Addison-Wesley.

Arpey, N. C., Gaglioti, A. H., & Rosenbaum, M. E. (2017). How socioeconomic status affects patient perceptions of health care: a qualitative study. *Journal of Primary Care & Community Health, 8*(3), 169-175. https://doi/full/10.1177/2150131917697439

Arrow, K. (1963). *Uncertainty and the Welfare Economics of Medical Care. 53 American Economic Review,* Columbia University Press.

Ausserhofer, D., Schubert, M., Desmedt, M., Blegen, M. A., De Geest, S., & Schwendimann, R. (2013*).* The association of patient safety climate and nurse-related organizational factors with selected patient outcomes: a cross-sectional survey. *International journal of nursing studies*, *50*(2), 240-252. https://doi.org/10.1016/j.ijnurstu.2012.04.007

Australian Bureau of Statistics (2016) *National, State and Territory Information*. (202006) Retrieved February 27, 2020 from https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release.

Australian Commission (2017). *The National Safety and Quality Health Service Standards*. Retrieved March 3, 2020 from https://www.safetyandquality.gov.au/standards/nsqhs-standards.

Australian Healthcare and Hospitals Association (2016). *Affordability and equity must be balanced against competition, contestability and choice in human services*. Retrieved from https://ahha.asn.au/news/affordability-and-equity-must-be-balanced-against-competition-contestability-and-choice-human.

Australian Institute of Health and Welfare (2019). *Health Expenditure Australia 2017-18*. Canberra: AIHW. https://doi: /5ec5ba12ed174

Australian Institute of Health and Welfare (2020). *Australia's hospitals at a glance 2018-19.* Retrieved February 27, 2020 from https://www.aihw.gov.au/reports/hospitals/australias-hospitals-at-a-glance-2018-19/contents/summary

Australian Medical Association (2017) *Media Release: Australia's Public Hospitals in a Constant State of Emergency due to Funding Shortfalls, AMA Public Hospital Report Card*. Retrieved February 17, 2017 from https://ama.com.au/media/public-hospitals-state-emergency

Australian Medical Association (2017). *Annual Report 2017*. Retrieved September 17, 2017 from https://ama.com.au/sites/default/files/annual-report/AMA%20AR1718%20Online_FA.pdf.

Babbie, E. R. (2016). *The practice of social research* (14th ed.). Cengage Learning.

Babić-Hodović, V., & Arslanagić-Kalajdžić, M. (2019). Perceived Corporate Reputation and Pride as Drivers of Frontline Employees' Reputation Impact Awareness: Mediating role of job satisfaction. *Market, 31*(2), 171-185. https://www.ceeol.com/search/article-detail?id=820904

Baer, M. D., Bundy, J., Garud, N., & Kim, J. K. (2018). The benefits and burdens of organizational reputation for employee well-being: A conservation of resources approach. *Personnel Psychology, 71*(4), 571-595. https:// doi/abs/10.1111/peps.12276

Bailey, B., Benson, A. J., & Bruner, M. W. (2019). Investigating the organisational culture of CrossFit. *International Journal of Sport and Exercise Psychology*, *17*(3), 197-211. https:// doi/abs/10.1080/1612197X.2017.1329223

Balthazard, P. A., Cooke, R. A., & Potter, R. E. (2006). Dysfunctional culture, dysfunctional organization: Capturing the behavioural norms that form organizational culture and drive performance. *Journal of Managerial Psychology*, *21*(8), 709-732. https://doi:10.1108/02683940610713253

Barnett, M. L., Jermier, J. M., & Lafferty, B. A. (2006). Corporate reputation: The definitional landscape. *Corporate reputation review*, *9*(1), 26-38. https://doi. 10.1057/palgrave.crr.1550012

Barney, J. B. (1989). Asset stocks and sustained competitive advantage: A comment. *Management science, 35*(12), 1511-1513. https:// doi/abs/10.1287/mnsc.35.12.1511

Barney, J. (1991). Firm resources and sustained competitive advantage. Journal of Management, *17*(1), 99-120.

Barney, J. B. (2001). Resource-based theories of competitive advantage: A ten-year retrospective on the resource-based view. *Journal of Management*, *27*(6), 643-650. https:// doi/abs/10.1287/mnsc.35.12.1511

Barney J. B., & Arikan A.M., (2001) The Resource-based view: Origins and implications In M. A. Hitt, R. E. Freeman & J. S. Harrison(Eds) *The Blackwell Handbook of Strategic Management* (pp. 124–188) Blackwell Publishers. https://doi/book/10.1111/b.9780631218616.2006.x#page=194

Barney, J. B. & Clark, D. N. (2007) *Resource-based theory: Creating and sustaining competitive advantage*. Oxford University Press.

Barney, J.B., Ketchen, Jr. D.J., & Wright, M. (2011). The Future of Resource-Based Theory: Revitaliszation or Decline? *Journal of Management.* Vol. *37*(5), pp. 1299-1315. https:// doi/abs/10.1177/0149206310391805

Bartunek, J. M., & Moch, M. K. (1991). Multiple constituencies and the quality of working life - intervention at FoodCom. P. J. Frost, L. F. Moore, M. R. Louis, C.C.

Lundberg & J. Martin (Eds.), *Reframing Organizational Culture*, (pp. 104-114). Sage Publications.

Basdeo, D. K., Smith, K. G., Grimm, C. M., Rindova, V. P., & Derfus, P. J. (2006). The impact of market actions on firm reputation. *Strategic Management Journal*, *27*(12), 1205-1219. https://doi:10.1002/smj.556

Belasen, A. R., & Belasen, A. T. (2018). Dual effects of improving doctor-patient communication: Patient satisfaction and hospital ratings. *Health Economics Journal.* http://dx.doi.org/10.2139/ssrn.3096056

Bell, R., & Krivich, M. J. (2000). How to use patient satisfaction data to improve healthcare quality. *Journal for Health care Quality. 23*(4), 45. https://journals.lww.com/jhqonline/Citation/2001/07000/How_to_Use_Patient_Satisfaction_Data_to_Improve.16.aspx

Bellot, J. (2011). Defining and assessing organizational culture. *Nursing Forum, 46*(1), 29–37. https://doi:10.1111/j.1744-6198.2010.00207.x

Bennett, C. C. (2009). A healthier future for all Australians: An overview of the final report of the National Health and Hospitals Reform Commission. *Medical Journal of Australia, 191*(7), 383-387. https://doi:10.5694/j.1326-5377.2009.tb02845.x

Bennett, C. C. (2013). Are we there yet? A journey of health reform in Australia. *Medical Journal of Australia, 199*(4), 251-255. https://doi:10.5694/mja13.10839

Bergh, D. D., Ketchen, D. J., Boyd, B. K., & Bergh, J. (2010). New frontiers of the Reputation—Performance relationship: Insights from multiple theories. *Journal of Management, 36*(3), 620-632. https://doi:10.1177/0149206309355320

Bettenhausen, K., & Murnighan, J. K. (1985). The emergence of norms in competitive decision-making groups. *Administrative science quarterly*, *30*(3), 350-372. https://doi.org/10.2307/2392667

Beyari, H., & Abareshi, A. (2016). The conceptual framework of the factors influencing consumer satisfaction in social commerce. *The journal of developing areas*, *50*(6), 365-376. https://doi. 10.1353/jda.2016.0139

Boateng, H., & Okoe, A. F. (2015). Consumers' attitude towards social media advertising and their behavioural response. *Journal of Research in Interactive Marketing. 9*(4), 299-312. https://doi/10.1108/JRIM-01-2015-0012/full/html?fullSc=1&mbSc=1

Boeije, H. (2010). Analysis in Qualitative Research. *A journal for Language and Learning. 26*(2), 90-91. https://dx.doi.org/10.5785/26-2-24

Bogdan, R. & Biklen, S. (1982). *Qualitative research for education*. Boston: Allyn & Bacon.

Boivie, S., Graffin, S. D., & Gentry, R. J. (2016). Understanding the direction, magnitude, and joint effects of reputation when multiple actors' reputations collide. *Academy of Management Journal*, *59*(1), 188-206. https://doi:10.5465/amj.2014.0521

Boyd, B. K., Bergh, D. D., & Ketchen Jr, D. J. (2010). Reconsidering the reputation—performance relationship: A resource-based view. *Journal of Management*, *36*(3), 588-609. https:// doi/abs/10.1177/0149206308328507

Braithwaite, J., Hyde, P., Pope, C., & Palgrave, M. (2010). *Culture and climate in health care organizations*. Basingstoke, Palgrave Macmillan.

Braithwaite, J., Herkes, J., Ludlow, K., Testa, L., & Lamprell, G. (2017). Association between organisational and workplace cultures, and patient outcomes: Systematic review. *BMJ Open*, *7*(11), e017708-e017708. https://doi:10.1136/bmjopen-2017-017708

Braithwaite, J. & Westbrook, MT (2005). Rethinking clinical organisational structures: an attitude survey of doctors, nurses and allied health staff in clinical directorates. *Journal of Health Services Research and Policy*, *10*(1), pp. 10–7. https:// doi/abs/10.1177/135581960501000105

Brammer S., & Pavelin, S. (2006). Voluntary Environmental Disclosures by Large UK Companies. *Journal of Business Finance & Accounting*, *33*(7-8), 1168–1188. https:// doi/abs/10.1111/j.1468-5957.2006.00598.x

Breitinger, D., & Bonardi, J. P. (2019). Firms, breach of norms, and reputation damage. *Business & Society*, *58*(6), 1143-1176. https:// doi/abs/10.1177/0007650317695531

Brinkmann, S., & Kvale, S. (2018). *Doing interviews.* SAGE Publications Ltd. https://doi:10.4135/9781529716665

Briody, C., Rubenstein, L., Roberts, L., Penney, E., Keenan, W., & Horbar, J. (2018). Review of attacks on health care facilities in six conflicts of the past three decades. *Conflict and Health*, *12*(1), 19-19. https://doi:10.1186/s13031-018-0152-2

Bromley, D. B. (2001). Relationships between personal and corporate reputation. *European Journal of Marketing. 35*(3-4), 316-334. https:// doi/10.1108/03090560110382048

Brown, A. (2020). Communication and leadership in healthcare quality governance findings from comparative case studies of eight public hospitals in Australia. *Journal of Health Organization and Management*, *34*(2), 144-161. https://doi:10.1108/JHOM-07-2019-0194

Brown, A. D. (1998). *Organisational culture* (2nd ed.). Pitman.

Brown, B., & Perry, S. (1994). Removing the financial performance halo from fortune's "most admired" companies. *Academy of Management Journal*, *37*(5), 1347-1359. https://doi:10.2307/256676

Bruhn, J. G. (2001). *Trust and the Health of Organizations.* Springer Science and Business Media.

Brydon-Miller, M., Kral, M., Maguire, P., Noffke, S., Sabhlok, A., Denzin, N. K., & Lincoln, Y. S. (2011). *The SAGE handbook of qualitative research* (4th ed.). Sage Publications.

Bryman, A. (2016). *Social research methods* (5th ed.). Oxford University Press.

Bryson, J. M., Ackerman, F., & Eden, C. (2007). Putting the resource-based view of strategy and distinctive competence to work in public organizations. *Public Administration Review, 67*(4), 702-17. https://doi.org/10.1111/j.1540-6210.2007.00754.x

Burke, R. J., Martin, G., & Cooper, C. L. (Eds.). (2011). *Corporate reputation*. Gower.

Buse, K., Mays, N., & Walt, G. (2012). *Making health policy*. McGraw-hill education.

Bustaman, H. A., Mohd nor, M. N., Taha, A. Z., & Zakaria, M. (2020). Job seeker attraction to organizational justice mediated by organizational reputation. *Cogent Psychology, 7*(1). https://doi:10.1080/23311908.2020.1816255

Butler, T. (1998). Towards a hermeneutic method for interpretive research in information systems. *Journal of Information Technology, 13*, 285-300. https://doi. 10.1057/jit.1998.7

Byrkjeflot, H., & du Gay, P. (2012). Bureaucracy: An idea whose time has come (again)? *Sociology of organisations, 35,* 85-109. https://doi:10.1108/S0733-558X(2012)0000035006

Cable, D. M., & Graham, M. E. (2000). The determinants of job seekers' reputation perceptions. *Journal of Organizational Behavior, 21*(8), 929-947. https://doi:10.1002/1099-1379(200012)21:8<929::AID-JOB63>3.0.CO;2-O

Çakır, T., Özmen, A., & Doğan, İ. (2014). The Relationship Between Employees Perceptions Towards Sectoral Reputation and Corporate Reputation In Health Care Institutions and the effective Factors. *Journal of Yaşar University, 9*(33), 6083-6098. https://journal.yasar.edu.tr/wp-content/uploads/2014/04/15_Vol9_NO34_T.-%C3%87AKIR_A.-%C3%96ZMEN_-%C4%B0.-DO%C4%9EAN.pdf

Caliskan, E., Icke, B., & Ayturk, Y. (2011). Corporate reputation and financial performance: evidence from Turkey. *Research Journal of International Studies, 18*(1), 61-72. https:// doi:10.1057/crr.2011.3

Callan, V. J., Gallois, C., Mayhew, M. G., Grice, T. A., Tluchowska, M., & Boyce, R. (2007). Restructuring the multi-professional organization: professional identity and adjustment to change in a public hospital. *Journal of Health and Human Services Administration, 29*(4), 448-477. https://www.jstor.org/stable/25790703

Carmeli, A., Gilat, G., & Weisberg, J. (2006). Perceived external prestige, organizational identification and affective commitment: A stakeholder approach. *Corporate Reputation Review, 9*(2), 92-104. https://doi:10.1057/palgrave.crr.1550014

Carpenter, J., Doverspike, D., & Miguel, R. F. (2012). Public service motivation as a predictor of attraction to the public sector. *Journal of Vocational Behavior, 80*(2), 509-523. https://doi.org/10.1016/j.jvb.2011.08.004

Carson, D., Gilmore, A., Perry, C., & Gronhaug, K. (2001). *Qualitative marketing research* (1st ed.). Sage Publications.

Castellano, S., & Dutot, V. (2017). Investigating the influence of e-word-of-mouth on e-reputation. *International Studies of Management & Organization*, *47*(1), 42-60. https://doi.org/10.1080/00208825.2017.1241088

Carter, S. M., & Dukerich, J. M. (1997). Part VI: How should reputations be managed in good times and bad times?: Corporate reputation and its effect on organizational actions: How reputations are managed. *Corporate Reputation Review, 1*(2), 152-156. https://doi:10.1057/palgrave.crr.1540036

Chao, D., Yu, N., Liu, Y., & Lin, T. (2016). The effect of healthcare word-of-mouth and behavioral status on improving patient self-management: 1-on-1 interviews with volunteers regarding their own experiences. *Diabetes Research and Clinical Practice*, *120*, 152-153. https://doi:10.1016/S0168-8227(16)31321-3.

Chapleo, C. (2004). Interpretation and implementation of Reputation/Brand management by UK university leaders. *International Journal of Educational Advancement*, *5*(1), 7-23. https://doi:10.1057/palgrave.ijea.2140201.

Charmaz, K. (2000). *Grounded theory: Objectivist and constructivist methods*. In N. K. Denzin and Y. S. Lincoln (Eds.*), Handbook of Qualitative Research* (2nd ed., pp. 509–536). Sage Publications.

Christensen, T., & Lodge, M. (2018). Reputation management in societal security: A comparative study. The American Review of Public Administration, *48*(2), 119-132.

Chun, R. (2005). Corporate reputation: Meaning and measurement. International *Journal of Management Reviews, 7*(2), 91-109. https://doi:10.1111/j.1468-2370.2005.00109.x.

Chun, R., Argandoña, A., Choirat, C., & Siegel, D. S. (2019). Corporate Reputation: Being Good and Looking Good. *Business & Society*, *58*(6), 1132-1142. https://doi.org/10.1177/0007650319826520

Cian, L., & Cervai, S. (2014). Under the reputation umbrella: An integrative and multidisciplinary review for corporate image, projected image, construed image, organizational identity, and organizational culture. *Corporate Communications*, *19*(2), 182-199. https://doi:10.1108/CCIJ-10-2011-0055.

Clardy, A. (2012). Organizational reputation: Issues in conceptualization and measurement. *Corporate Reputation Review*, *15*(4), 285-303. https://doi:10.1057/crr.2012.17.

Clarke, A., & MacDonald, A. (2019). Outcomes to partners in multi-stakeholder cross-sector partnerships: A resource-based view. Business & Society, 58(2), 298-332. https://doi.org/10.1177/0007650316660534

Clegg, S., Kornberger, M., & Pitsis, T., (2005). *Managing and organizations: An introduction to theory and practice* (4th ed.). Sage Publications.

Commonwealth of Australia (1993) *Independent Committee of Inquiry into Competition Policy in Australia*, *National Competition Policy* (1993) (Hilmer Committee Report). Australian Government. https://www.australiancompetitionlaw.org/reports/1993hilmer.html

Commonwealth of Australia (2003). *Australia's National Competition Policy: Its Evolution and Operation*. Retrieved February 20, 2020 from https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/Publications_Archive/archive/ncpebrief.

Commonwealth of Australia (2006). The Blame Game: Report on the inquiry into health funding. House of Representatives Standing Committee on Health and Ageing. [Report November 2006] Australian Government. https://www.aph.gov.au/parliamentary_business/committees/House_of_Representatives_Committees?url=haa/./healthfunding/report.htm

Commonwealth of Australia (2009). *A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission*. (Final Report 2009) Australian Government. https://apo.org.au/sites/default/files/resource-files/2009-07/apo-nid17921.pdf

Commonwealth of Australia (2010). *A National Health and Hospitals Network for Australia's Future - Delivering better health and better hospitals*. [Paper based publication]. https://apo.org.au/sites/default/files/resource-files/2010-03/apo-nid20570.pdf

Commonwealth of Australia (2011). National Health Reform Amendment (National Health Performance Authority) [Bills Digest no. 86 2010–11] Australian Government. https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/bd/bd1011a/11bd086

Commonwealth of Australia (2014). *The Report of the National Commission of Audit: Towards a Responsible Government. Australian Government,* National Commission of Audit.

Commonwealth of Australia (2015). *Competition Policy Review Final Report (Harper Review 2015*).Media & Publications. https://www.australiancompetitionlaw.org/reports/2015harper-report.html#report

Commonwealth of Australia (2018). *Recent developments in federal government funding for public hospitals: a quick guide.* Retrieved February 20, 2020 from https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1819/Quick_Guides/FundingPH

Commonwealth of Australia (2019). *The Australian Health System*. Retrieved February 20, 2020 from https://www.health.gov.au/about-us/the-australian-health-system.

Commonwealth of Australia (2020). *Economic Recovery Plan for Australia. Guaranteeing the Essential Services.* [Budget 2020/21] Media and Publications. https://budget.gov.au/202021/content/download/glossy_guaranteeing_essentials.pdf.

Commonwealth of Australia (2020a). *Steering Committee for the Review of Government Service Provision.* Retrieved February 20, 2020 from https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/health/public-hospitals.

Coombs, W. T. (2007). Protecting organization reputations during a crisis: The development and application of situational crisis communication theory. *Corporate reputation review*, *10*(3), 163-176. https://doi. 10.1057/palgrave.crr.1550049

Coombs, W. T., & Holladay, S. J. (2009). Further explorations of post-crisis communication: Effects of media and response strategies on perceptions and intentions. *Public Relations Review*, *35*(1), 1-6. https://doi.org/10.1016/j.pubrev.2008.09.011

Council of Australian Governments (2020). *About COAG*. Retrieved February 5, 2020 from https://www.coag.gov.au/about-coag.

Council of Australian Governments (2012), *National Healthcare Agreement 2012*, (Report No.A-2). Media and Publications. http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/healthcare_national-agreement.pdf

Council of Australian Governments (2020a). *The Federal Financial Relations Framework.* Retrieved 13 April, 2020 from https://www.coag.gov.au/federal-financial-relations

Corfield, A., & Paton, R. (2016). Investigating knowledge management: Can KM really change organisational culture*? Journal of Knowledge Management*, *20*(1), 88-103. https://doi:10.1108/JKM-12-2014-0502

Cravens, K. S., Oliver, E. G., & Perryman, A. A. (2014). Followers, likes, and page clicks–Oh my! A new frontier for social media in Western Europe. *Business Horizons*, *6*(57), 691-693. https://doi.10.1016/j.bushor.2014.06.005

Creswell, J. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches.* Sage Publications.

Creswell, J. W. (2013). *Steps in conducting a scholarly mixed methods study*. DBER Speaker Series. 48. https://digitalcommons.unl.edu/dberspeakers/48

Creswell, J. W. (2014*). Research design: Qualitative, quantitative, and mixed methods approaches.* (4th ed.). Sage Publications.

Creswell, J. W., & Clark, V. L. P. (2007). *Designing and conducting mixed methods research* (2nd ed.). Sage Publications.

Creswell, J. W., & Poth, C. (2018). Qualitative Inquiry and Research Design (4th ed.). Sage Publications.

Crook, T. R., Ketchen, D. J., Combs, J. G., & Todd, S. Y. (2008). Strategic resources and performance: A meta-analysis. Strategic Management Journal, 29(11), 1141-1154. https://doi.org/10.1002/smj.703

Crotty, M. (1998*). The foundations of social research: Meaning and perspective in the research process*. Sage Publications.

Crotty, M. (2003*). Research Design: qualitative, quantitative, and mixed methods approaches* (2nd ed.). Sage Publications.

Cruickshank, J. (2017). A tale of two ontologies: An immanent critique of critical realism. *The Sociological Review*, 52(4), 567-585. https://doi:10.1111/j.1467-954x.2004.00496.x

Cunliffe, A. L. (2011). Crafting qualitative research: Morgan and Smircich, 30 years on. *Organizational Research Methods*, *14*(4), 647-673. https://doi.org/10.1177/1094428110373658

Currall, S. C., & Towler, A. J. (2003). Research methods in management and organizational research: Toward integration of qualitative and quantitative techniques. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 513-526). Sage Publications.

Curry, L. A., Brault, M. A., Linnander, E. L., McNatt, Z., Brewster, A. L., Cherlin, E., & Bradley, E. H. (2018). Influencing organisational culture to improve hospital performance in care of patients with acute myocardial infarction: a mixed-methods intervention study. *BMJ quality & safety*, *27*(3), 207-217. http://dx.doi.org/10.1136/bmjqs-2017-006989

Cusack, L., Drioli-Phillips, P. G., Brown, J. A., & Hunter, S. (2019). Re-engaging concepts of professionalism to inform regulatory practices in nursing. *Journal of Nursing Regulation*, *10*(3), 21-27. https://doi.org/10.1016/S2155-8256(19)30144-9

Cutler (2015). *The case for competition in Australian healthcare*. Business Spectator. Retrieved February 10, 2020 from https://www.theaustralian.com.au/business/business-spectator/news-story/the-case-for-competition-in-australian-healthcare/4852f635888744b44a5fc063ea0b69b9

Czarniawaska-Joerges, B. (1992). *Exploring Complex Organisations: A Cultural Perspective*. Sage Publications.

Daley, A. M., Polifroni, E. C., & Sadler, L. S. (2019). The essential elements of adolescent-friendly care in school-based health centers: A mixed methods study of the perspectives of nurse practitioners and adolescents. *Journal of Pediatric Nursing*, *47*, 7-17. https://doi:10.1016/j.pedn.2019.03.005

Da Silva, R., & Batista, L. (2007). Boosting government reputation through CRM. *International journal of Public Sector Management, 20*(7), 588-607. https://doi.org/10.1108/09513550710823506

David, R. J., & Han, S. (2004). A systematic assessment of the empirical support for transaction cost economics. *Strategic Management Journal*, *25*(1), 39-58. https://doi:10.1002/smj.359

Davies, G., & Chun, R. (2009). The leader's role in managing reputation. *In Reputation Capital* (pp. 311-323). Springer, Berlin, Heidelberg. https://doi.org/10.1007/978-3-642-01630-1_21

Davies, H., Nutley, S., & Mannion, R. (2000). Organisational culture and quality of health care. *Quality in Health Care*, *9*, 111–119. http://dx.doi.org/10.1136/qhc.9.2.111

Davis, S.M. (1984), *Managing Corporate Culture*, Ballinger Publishing.

Davis, J. (2002). Forging ahead: Austin iron works hammers out a reputation for artistic utility. (growth strategies). *The Business Journal, 20*(22), 11.

Davis, S. T. (2016). *Solutions or legitimations? How the conceptualization of organizational identity shapes the social relevance of CSR initiatives in two Japanese corporations*. (pp. 67-98). Cham: Springer International Publishing. https://doi:10.1007/978-3-319-43536-7_4

Davis, M. V., Mahanna, E., Joly, B., Zelek, M., Riley, W., Verma, P., & Fisher, J. S. (2014). Creating quality improvement culture in public health agencies. *American Journal of Public Health, 104*(1), 98-104. https://doi:10.2105/AJPH.2013.301413.

Dayanç-Kıyat, B. (2019). Research on corporate reputation quotient and financial indicators in retail sector in Turkey. *Gaziantep University Journal of Social Sciences, 18*(1), 227-241. https://doi:10.21547/jss.472183.

Daymon, C. (2000). Culture formation in a new television station: A multi-perspective analysis. *British Journal of Management, 11*(2), 121-135. https://doi:10.1111/1467-8551.00155

Dedman, G., Nowak, M., & Klass, D. (2011). The dimensions of efficiency and effectiveness of clinical directors: perceptions of clinical directors and senior management in Western Australian public teaching hospitals. *The International Journal of Clinical Leadership, 17*(2), 61-71. https://espace.curtin.edu.au/bitstream/handle/20.500.11937/32310/162616_162616.pdf?sequence=2

Deephouse, D. L. (2000). Media reputation as a strategic resource: An integration of mass communication and resource-based theories. *Journal of management, 26*(6), 1091-1112. https://doi.org/10.1016/S0149-2063(00)00075-1

Deephouse, D. L., & Carter, S. M. (2005). An examination of differences between organizational legitimacy and organizational reputation. *Journal of Management Studies, 42*(2), 329-360. https://doi:10.1111/j.1467-6486.2005.00499.x.

Deephouse, D. L., & Carter, S. M. (2005). An examination of differences between organizational legitimacy and organizational reputation. *Journal of Management Studies, 42*(2), 329-360. https://doi:10.1111/j.1467-6486.2005.00499.x.

Deephouse, D., Gardberg, N., & Newburry, W. (2019). *Global aspects of reputation and strategic management.* Emerald Publishing Limited.

Degeling, P. & Carr, A. (2004). Leadership for systemization of health care: the unaddressed issue in health care reform. *Journal of Health Organization and Management, 18*(6), 399-414. https://doi:10.1108/14777260410569975.

Denison, D. R. (1984). Bringing corporate culture to the bottom line. *Organizational dynamics, 13*(2), 5-22. https://doi.org/10.1016/0090-2616(84)90015-9

Denison, D. R. (1990). *Corporate culture and organizational effectiveness*. Wiley.

Denison, D. R. (2012). *Leading culture change in global organizations: Aligning culture and strategy* (1st ed.). Jossey-Bass.

Dentchev, N. A., & Heene, A. (2003). Reputation management: Sending the right signal to the right stakeholder (No. 03/175). Ghent University, Faculty of Economics and Business Administration.

Dentchev, N. A., & Heene, A. (2004). Managing the reputation of restructuring corporations: Send the right signal to the right stakeholder. *Journal of Public Affairs*, *4*(1), 56-72. https://doi:10.1002/pa.171

Denzin, N. K. & Lincoln, Y.S. (1994) *Handbook of Qualitative Research*. Sage Publications.

Denzin, N. K., & Lincoln, Y. S. (2005). *The sage handbook of qualitative research* (3rd ed.). Sage Publications.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2011). *The Sage handbook of qualitative research*. Sage Publications.

De Quevedo-Puente, E., & Pérez-Cornejo, C. (2020). *Non-profit organization reputation and its role in success: Antecedents and effects.* (1st ed.). Routledge. https://doi:10.4324/9780429265419-7.

Deutsch, Y., & Ross, T. W. (2003). You are known by the directors you keep: Reputable directors as a signalling mechanism for young firms. *Management science*, *49*(8), 1003-1017. https://doi.org/10.1287/mnsc.49.8.1003.16399

Dijs-Elsinga, J., Otten, W., Versluijs, M. M., Smeets, H. J., Kievit, J., Vree, R., & Marang-van de Mheen, P. J. (2010). Choosing a hospital for surgery: The importance of information on quality of care. *Medical Decision Making*, *30*(5), 544-555. https://doi:10.1177/0272989x09357474.

DiMaggio, P. (1997). Culture and cognition. *Annual Review of Sociology*, *23*(1), 263-287. https://doi:10.1146/annurev.soc.23.1.263.

DiMaggio, P. J., & Powell, W. W. (1983). The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields. *American Sociological Review 48*(2), 147-160. https://doi.org/10.2307/2095101

Disken, S., Dixon, M., Halpern, G., & Shocket, G. (1990). *Models of clinical management.* Institute of Health Services Management.

DiStaso, M. W., McCorkindale, T., & Wright, D. K. (2011). How public relations executives perceive and measure the impact of social media in their organizations. *Public relations review*, *37*(3), 325-328. https://doi.org/10.1016/j.pubrev.2011.06.005

Dixon-Woods, M., Baker, R., Charles, K., Dawson, J., Jerzembek, G., Martin, G. & Willars, J. (2014). Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *BMJ quality & safety*, *23*(2), 106-115. http://dx.doi.org/10.1136/bmjqs-2013-001947

Dolan, P., & Connolly, J. (2018). Beyond logic and norms: A figurational critique of institutional theory in organisation studies. Cambio. *Rivista Sulle Trasformazioni Sociali*, *7*(14), 139-149. https://doi:10.13128/cambio-22915

Dolnicar, S., & Lazarevski, K. (2009). Methodological reasons for the theory/practice divide in market segmentation. *Journal of Marketing Managemen*t, *25*(3-4), 357-373. https://doi:10.1362/026725709X429791.

Doorley, J., & Garcia, H. F. (2020). *Reputation management: The key to successful public relations and corporate communication*. Routledge.

Dosi, G., Faillo, M., & Marengo, L. (2008). Organizational capabilities, patterns of knowledge accumulation and governance structures in business firms: An introduction. Organization Studies, 29(8-9), 1165-1185. https://doi.org/10.1177/0170840608094775

Dowling, G. R. (2016). *Winning the reputation game: Creating stakeholder value and competitive advantage*. MIT Press.

Dowling, G., & Moran, P. (2012). Corporate reputations: built in or bolted on? *California Management Review*, *54*(2), 25-42. https://doi.org/10.1525/cmr.2012.54.2.25

Drotz, E. & Poksinska, B. (2014), Lean in healthcare from employees' perspectives, *Journal of Health Organization and Management*, *28*(2), 177-195. https:// doi/10.1108/JHOM-03-2013-0066/full/html

Duckett, S., & Wilcox, S. (2015). *Australian health care system* (5th ed.). Oxford University Press.

Dukerich, J. M., & Carter, S. M. (2000) Distorted images and reputation repair, In M. Schultz, M. J. Hatch and M. H. Larsen (Eds.), *The Expressive Organization: Linking Identity, Reputation, and the Corporate Brand*, Oxford University Press.

Eagar, K., Sansoni, J., Loggie, C., Elsworthy, A., McNamee, J., Cook, R., & Grootemaat, P. (2013). A literature review on integrating quality and safety into hospital pricing systems. *Australian Health Services Research Institute*. https://ro.uow.edu.au/ahsri/385

Eberl, M., & Schwaiger, M. (2005). Corporate reputation: Disentangling the effects on financial performance. *European Journal of Marketing*, *39*(7/8), 838-854. https://doi:10.1108/03090560510601798

Eckert, C. (2017). Corporate reputation and reputation risk: Definition and measurement from a (risk) management perspective. *Journal of Risk Finance, 18*(2), 145-158. https://doi:10.1108/JRF-06-2016-0075

Einwiller, S. A., & Steilen, S. (2015). Handling complaints on social network sites – an analysis of complaints and complaint responses on Facebook and twitter pages of large US companies. *Public Relations Review*, *41*(2), 195-204. https://doi:10.1016/j.pubrev.2014.11.012

Eisenhardt, K. M., & Martin, J. A. (2000). Dynamic capabilities: What are they? Strategic Management Journal, 21(10/11), 1105-1121. https://doi.org/10.1002/1097-0266(200010/11)21:10/11<1105::AID-SMJ133>3.0.CO;2-E

Eldridge, J. E. T., & Crombie, A. D. (1974). *A sociology of organisations* (8th ed.). Allen and Unwin.

Eljiz, K. (2009). *Who really matters: A mixed methods investigation into interoccupational and professional dynamics when managing patient flow* [Unpublished doctoral dissertation]. University of Western Sydney.

Ely, M., Anzul, M., Freidman, T., Garner, D., & McCormack-Steinmetz, A. (1991). *Doing qualitative research: Circles within circles* (3rd ed.). Psychology Press.

Erlandson, D. A., Harris, E. L., Skipper, B. L., & Allen, S. D. (1993). *Doing naturalistic inquiry: A guide to methods*. Sage Publications.

Faber, M., Bosch, M., Wollersheim, H., Leatherman, S., & Grol, R. (2009). Public reporting in health care: how do consumers use quality-of-care information? A systematic review. *Medical care*, *47*(1), 1-8. https://www.jstor.org/stable/40221830

Falconer, D. J., & Mackay, D. R. (1999, December). *The key to the mixed method dilemma.* [Conference Paper]. 10th Australasian Conference on Information Systems. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.5.148&rep=rep1&type=pdf

Fandrejewska, A., & Wasilik, K. (2018). Cultural differences and barriers in communication and functioning of an international organisation. *Handel Wewnętrzny*, 1(372), 203-215. https://www.ceeol.com/search/article-detail?id=665491

Fang, L. H. (2005). Investment bank reputation and the price and quality of underwriting services. *The Journal of Finance*, *60*(6), 2729-2761. https://doi:10.1111/j.1540-6261.2005.00815.x

Feldman, S. S., Buchalter, S., & Hayes, L. W. (2018). Health information technology in healthcare quality and patient safety: literature review. *JMIR medical informatics*, *6*(2), e10264. https://doi:10.2196/10264

Ferlie, E. & Ongaro, E. (2015). *Strategic Management in Public Services Organizations: Concepts, Schools and Contemporary Issues*. Routledge.

Fetterman, D.F. (2010), *Ethnography: Step by Step* (3rd ed.). Sage Publications.

Fillis, I. (2003). Image, reputation and identity issues in the arts and crafts organization. *Corporate Reputation Review*, *6*(3), 239-251. https://doi:10.1057/palgrave.crr.1540203

Fischer, E., & Reuber, R. (2007). The good, the bad, and the unfamiliar: The challenges of reputation formation facing new firms. *Entrepreneurship theory and Practice*, *31*(1), 53-75. https://doi.org/10.1111/j.1540-6520.2007.00163.x

Fitzgerald, J. (2002). *Doctors and nurses working together: a mixed method study into the construction and changing of professional identities* [Unpublished doctoral dissertation]. University of Western Sydney.

Fitzgerald, L & Dufour, Y (1998), Clinical management as boundary management: a comparative analysis of Canadian and UK health-care institutions, *Journal of*

Management in Medicine, *12*(4/5), 199. https://doi.org/10.1108/09513559710156689

Fitzgerald, L & Ferlie, E (2000), Professionals: back to the future? *Human Relations*, *53*(5), 713–40. https://doi.org/10.1177/0018726700535005

Flanagan, D. J., & O'Shaughnessy, K. C. (2005). The Effect of Layoffs on Firm Reputation. *Journal of Management*, *31*(3), 445-463. https://doi.org/10.1177/0149206304272186

Flatt, S. J., & Kowalczyk, S. J. (2000). Do corporate reputations partly reflect external perceptions of organizational culture? *Corporate Reputation Review*, *3*(4), 351-358. https://doi:10.1057/palgrave.crr.1540125

Flatt, S. J., & Kowalczyk, S. J. (2006). Corporate reputation as a mediating variable between corporate culture and financial performance. [Academic paper] Reputation Institute Conference. Boston

Flatt, S. J., & Kowalczyk, S. J. (2008). Creating competitive advantage through intangible assets: The direct and indirect effects of corporate culture and reputation. *Journal of Competitiveness Studies*, *16*(1/2), 13-30. https://search.proquest.com/openview/9cc13a8cf0508134d48769632c3fd1f6/1?pq-origsite=gscholar&cbl=32907

Fombrun, C. J. (1996). *Reputation: Realizing Value from the Corporate Image*. Harvard Business School Press.

Fombrun, C. J. (2001). Corporate reputation–its measurement and management. *Thexis*, *18*(4), 23-26.

Fombrun, C. J., & van Riel, C. (2003). *Fame & fortune: How successful companies build winning reputations* (1st ed.). Pearson.

Fombrun, C. J., & Gardberg, N. (2000). Who's tops in corporate reputation? *Corporate Reputation Review*, *3*(1), 13-17. https://doi:10.1057/palgrave.crr.1540095.

Fombrun, C. J., Gardberg, N. A., & Server, J. W., (2000). The Reputation Quotient SM: A Multi-Stakeholder Measure of Corporate Reputation. *The Journal of Brand Management 7*(4), 241–255. https://doi:10.1057/bm.2000.10.

Fombrun, C. J., & Rindova, V. (1996). Who's tops and who decides? The social construction of corporate reputations. *New York University, Stern School of Business, Working Paper*, 5-13.

Fombrun, C., & Shanley, M. (1990). What's in a name? Reputation building and corporate strategy. *Academy of Management Journal*, *33*(2), 233-258. https://doi:10.2307/256324

Fombrun, C. J., & van Riel, C. (2003). *Fame & fortune: How the world's top companies develop winning reputations*. Pearson Education.

Fombrun, C. J., & van Riel, C. (1997). The reputational landscape. *Corporate Reputation Review*, *1*(1), 5-13. https://doi:10.1057/palgrave.crr.1540008

Foreman, J., & Argenti, P. A. (2005). How corporate communication influences strategy implementation, reputation and the corporate brand: an exploratory qualitative study. *Corporate Reputation Review*, *8*(3), 245-264. https://doi.org/10.1057/palgrave.crr.1540253

Foreman, P. O., Whetten, D. A., & Mackey, A. (2012). An identity-based view of reputation, image, and legitimacy: Clarifications and distinctions among related constructs. In M. L., Barnett, & T., G. Pollock, (Eds.) *The Oxford handbook of corporate reputation*. Oxford University Press. https://10.1093/oxfordhb/9780199596706.013.0009

Fredricks E. (2005). Infusing flexibility into business to business firms: A contingency theory and resource-based view perspective and practical implications. *Industrial Marketing Management. 34*(6), 555-565. https://doi.org/10.1016/j.indmarman.2004.09.022

Freidson, E. (2001). *Professionalism, the third logic: On the practice of knowledge*. University of Chicago press.

Fryxell, G. E., & Wang, J. (1994). The fortune corporate 'reputation' index: Reputation for what? *Journal of Management, 20*(1), 1-14. https://doi:10.1177/014920639402000101

Fu, Y., & Chan, T. (2014). A conceptual evaluation framework for organisational safety culture: An empirical study of Taipei Songshan Airport. *Journal of Air Transport Management, 34*, 101-108. https://doi:10.1016/j.jairtraman.2013.08.005

Fu, H., Li, Y., & Duan, Y. (2014). Does employee-perceived reputation contribute to citizenship behavior? *International Journal of Contemporary Hospitality Management*. *26*(4), 593-609. https://doi.org/10.1108/IJCHM-02-2013-0082

Fulop, L., & Day, G. E (2010). From leader to leadership: clinician managers and where to next? *Australian Health Review*. *34*(3), 344–351. https://doi. 10.1071/AH09763

Fulop, L., Linstead, S., & Clarke, R. J. (1999). *A critical text in Management.* Macmillan Publishers. https://doi.org/10.1007/978-1-349-15064-9

Gatzert, N. (2015). The impact of corporate reputation and reputation damaging events on financial performance: Empirical evidence from the literature. *European Management Journal, 33*(6), 485-499. https://doi:10.1016/j.emj.2015.10.001.

Gatzert, N., Schmit, J. T., & Kolb, A. (2016). Assessing the risks of insuring reputation risk. *Journal of Risk and Insurance*, *83*(3), 641-679. https://doi.org/10.1111/jori.12065

Gaynor, M., Moreno-Serra, R., & Propper, C. (2011). Competition in Healthcare: Competition could substantially benefit healthcare. *British Medical Journal, 343*, https://doi:10.1136/bmj.d4727

Geertz, C. (1973). *The interpretation of cultures: Selected essays.* Basic Books.

Gheorghe, C. M., Purcărea, V. L., & Gheorghe, I. R. (2018). Don’t cry over spilt milk: a review on consumer-based corporate reputation in private ophthalmology services.

Romanian Journal of Ophthalmology, *62*(3), 194. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6256079

Ghosh, K. (2017). Corporate reputation, social performance, and organizational variability in an emerging country perspective. *Journal of Management & Organization*, *23*(4), 545-565. https://doi.org/10.1017/jmo.2016.25

Gibbs, G. R. (2002). *Qualitative data analysis: Explorations with NVivo*. Open University Press.

Ginter, P. M., Duncan, & W. J. & Swayne, L.E. (2018). *Strategic management of health care organizations* (8th ed.). Wiley.

Gioia, D. A., Schultz, M., & Corley, K. G. (2000). Organizational identity, image, and adaptive instability. *Academy of Management Review*, *25*(1), 63. https://doi.org/10.5465/amr.2000.2791603

Glesne, C., & Peshkin, A. (1992). *Becoming qualitative researchers: An introduction*. (5th ed.) Pearson.

Glouberman, S., & Mintzberg, H. (2001a). Managing the care of health and the cure of disease—Part I: Differentiation. *Health care management review*, *26*(1), 56-69. https://doi:10.1097/00004010-200101000-00006

Glouberman, S., & Mintzberg, H. (2001b). Managing the care of health and the cure of disease—Part II: Integration. *Health care management review*, *26*(1), 70-84. https:// doi:10.1097/00004010-200101000-00007

Goddard, M. (2015). Competition in healthcare: Good, bad or ugly? *International Journal of Health Policy and Managemen*t, *4*(9), 567-569. https://doi:10.15171/ijhpm.2015.144

Gogheri, A. S., Nawaser, K., Vesal, S. M., Jahanshahi, A. A., & Kazi, R. (2013). Which organizational culture moves towards organizational excellency? *Asian Social Science*, *9*(11), 221-236. https://doi:10.5539/ass.v9n11p221

Golenko, X. (2017). *A Mixed Methods Approach to Investigating the Link Between Organisational Control Mechanisms and Organisational Culture in the Acute Sector of a Public Healthcare Organisation*. [Doctor of Philosophy Thesis. Griffith University] Griffith Business School. http://hdl.handle.net/10072/365741

Goldkuhl, G. (2012). Pragmatism vs interpretivism in qualitative information systems research. *European journal of information systems*, *21*(2), 135-146. https:// doi:10.1057/ejis.2011.54

González-Rodríguez, M. R., Martín-Samper, R. C., Köseoglu, M. A., & Okumus, F. (2019). Hotels' corporate social responsibility practices, organizational culture, firm reputation, and performance. *Journal of Sustainable Tourism*, *27*(3), 398-419. https://doi:10.1080/09669582.2019.1585441

Gotsi, M., & Wilson, A. M. (2001). Corporate reputation: Seeking a definition. *Corporate Communications*, *6*(1), 24-30. https://doi:10.1108/13563280110381189

Gotsi, M., & Wilson, A. (2001a). Corporate reputation management: "living the brand". *Management Decision*, *39*(2), 99-104. https://doi:10.1108/eum0000000005415

Grant, J., Parry, Y., & Guerin, P. (2013). An investigation of culturally competent terminology in healthcare policy finds ambiguity and lack of definition. *Australian and New Zealand Journal of Public Health*, *37*(3), 250-256. https://doi:10.1111/1753-6405.12067

Grant J, Parry Y, Guerin P. (2016). An investigation of culturally competent terminology in healthcare policy finds ambiguity and lack of definition. *Australian and New Zealand Journal Public Health. 37*(3), 250-256. https:// doi:10.1111/1753-6405.12067

Gray, E. R., & Balmer, J. M. T. (1998). Managing corporate image and corporate reputation. *Long Range Planning*, *31*(5), 695-702. https://doi:10.1016/s0024-6301(98)00074-0

Green, J. C., & Griesinger, D. W. (1996). Board performance and organizational effectiveness in non-profit social services organizations. *Non-profit Management & Leadership*, *6*(4), 381-402. https://doi:10.1002/nml.4130060407

Greenhalgh, T. (2004). Meta-narrative mapping: a new approach to the systematic review of complex evidence. In B. Hurtwitz, T. Greenhalgh, & V. Skultans (Eds.), *Narrative Research in Health and Illness*, (pp. 349-381) Blackwell Publishing.

Greenhalgh, T, Humphrey, C, Hughes, J, Macfarlane, F, Butler, C & Pawson, R (2009), How do you modernize a health service? A realist evaluation of whole-scale transformation in London, *Milbank Quarterly*, *87*(2), 391-416. https://doi:10.1111/j.1468-0009.2009.00562.x

Grieb, S. D., Eder, M., Smith, K. C., Calhoun, K., & Tandon, D. (2015). Qualitative research and community-based participatory research: Considerations for effective dissemination in the peer-reviewed literature. *Progress in Community Health Partnerships*, *9*(2), 275-282. https://doi:10.1353/cpr.2015.0041

Griffith University (2020). *Griffith University Research Ethics Manual.* Griffith University.

Grunig, J. E. & Hunt, T. (1984), *Managing Public Relations.* Harcourt Brace Jovanovich College.

Guan, Y., Roter, D. L., Erby, L. H., Wolff, J. L., Gitlin, L. N., Roberts, J. S., & Christensen, K. D. (2018). Communication predictors of patient and companion satisfaction with Alzheimer's genetic risk disclosure. *Journal of health communication*, *23*(8), 807-814. https:// doi:10.1080/10810730.2018.1528319

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K., Denzin (Ed.) *Handbook of qualitative research*, (Vol. 2 pp.163-194), Sage Publications.

Hall, J. (2015). Australian Health Care — The Challenge of Reform in a Fragmented System. *New England Journal of Medicine*, *373*(6), 493-497. https://doi:10.1056/NEJMp1410737

Hall, R. (1992). The strategic analysis of intangible resources. *Strategic Management Journal*, *13*(2), 135-144. https://doi:10.1002/smj.4250130205

Hall, J. A., & Dornan, M. C. (1990). Patient sociodemographic characteristics as predictors of satisfaction with medical care: a meta-analysis. *Social science & medicine*, *30*(7), 811-818. https:// doi:10.1016/0277-9536(90)90205-7

Hall, E.H. and Lee, J. (2014), Assessing the impact of firm reputation on performance: an international point of view, *International Business Research*. *7*(12), 1-13. http://dx.doi.org/10.5539/ibr.v7n12p1

Hallier, J., & Forbes, T. (2005). The role of social identity in doctors' experiences of clinical managing, *Employee Relations*, *27*(1), 47–70. https:// doi:10.1108/01425450510569300

Hammersley, M., & Atkinson, P. (2019). *Ethnography: Principles in practice* (4th ed.). Routledge. https://doi:10.4324/9781315146027

Harding, A., & Preker, A. S. (2003). *Innovations in Health Service Delivery. The Corporatization of Public Hospitals*. The World Bank.

Harris, M. G. (2006). *Managing health services: Concepts and practice* (2nd ed.). Elsevier Australia.

Harris, K., & Buntin, M. (2008, May). *Choosing a health care provider: the role of quality information.* (Report No. 14) Robert Wood Johnson Foundation. http://hdl.handle.net/10244/612

Härtel, C. E., & Ashkanasy, N. M. (2011). *The handbook of organizational culture and climate.* Sage Publications.

Hatch, M. J. (1993). The dynamics of organizational culture. *Academy of Management Review*, *18*(4), 657-693. https:// doi:10.2307/258594

Hatch, M. J., & Schultz, M. (2000). Scaling the tower of babel: relational differences between identity, image, and culture in organizations. In M., Schultz, & M., Hatch, & L. M. Holten (Eds.), *The Expressive Organization*, (pp. 11-35). Oxford University Press.

Hatch, M. J., & Schultz, M. (2004). *Organizational identity: A reader*. Oxford University Press.

Heng, S., Meyer, T., & Stobbe, A. (2007). Implications of Web 2.0 for financial institutions: Be a driver, not a passenger. *Deutsche Bank Research E-conomic*s, *63*, 1-11. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1003973

Herbig, P., & Milewicz, J. (1997). The relationship of reputation and credibility to brand success. *Pricing Strategy and Practice*, *5*(1), 25-29. https:// doi:10.1108/07363769510795697

Hewitt, J. E. (2018). National competition policy and Australia's health care system: A look at the policy landscape with new eyes. *Journal of Law and Medicine, 26*(1), 103-127. https://core.ac.uk/download/pdf/161812788.pdf

Hibbard, J. H., Stockard, J., & Tusler, M. (2005). Hospital performance reports: impact on quality, market share, and reputation. *Health affairs*, *24*(4), 1150-1160. https:// doi:10.1377/hlthaff.24.4.1150

Höflinger, P. J., Nagel, C., & Sandner, P. (2018). Reputation for technological innovation: Does it actually cohere with innovative activity? *Journal of Innovation & Knowledge, 3*(1), 26-39. https://doi:10.1016/j.jik.2017.08.002

Hofstede, G. (1984). *Culture's consequences: International differences in work-related values*. Sage Publications.

Hofstede, G. (2016). Attitudes, values and organizational culture: Disentangling the concepts. *Organization Studies, 19*(3), 477-493. https://doi:10.1177/017084069801900305

Hope, C., & Mühlemann, A. (1997). *Service operations management: Strategy, design, and delivery*. Prentice Hall.

Horn, I. S., Taros, T., Dirkes, S., Hüer, L., Rose, M., Tietmeyer, R., & Constantinides, E. (2015). Business reputation and social media: A primer on threats and responses. *Journal of direct, data and digital marketing practice, 16*(3), 193-208. https:// doi:10.1057/dddmp.2015.1

Houghton, C, Casey, D, Shaw, D & Murphy, K (2013). Rigour in qualitative case-study research, *Nurse Researcher*. *20*(4), 12-17. https:// doi:10.7748/nr2013.03.20.4.12.e326

Howe, K., & Eisenhart, M. (1990). Standards for qualitative (and quantitative) research: A prolegomenon. *Educational Researcher, 19*(4), 2–9. https:// doi:10.3102/0013189X019004002

Hyett, N., Kenny, A., & Dickson-Swift, V. (2014). Methodology or method? A critical review of qualitative case study reports. *International Journal of Qualitative Studies on Health and Well-being, 9*(1), 23606-23606. https://doi:10.3402/qhw.v9.23606

Iwu-Egwuonwu, P. C. (2011), Corporate Reputation & Firm Performance: Empirical Literature Evidence, *International Journal of Business and Management*. *6*(4), 197-204.

Jacobs, R., Mannion, R., Davies, H. T., Harrison, S., Konteh, F., & Walshe, K. (2013). The relationship between organizational culture and performance in acute hospitals. Social Science & Medicine, 76, 115-125. https://doi:10.1016/j.socscimed.2012.10.014

Jaramillo, J. & Srikant, R. (2010). A game theory based reputation mechanism to incentivize cooperation in wireless ad hoc networks. *Ad Hoc Networks, 8*(4), 416-429. https://doi.org/10.1016/j.adhoc.2009.10.002

Jaworski, B. J. & Kohli, A. K., (1993). Market orientation: antecedents and consequences. *Journal of Marketing, 57*(3), 53-70. https://doi:10.1177/002224299305700304

Jensen, M., Schultz, M., Fombrun, C. J., Pollock, T. G., Olegario, R., Morris, T., Elsbach, K. D. (2012). *Show me the money: A multidimensional perspective on reputation as an intangible asset*. Oxford University Press. https://doi:10.1093/oxfordhb/9780199596706.013.0002.

Johansson, P., Oléni, M., & Fridlund, B. (2002). Patient satisfaction with nursing care in the context of health care: a literature study. *Scandinavian Journal of Caring Sciences, 16*(4), 337-344. https://doi:10.1046/j.1471-6712.2002.00094.x

Jung, K., Feldman, R., & Scanlon, D. (2011). Where would you go for your next hospitalization? *Journal of Health Economics, 30*(4), 832-841. https://doi:10.1016/j.jhealeco.2011.05.006.

Jung, T., Scott, T., Huw T. O. Davies, Bower, P., Whalley, D., McNally, R., & Mannion, R. (2009). Instruments for exploring organizational culture: A review of the literature. *Public Administration Review, 69*(6), 1087-1096. https://doi:10.1111/j.1540-6210.2009.02066.x.

Kane, R. L., Shamliyan, T., Mueller, C., Duval, S., & Wilt, T. J. (2007). Nurse staffing and quality of patient care. *Evidence report/technology Assessment (Full R*eport), *(151),* 1-115.

Kansal, M., Joshi, M., & Batra, G. S. (2014). Determinants of corporate social responsibility disclosures: Evidence from India. *Advances in Accounting, 30*(1), 217-229. https://doi:10.1016/j.adiac.2014.03.009

Kanungo, S., & Jain, V. (2013). Organizational culture and E-government performance: An empirical study. *International Journal of Electronic Government Research 7*(2), 36-58. https://doi:10.4018/jegr.2011040103

Kappos, A., & Rivard, S. (2008). A three-perspective model of culture, information systems, and their development and use. *Management Information Systems Quarterly, 32*(3), 601-634. https://doi:10.2307/25148858

Kassing, J. W. (2002). Speaking up: Identifying employees' upward dissent strategies. *Management Communication Quarterly, 16*(2) 187-209. https://doi:10.1177/089331802237234

Kaur, A., & Singh, B. (2020). Disentangling the reputation – performance paradox: Indian evidence. *Journal of Indian Business Research, 12*(2), 153-167. https://doi:10.1108/JIBR-02-2018-0081.

Kelley, K. J., Hemphill, T. A., & Thams, Y. (2019). Corporate social responsibility, country reputation and corporate reputation: A perspective on the creation of shared value in emerging markets. *Multinational Business Review, 27*(2), 178-197. https://doi:10.1108/MBR-07-2017-0047

Kellermanns, F., Walter, J., Crook, T. R., Kemmerer, B., & Narayanan, V. (2016). The resource-based view in entrepreneurship: A content-analytical comparison of researchers' and entrepreneurs' views. Journal of Small Business Management, 54(1), 26-48. https://doi.org/10.1111/jsbm.12126

Kıdak, L. B., & Aksaraylı, M. (2008). Appraising and monitoring the satisfaction level of inpatients: an application in an education & research hospital. *Social Sciences, 10*(3), 87-122. http://www.acarindex.com/dosyalar/makale/acarindex-1423874648.pdf

Kietzmann, J. H., Hermkens, K., McCarthy, I. P., & Silvestre, B. S. (2011). Social media? Get serious! Understanding the functional building blocks of social media. *Business Horizons, 54*(3), 241-251. https://doi:10.1016/j.bushor.2011.01.005

Kim, S. (2019). The process model of corporate social responsibility (CSR) communication: CSR communication and its relationship with consumers' CSR knowledge, trust, and corporate reputation perception. *Journal of Business Ethics, 154*(4), 1143-1159. https://doi:10.1007/s10551-017-3433-6

Kippist, L & Fitzgerald, A. (2009). Organisational professional conflict and hybrid clinician managers. *Journal of Health Organization and Management, 23*(6). https://doi:10.1108/14777260911001653

Klein, P. G., Mahoney, J. T., McGahan, A. M., & Pitelis, C. N. (2010). *Resources, capabilities, and routines in public organizations.* Social Science Research Network.

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice, 24*(1), 120-124. https://doi:10.1080/13814788.2017.1375092

Kotter, J. P., & Heskett, J. L. (1992). *Corporate culture and performance*. Free Press.

Kowalczyk, S. J., & Pawlish, M. J. (2002). Corporate branding through external perception of organizational culture. *Corporate Reputation Review, 5*(2-3), 159-174. https://doi:10.1057/palgrave.crr.1540172

Kraaijenbrink, J., Spender, J. -., & Groen, A. J. (2010). The resource-based view: A review and assessment of its critiques. SAGE Publications. https://doi.org/10.1177/0149206309350775

Kreiner, K., & Schultz, M. (1995). Soft cultures: The symbolism of cross-border organizing. *Studies in Cultures, Organizations and Societies, 1*(1), 63-81. https://doi:10.1080/10245289508523446

Krupski, R. (2012). Study of the importance of intangible resources in the company's strategy. In: A. Kaleta and M. Moszkowicz (Eds.). *Strategic management in practice and theory*. Wrocław University of Economics.

Kuhn, L., & Woog, R. (2005). Vortical postmodern ethnography: Introducing a complexity approach to systemic social theorizing. *Systems Research and Behavioral Science: The Official Journal of the International Federation for Systems Research, 22*(2), 139-150. https://doi:10.1002/sres.681

Kummerow, E., & Kirby, N. (2014). *Organisational Culture: Characteristics of Good Workers.* World Scientific.

Kuoppakangas, P. (2015). Decision-making and choice in the adoption of a municipal enterprise form in public healthcare organisations-reasoning, goals, legitimacy and core dilemmas. Unpublished. https://doi:10.13140/rg.2.1.3544.8409

Kuoppakangas, P., Suomi, K., Stenvall, J., Pekkola, E., Kivistö, J., & Kallio, T. (2019). Revisiting the five problems of public sector organisations and reputation management—the perspective of higher education practitioners and ex-academics.

International Review on Public and Non-profit Marketing, 16(2), 147-171. https://doi:10.1007/s12208-019-00223-5

Kvale, S. (1996). The 1,000-page question. *Qualitative Inquiry*, *2*(3), 275-284. https://doi:10.1177/107780049600200302

Lang, T. A., Hodge, M., Olson, V., Romano, P. S., & Kravitz, R. L. (2004). Nurse–patient ratios: a systematic review on the effects of nurse staffing on patient, nurse employee, and hospital outcomes. *The Journal of Nursing Administration, 34*(7), 326-337. https://doi:10.1097/00005110-200407000-00005

Lange, D., Lee, P. M., & Dai, Y. (2011). Organizational reputation: A review. *Journal of Management, 37*(1), 153-184. https://doi:10.1177/0149206310390963

Latta, G. F. (2019). A complexity analysis of organizational culture, leadership and engagement: Integration, differentiation and fragmentation. *International Journal of Leadership in Education. 23*(3), 1-26. https://doi:10.1080/13603124.2018.1562095

Lee, J., & Jungbae Roh, J. (2012). Revisiting corporate reputation and firm performance link. *Benchmarking: An International Journal, 19*(4/5), 649-664. https://doi:10.1108/14635771211258061

Le Grand, J. (2009). *The other invisible hand: Delivering public services through choice and competition*. Princeton University Press.

Leijerholt, U., Biedenbach, G., & Hultén, P. (2019). Branding in the public sector: A systematic literature review and directions for future research. *The Journal of Brand Management, 26*(2), 126-140. https://doi:10.1057/s41262-018-0116-2

Leijerholt, U., Chapleo, C., & O'Sullivan, H. (2019). A brand within a brand: An integrated understanding of internal brand management and brand architecture in the public sector. *The Journal of Brand Management, 26*(3), 277-290. https://doi:10.1057/s41262-018-0128-y

Leonard, D. L. (2017). *Exploring Customer Service Through Hospital Management Strategies.* (Doctoral Dissertation) [Walden University] Walden Dissertations and Doctoral Studies. https://scholarworks.waldenu.edu/dissertations/3700

Levers, L. L. (2012). *Trauma counselling: Theories and interventions* (1st ed.). Springer Publications.

Lewellyn, P. G. (2002). Corporate reputation: Focusing the Zeitgeist. *Business & Society, 41(*4), 446-455. https://doi:10.1177/0007650302238777.

Lichterman, P. (2017). Interpretive reflexivity in ethnography. Ethnography, 18(1), 35-45. https://doi.org/10.1177/1466138115592418

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. Sage Publications.

Lincoln, J. R. & A. L. Kalleberg. (1990). *Culture, control, and commitment: A study of work organization and work attitudes in the United States and Japan.* Cambridge University Press.

Linstead, S., Lilley, S., & Fulop, L. (2004). *Management and organization: A critical text.* Palgrave Macmillan.

Lofland, J., & Lofland, L. H. (1995). *Analyzing Social Settings: A Guide to Qualitative Observation and Analysis* (4th ed.). Wadsworth/Thomson Learning.

Lok, P., Rhodes, J., & Westwood, B. (2011). The mediating role of organizational subcultures in health care organizations. *Journal of Health Organization and Management, 25*(5), 506-525. https://doi:10.1108/14777261111161860

Lordanides, G., Tsakiridou, H., & Balasi, A. (2015). Greek primary schools' organisational culture: An empirical study. *Leading and Managing, 21*(1), 86-104 https://doi:10.415239894904718;res=IELHSS

Louis, M. R. (1985). An investigator's guide to workplace culture. In P. J. Frost, L. F. Moore, M. R. Louis, & J. Martin (Eds.), *Organizational culture (*pp. 73–94). Sage Publications.

Love, E. G., & Kraatz, M. (2009). Character, conformity, or the bottom line? How and why downsizing affected corporate reputation. *Academy of Management Journal, 52*(2), 314-335. https://doi:10.5465/amj.2009.37308247

Lowndes, V., Marsh, D., & Stoker, G. (2017). Theory and methods in political science. Macmillan Education.

Lubalin, J. S., & Harris-Kojetin, L. D. (1999). What do consumers want and need to know in making health care choices? *Medical Care Research and Review, 56*(1_suppl), 67-102. https://doi:10.1177/107755899773743873

Luoma-aho, V. (2007). Neutral reputation and public sector organizations. *Corporate Reputation Review, 10*(2), 124-143. https://doi:10.1057/palgrave.crr.1550043

Luoma-aho, V. L., & Makikangas, M. E. (2014). Do public sector mergers (re) shape reputation? *International Journal of Public Sector Management*, 27(1), 39-52 https://doi/10.1108/IJPSM-09-2012-0120/full/html

Luxford, K., Safran, D. G., & Delbanco, T. (2011). Promoting patient-centred care: A qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving the patient experience. *International Journal for Quality in Health Care, 23*(5), 510-515. https://doi:10.1093/intqhc/mzr024

Ma, C., Olds, D. M., & Dunton, N. E. (2015). Nurse work environment and quality of care by unit types: A cross-sectional study. *International Journal of Nursing Studies, 52*(10), 1565-1572.

MacIntosh, E.W. & Doherty, A. (2010). The influence of organizational culture on job satisfaction and intention to leave. *Sport Management Review, 13*(2) pp. 106-117. https://doi.org/10.1016/j.smr.2009.04.006

Maddern J, Courtney M, Montgomery J, & Nash R. (2006) Strategy and Organisational Design in Healthcare. In Harris MG (Ed.) *Managing Health Services – Concepts and practice.* (2nd ed. pp. 270-298). MacLennan and Petty.

Mahon, J. F. (2002). Corporate reputation: Research agenda using strategy and stakeholder literature. *Business & Society, 41*(4), 415-445. https://doi:10.1177/0007650302238776

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: guided by information power. *Qualitative Health Research, 26*(13), 1753-1760. https://doi:10.1177/1049732315617444

Mannion, R., Konteh, F. H., & Davies, H. T. O. (2009). Assessing organisational culture for quality and safety improvement: a national survey of tools and tool use. *BMJ Quality & Safety, 18(*2), 153-156. https://doi:10.1136/qshc.2007.024075

Mannion, R., Marshall, M., Davies, H., & Scott, T. (2018). *Healthcare performance and organisational* culture .CRC Press.

Marakanon, L., & Panjakajornsak, V. (2017). Perceived quality, perceived risk and customer trust affecting customer loyalty of environmentally friendly electronics products. *Kasetsart Journal of Social Sciences, 38*(1), 24-30. https://doi:10.1016/j.kjss.2016.08.012

Markowitsch, J. (2018). Is there such a thing as school quality culture? In search of conceptual clarity and empirical evidence. *Quality Assurance in Education, 26*(1), 25-43. https://doi:10.1108/QAE-07-2015-0026.

Marquis, C., & Tilcsik, A. (2016). Institutional equivalence: How industry and community peers influence corporate philanthropy. *Organization Science 27*(5), 1325-1341. https://doi:10.1287/orsc.2016.1083

Marsh, D., Ercan, S.A., & Furlong, P. (2018). A skin is not a sweater: Ontology and epistemology in political science. In V. Lowndes, D. Marsh & G. Stoker (Eds), *Theory and Methods in Political Science*, (4th ed. pp. 177-198). Palgrave

Marshall, M. N. (1996). Sampling for qualitative research. *Family practice, 13*(6), 522-526. https://doi:10.1093/fampra/13.6.522

Martin, C. M. (2018). Complex adaptive systems approaches in health care: A slow but real emergence? *Journal of Evaluation in Clinical Practice, 24*(1), 266-268. https://doi:10.1111/jep.12878

Martin, J. (1992). *Cultures in organizations: Three perspectives*. Oxford University Press.

Martin, J. (2002). *Organizational culture: Mapping the terrain.* Sage Publications.

Martin, J., & Siehl, C. (1983). Organizational culture and counterculture: An uneasy symbiosis. *Organizational Dynamics, 12*(2), 52-64. https://doi:10.1016/0090-2616(83)90033-5

Martin, J., & Meyerson, D. (1988) Managing Ambiguity and Change. In L. R. Pondy, R. J. Boland Jr. & H. Thomas (Eds.) *Managing Ambiguity and Change* (1st Ed.). Wiley.

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual review of psychology, 52*(1), 397-422. https://doi.org/10.1146/annurev.psych.52.1.397

Mason, J. (2002). *Qualitative researching*, (2nd ed.). Sage Publications.

Masso, M, Robert, G, McCarthy, G & Eagar, K. (2010). The clinical services redesign program in New South Wales: perceptions of senior health managers. *Australian Health Review*, 34(3), 352–359. https://doi:10.1071/AH08720

Mathew, J. (2019). Organisational culture and effectiveness: a multi-perspective analysis on Indian knowledge-intensive firm. *Employee Relations, 41*(3), 538-551. https://doi.org/10.1108/ER-09-2017-0219

Maxwell, J. A., (2013). *Qualitative research design: An interactive approach* (3rd ed.). Sage Publications.

McGuire, J. B., Schneeweis, T., & Branch, B. (1990). Perceptions of firm quality: A cause or result of firm performance. *Journal of Management, 16*(1), 167-180. https://doi:10.1177/014920639001600112

McLean, L. D. (2005). Organizational culture's influence on creativity and innovation: A review of the literature and implications for human resource development. *Advances in Developing Human Resources, 7*(2), 226-246. https://doi:10.1177/1523422305274528

Menzel, H. (1978). *Meaning: Who needs it: The social contexts of method,* St Martin's Press.

Merriam, S. B., & Grenier, R. S., (2019). *Qualitative research in practice: Examples for discussion and analysis*, (1st ed.). Jossey-Bass.

Meyerson, D. E. (1991). Acknowledging and uncovering ambiguities in cultures. In P. J. Frost, L. F. Moore, M. R. Louis, C. C. Lundberg & J. Martin (Eds.). *Reframing organizational culture* (pp. 254–270). Sage Publications.

Meyerson, D., & Martin, J. (1987). Cultural Change: an integration of three different views [1]. *Journal of Management Studies, 24*(6), 623-647. https://doi:10.1111/j.1467-6486.1987.tb00466.x

Miah, M. K., & Berd. A. (2007). The Impact of Culture on HRM Styles and Firm Performance: Evidence from Japanese Parents, Japanese Subsidiaries/Joint Ventures and South Asian Local Companies. *International Journal of Human Resource Management, 18*(5), 908-923. https://doi:10.1080/09585190701249537

Michel, T. (2012). In Heidegger's shadow: A phenomenological critique of critical realism. *Review of International Studies, 38*(1), 209-222. https://doi:10.1017/S0260210511000647

Miles, M., Huberman, A. M., & Saldana, J. (2020). *Qualitative data analysis: A methods sourcebook.* (4th ed.). Sage publications.

Miles, S. J., & Mangold, W. G. (2014). Employee voice: Untapped resource or social media time bomb? *Business Horizons, 57*(3), 401-411. https:doi:10.1016/j.bushor.2013.12.011

Miles, S. J., & Muuka, G. N. (2011). Employee choice of voice: a new workplace dynamic. *Journal of Applied Business Research, 27*(4), 91-104. https://doi:10.19030/jabr.v27i4.4659

Mills, P. K. (1983). Self-management: Its control and relationship to other organizational properties. *Academy of Management Review, 8*(3), 445–453. https://doi:10.5465/amr.1983.4284594.

Mintzberg, H. (1989). *Mintzberg on management: Inside our strange world of organizations.* Free Press.

Mira, J. J., Lorenzo, S., & Navarro, I. (2014). Hospital reputation and perceptions of patient safety. *Medical Principles and Practice, 23*(1), 92-94. https://doi:10.1159/000353152

Moorman, R., Brower, H., & Grover, S. (2018). Organizational citizenship behavior and trust: The double reinforcing spiral. In S. B. Mackenzie, P. M. Podsakoff & N. P. Podsakoff (Eds.). *The Oxford Handbook of Organizational Citizenship Behavio*r (1st ed.). Oxford University Press. https://doi:10.1093/oxfordhb/9780190219000.013.20

Morgan, P. I., & Ogbonna, E. (2008). Subcultural dynamics in transformation: a multi-perspective study of healthcare professionals. *Human Relations, 61*(1), 39-65. https://doi:10.1177/0018726707085945

Morgan, G., & Smircich, L. (1980). The case for qualitative research. *Academy of Management Review, 5*(4), 491-500. https://doi:10.5465/amr.1980.4288947

Morris, M. W., Leung, K., Ames, D., & Lickel, B. (1999). Views from inside and outside: Integrating emic and etic insights about culture and justice judgment. *Academy of Management Review, 24*(4), 781-796. https://doi:10.5465/amr.1999.2553253

Morse, J. M. (1994). Emerging from the data: Cognitive processes of analysis in qualitative inquiry. In J.M. Morse (Ed). *Critical issues in qualitative research methods* (pp. 23-43). Sage Publications.

Mortimore, A., & Cooper, S. (2007). The "4-hour target": Emergency nurses' views. *Emergency Medicine Journal, 24*(6), 402-404. https://doi:10.1136/emj.2006.044933

Mouton, N., Just, S. N., & Gabrielsen, J. (2012). Creating organizational cultures: Re-conceptualizing the relations between rhetorical strategies and material practices. *Journal of Organizational Change Management, 25*(2), 315-331. https://doi:10.1108/09534811211213973

Mouzelis, N. P. (2008). Social causation: Between social constructionism and critical realism. *Science and Society: A Review of Political and Ethical* Theory 17(307), 191-214. https://doi:10.1017/CBO9780511811418.013

Myers, M. D. (2009). *Qualitative research in business & management*. Sage Publishing.

Naranjo-Valencia, J. C., Jiménez-Jiménez, D., & Sanz-Valle, R. (2016). Studying the links between organizational culture, innovation, and performance in Spanish companies. *Revista Latino Americana De Psicología, 48*(1), 30-41. https://doi:10.1016/j.rlp.2015.09.009

Naranjo-Valencia, J. C., Jimenez-Jimenez, D., & Sanz-Valle, R. (2017). Organizational culture and radical innovation: Does innovative behavior mediate this relationship? *Creativity and Innovation Management, 26*(4), 407-417. https://doi:10.1111/caim.12236

Neuman, W. L. (2014). *Basics of social research*. Pearson, Allyn and Bacon.

Newbert, S. L. (2007). Empirical research on the resource-based view of the firm: an assessment and suggestions for future research. *Strategic Management Journal, 28*(2), 121-146. https://doi:10.1002/smj.573

Nguyen, N. (2010). Competence and benevolence of contact personnel in the perceived corporate reputation: An empirical study in financial services. *Corporate Reputation Review, 12*(4), 345-356. https://doi:10.1057/crr.2009.25

Nguyen, N., & Leblanc, G. (2001). Corporate image and corporate reputation in customers' retention decisions in services. *Journal of retailing and Consumer Services, 8*(4), 227-236. https://doi:10.1016/s0969-6989(00)00029-1

Nieminen, L., Biermeier-Hanson, B., & Denison, D. (2013). Aligning leadership and organizational culture: The leader-culture fit framework for coaching organizational leaders. *Consulting Psychology Journal, 65*(3), 177-198. https://doi:10.1037/a0034385

Nightingale, A. (2018). Developing the organisational culture in a healthcare setting. *Nursing Standard, 32*(21), 53-63. https://doi:10.7748/ns.2018.e11021.

Obloj, T., & Obloj, K. (2007). Diminishing returns from reputation: Do followers have a competitive advantage? *Corporate Reputation Review, 9*(4), 213-224. https://doi:10.1057/palgrave.crr.1550029

Odriozola, M. D., & Baraibar-Diez, E. (2017). Is corporate reputation associated with quality of CSR reporting? Evidence from Spain. *Corporate Social-Responsibility and Environmental Management, 24*(2), 121-132. https://doi:10.1002/csr.1399

Ogbonna, E. (1992). Managing organisational culture: Fantasy or reality? Human *Resource Management Journal, 3*(2), 42-54. https://doi:10.1111/j.1748-8583.1992.tb00309.x

O'Leary, Z. (2014). Chapter 3. Developing your research question. In Z. O'Leary (Ed.). *The essential guide to doing your research project,* Sage Publications.

Oliver, G. (2011). *Organisational culture for information managers* (1st ed.). Chandos Publishing. https://doi:10.1533/9781780632759

Olmedo-Cifuentes, I., & Martínez-León, I. M. (2014). Influence of management style on employee views of corporate reputation. Application to audit firms. *Business Research Quarterly, 17*(4), 223-241. https://doi:10.1016/j.brq.2013.08.001

Olsen, J. P. (2005). Maybe it is time to rediscover bureaucracy. *Journal of Public Administration Research and Theory, 16*(1), 1-24. https://doi:10.1093/jopart/mui027

O'Neill, O. A., Salazar, M. R., González-Romá, V., Albrecht, S. L., Kramer, W. S., Jex, S. M., & Feitosa, J. (2014). *Climate and culture for health care performance*. Oxford University Press. https://doi:10.1093/oxfordhb/9780199860715.013.0018

Önsüz, M. F., Topuzoğlu, A., Cöbek, U. C., Ertürk, S., Yılmaz, F., & Birol, S. (2008). Satisfaction levels of hospitalized patients in a university hospital in Istanbul. *Marmara Medical Journal,* 1309-9469. https://hdl.handle.net/11424/2318

Onwuegbuzie, A. J., & Johnson, R. B. (2006). The validity issue in mixed research. *Research in the Schools, 13*(1), 48-63. http://search.proquest.com.libraryproxy.griffith.edu.au/scholarly-journals/validity-issue-mixed-research/docview/211030483/se-2?accountid=14543

Otchere-Ankrah, B., Tenakwah, E. S., & Tenakwah, E. J. (2016). Organisational reputation and impact on employee attitude: A case study of MTN Ghana limited and Vodafon Ghana limited. *Journal of Public Affairs, 16*(1), 66-74. https://doi:10.1002/pa.1566

Ouchi, W. G., & Wilkins, A. L. (1985). Organizational culture. *Annual Review of Sociology, 11*(1), 457-483. https://doi:10.1146/annurev.so.11.080185.002325

Ozaras, G., & Abaan, S. (2018). Investigation of the trust status of the nurse–patient relationship. *Nursing Ethics, 25*(5), 628-639. https://doi:10.1177/0969733016664971

Palmer, G. R., & Short, S. D. (2014). *Health care and public policy: An Australian* Analysis (5th ed.). Palgrave Macmillan.

Park, D., & Berger, B. K. (2004). The presentation of CEOs in the press, 1990-2000: Increasing salience, positive valence, and a focus on competency and personal dimensions of image. *Journal of Public Relations Research, 16*(1), 93-125. https://doi:10.1207/s1532754xjprr1601_4

Parker, M. (2000). *Organizational culture and identity: Unity and division at work.* Sage Publications.

Patton, M. Q. (1988). Paradigms and pragmatism. In D. M. Fetterman (Ed.), *Qualitative approaches to evaluation in education: The silent scientific revolution* (pp. 116–137). Praeger.

Patton, M. Q. (1990). *Qualitative evaluation and research methods*. Sage Publications.

Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (Fourth ed.). Sage Publications.

Payne, G., & Payne, J., (2004). *Key concepts in social research*. Sage Publications.

Pehrson, C., Banerjee, S. C., Manna, R., Shen, M. J., Hammonds, S., Coyle, N., & Bylund, C. L. (2016). Responding empathically to patients: Development, implementation, and evaluation of a communication skills training module for oncology nurses. *Patient Education and Counselling, 99*(4), 610-616. https:// doi:10.1016/j.pec.2015.11.021

Pérez-Cornejo, C., Quevedo-Puente, E., & Delgado-García, J. B. (2020). Reporting as a booster of the corporate social performance effect on corporate reputation.

Corporate Social-Responsibility and Environmental Management, 27(3), 1252-1263. https://doi:10.1002/csr.1881

Peteraf, M. A., & Barney, J. B. (2003). Unraveling the resource-based tangle. Managerial and Decision Economics, 24(4), 309-323. https://doi.org/10.1002/mde.1126

Peters, T. J. (1978). Symbols, patterns and settings: An optimistic case for getting things done. *Organizational Dynamics, 7*(2), 3-23. https://doi:10.1016/0090-2616(78)90035-9

Pettigrew, A. M. (1979). On studying organizational cultures. *Administrative Science Quarterly, 24(*4), 570-581. https://doi:10.2307/2392363

Pike, K. L. (1967). *Etic and emic standpoints for the description of behavior.* (2nd rev. ed., pp. 37-72). Mouton & Co. https://doi:10.1037/14786-002

Pineiro-Chousa, J., Vizcaíno-González, M., & López-Cabarcos, M. Á. (2016). Reputation, game theory and entrepreneurial sustainability. *Sustainability (Basel, Switzerland), 8*(11), 1196. https://doi:10.3390/su8111196

Plewa, C., Ho, J., Conduit, J., & Karpen, I. O. (2016). Reputation in higher education: A fuzzy set analysis of resource configurations. Journal of Business Research, 69(8), 3087-3095. https://doi.org/10.1016/j.jbusres.2016.01.024

Ponzi, L. J., Fombrun, C. J., & Gardberg, N. A. (2011). RepTrak™ pulse: Conceptualizing and validating a short-form measure of corporate reputation. *Corporate Reputation Review, 14(*1), 15-35. https://doi:10.1057/crr.2011.5

Powell, T. C., & Dent-Micallef, A. (1997). Information technology as competitive advantage: The role of human, business, and technology resources. *Strategic Management Journal, 18*(5) 375-405. https:// https://www.jstor.org/stable/3088167

Prabhu, J., & Stewart, D. W. (2001). Signalling strategies in competitive interaction: Building reputations and hiding the truth. *Journal of Marketing Research, 38*(1), 62-72. https://doi:10.1509/jmkr.38.1.62.18826

Productivity Commission (2002). *Managed Competition in Health Care, Workshop Proceedings,* (Report 23 August) AusInfo, https://www.pc.gov.au/research/supporting/healthcare-competition/mcihc.pdf

Productivity Commission (2005). *Review of National Competition Policy Reforms,* (Report No 33). Media & Publications. http://www.pc.gov.au/projects/inquiry/ncp/docs/finalreport

Productivity Commission (2014). *Submission to the Competition Policy Review: Productivity Commission Submission* (June) Media & Publications. https://www.pc.gov.au/research/supporting/competition-policyreview/competition-policy-review-submission.pdf

Productivity Commission (2017). Improving human services through greater choice and competition. (August). Media & Publications. https://www.pc.gov.au/news-media/pc-news/pc-news-august-2017/human-services-reforms

Productivity Commission (2018). *Competition in the Australian Financial System,* (Report No. 89). Media & Publications. https://www.pc.gov.au/inquiries/completed/financial-system/report/financial-system-overview.pdf

Productivity Commission (2018a). *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services Productivity Commission Inquiry Report Overview & Recommendations.* (Report No. 85) Media & Publications. https://www.pc.gov.au/inquiries/completed/human-services/reforms/report/human-services-reforms-overview.pdf

Punch, K. (2005). *Introduction to social research: Quantitative and qualitative approaches* (2nd ed.). London: Sage Publications.

Pushor, D. (2008). Collaborative research. *The Sage encyclopaedia of qualitative research methods*. Sage Publications.

QSR International (2020). *NVivo software.* QSR International Retrieved February 21, 2020 from https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/about/nvivo.

Quagrainie, K. K., McCluskey, J. J., & Loureiro, M. L. (2003). A latent structure approach to measuring reputation. *Southern Economic Journal, 69*(4), 966-977. https://doi:10.2307/1061661.

Queensland Government. (2019) *Department of Health's Strategic Plan.* Department of Health.https://www.health.qld.gov.au/__data/assets/pdf_file/0029/989012/Department-of-Health-Strategic-Plan-2019-2023_V8.1.pdf

Raithel, S., & Schwaiger, M. (2015). The effects of corporate reputation perceptions of the general public on shareholder value. *Strategic Management Journal, 36*(6), 945-956. https:// doi:10.1002/smj.2248

Ranaei kordshouli, H., Baneshi, E., & Rezaei, B. (2013). Depicting favorite organizational culture: An empirical case study. *Management Science Letters, 3*(11), 2839-2846. https://doi:10.5267/j.msl.2013.09.024

Rao, H. (1994). The social construction of reputation: Certification contests, legitimation, and the survival of organizations in the American automobile industry: 1895–1912. *Strategic Management Journal, 15*(S1), 29-44. https:// doi:10.1002/smj.4250150904

Rashid, S., & Ghose, K. (2015). Organisational culture and the creation of brand identity: retail food branding in new markets. *Marketing Intelligence & Planning, 33*(1), 2-19. https://doi-org.libraryproxy.griffith.edu.au/10.1108/MIP-10-2013-003

Ravasi, D., & Schultz, M. (2006). Responding to organizational identity threats: Exploring the role of organizational culture. *Academy of Management Journal, 49*(3), 433-458. https://doi:10.5465/amj.2006.21794663

Rawnsley, M. M. (1998). Ontology, epistemology, and methodology: A clarification. *Nursing Science Quarterly, 11*(1), 2-4. https://doi:10.1177/089431849801100102

Reuber, A. R., & Fischer, E. (2005). The company you keep: How young firms in different competitive contexts signal reputation through their customers. *Entrepreneurship Theory and Practice, 29*(1), 57-78. https:// doi:10.1111/j.1540-6520.2005.00069.x

Reyes, V. (2020;2018;). Ethnographic toolkit: Strategic positionality and researchers' visible and invisible tools in field research. Ethnography, 21(2), 220-240. https://doi.org/10.1177/1466138118805121

Rhee, M., & Haunschild, P. R. (2006). The liability of good reputation: A study of product recalls in the U.S. automobile industry. *Organization Science (Providence, R.I.), 17*(1), 101-117. https://doi:10.1287/orsc.1050.0175

Richardson, A. (2002). Competitive advantage, implementing strategy in the NHS. *Nursing Management (Harrow, London, England), 9*(4), 14. https:// doi:10.7748/nm2002.07.9.4.14.c2110

Richter, A., & Koch, C. (2004). Integration, differentiation and ambiguity in safety cultures. *Safety Science, 42*(8), 703-722. https://doi:10.1016/j.ssci.2003.12.003

Rim, H., Yang, S., & Lee, J. (2016). Strategic partnerships with non-profits in corporate social responsibility (CSR): The mediating role of perceived altruism and organizational identification. *Journal of Business Research, 69*(9), 3213-3219. https://doi:10.1016/j.jbusres.2016.02.035

Rindova, V. P., (1997). Part VII: Managing reputation: Pursuing everyday excellence: The image cascade and the formation of corporate reputations, *Corporate Reputation Review, 1*(2) pp. 189-194. https:// doi:10.1057/palgrave.crr.1540042

Rindova, V. P., & Fombrun, C. J. (1999). Constructing competitive advantage: the role of firm–constituent interactions. *Strategic Management Journal, 20*(8), 691-710. https:// doi:10.1002/(SICI)1097-0266(199908)20:8<691::AID-SMJ48>3.0.CO;2-1

Rindova, V. P., & Martins, L. L. (2012). Show me the money: A multidimensional perspective on reputation as an intangible asset. In T. G. Pollock & M. L. Barnett (Eds.), *The Oxford handbook of corporate reputation.* (pp. 16-33). Oxford University Press. https://doi:10.1093/oxfordhb/9780199596706.013.0002

Rindova, V. P., Williamson, I. O., & Petkova, A. P. (2010). Reputation as an intangible asset: Reflections on theory and methods in two empirical studies of business school reputations. *Journal of Management, 36*(3), 610-619. https:// doi:10.1177/0149206309343208

Rindova, V. P., Williamson, I. O., Petkova, A. P., & Sever, J. M. (2005). Being good or being known: An empirical examination of the dimensions, antecedents, and consequences of organizational reputation. *Academy of Management Journal, 48*(6), 1033-1049. https:// doi:10.5465/amj.2005.19573108

Roach, D. E., & Wherry Sr. R. J. (1972). The use of hierarchical factor analysis in the determination of corporate image dimensions. *Educational and Psychological Measurement, 32*(1), 31-44. https://doi:10.1177/001316447203200103

Roberts, P. W., & Dowling, G. R. (2002). Corporate reputation and sustained superior financial performance. *Strategic Management Journal, 23*(12), 1077-1093. https://doi:10.1002/smj.274

Romenti, S. (2010). Reputation and stakeholder engagement: an Italian case study. *Journal of Communication Management (London, England), 14*(4), 306-318. https://doi:10.1108/13632541011090428

Rose, C., & Thomsen, S. (2004). The Impact of Corporate Reputation on Performance: Some Danish Evidence. *European Management Journal, 22*(2), 201-210. https://doi:10.1016/j.emj.2004.01.012

Rosen, B., & Swann, E. K. (2018). *Conscious: The Power of Awareness in Business and Life*. John Wiley & Sons.

Rosenthal, M., Desselle, S., & Holmes, E. (2017). How a more detailed understanding of culture is needed before successful educational change can be made. *Currents in Pharmacy Teaching and Learning, 9*(5), 741-745. https://doi:10.1016/j.cptl.2017.05.020

Rossi, I. and O'Higgins, E. (1980). The development of theories of culture, In Rossi, I. (Ed.), *People in Culture*, Praeger.

Ruberton, P. M., Huynh, H. P., Miller, T. A., Kruse, E., Chancellor, J., & Lyubomirsky, S. (2016). The relationship between physician humility, physician–patient communication, and patient health. *Patient Education and Counselling, 99*(7), 1138-1145. https://doi:10.1016/j.pec.2016.01.012

Rubin, H. J., & Rubin, I. (2005). *Qualitative interviewing: The art of hearing data* (2nd ed). Sage Publications.

Runtu, T. M., Novieastari, E., & Handayani, H. (2019). How does organizational culture influence care coordination in hospitals? A systematic review. Enfermeria Clinica, *29*, 785-802. https://doi:10.1016/j.enfcli.2019.04.119

Sackmann, S. A. (2011). *Success factor: Corporate culture: Developing a corporate culture for high performance and long-term competitiveness, six best practices* (2nd ed.). Verlag Bertelsmann Stiftung.

Sageder, M., Mitter, C., & Feldbauer-Durstmüller, B. (2018). Image and reputation of family firms: A systematic literature review of the state of research. *Review of Managerial Science, 12*(1), 335-377. https://doi:10.1007/s11846-016-0216-x

Sánchez, J. L. F., & Sotorrío, L. L. (2007). The creation of value through corporate reputation. *Journal of Business Ethics, 76*(3), 335-346. https://doi:10.1007/s10551-006-9285-0

Sarstedt, M., & Schloderer, M. P. (2010). Developing a measurement approach for reputation of non-profit organizations. *International Journal of Non-profit and Voluntary Sector Marketing, 15*(3), 276-299. https://doi:10.1002/nvsm.389

Sataøen, H. L., & Waeraas, A. (2015). Branding without unique brands: Managing similarity and difference in a public sector context. *Public Management Review, 17*(3), 443-461. https://doi:10.1080/14719037.2013.841976

Şatır, Ç. (2006). The nature of corporate reputation and the measurement of reputation components. *Corporate Communications: An International Journal, 11*(1), 56-63. https://doi:10.1108/13563280610643552

Schein, E. H. (1983). The role of the founder in creating organizational culture. *Organizational Dynamics, 12*, 13-28. https://doi.org/10.1016/0090-2616(83)900232

Schein, E. H. (1985). *Organizational Culture and Leadership*, (1st ed.). Jossey Bass.

Schein, E. H. (1990). Organizational culture. *The American Psychologist, 45*(2), 109-119. https://doi:10.1037/0003-066X.45.2.109

Schein, E. H. (1992). *Organizational culture and leadership* (2nd ed.). Jossey-Bass.

Schein, E. H. (2004). *Organizational culture and leadership* (3rd ed.). Jossey-Bass.

Schein, E. H. (2006). *Organizational culture and leadership*. Wiley.

Schein, E. H. (2015). Organizational psychology then and now: Some observations. *Annual Review of Organizational Psychology and Organizational Behavior*, *2*(1), 1-19. https://doi:10.1146/annurev-orgpsych-032414-111449

Schein, E. H., (2017). *Organizational culture and leadership* (5th ed.). Wiley.

Schein, E. H., Chatman, J. A., Denison, D., Ehrhart, M. G., Kinicki, A. J., & Nieminen, L. R. G. (2014). Clarifying organizational culture: Conceptual clarifications, extensions, and research directions. *Academy of Management Proceedings, 2014*(1), 11605. https://doi:10.5465/ambpp.2014.11605symposium

Schneider, B., (1990). *Organizational climate and culture* (1st ed.). Jossey-Bass.

Schneider, B., Ehrhart, M. G., & Macey, W. H. (2013). Organizational climate and culture. *Annual Review of Psychology, 64*(1), 361-388. https://doi:10.1146/annurev-psych-113011-143809

Schneider, B., González-Romá, V., Ostroff, C., & West, M. A. (2017). Organizational climate and culture: Reflections on the history of the constructs in the journal of applied psychology. *Journal of Applied Psychology, 102*(3), 468-482. https://doi:10.1037/apl0000090

Schram, A. W., Hougham, G. W., Meltzer, D. O., & Ruhnke, G. W. (2017). Palliative care in critical care settings: a systematic review of communication-based competencies essential for patient and family satisfaction. *American Journal of Hospice and Palliative Medicine, 34*(9), 887-895. https://doi: 10.1177/1049909116667071

Schroeder, R. G., Bates, K. A., & Junttila, M. A. (2002). A resource-based view of manufacturing strategy and the relationship to manufacturing performance. *Strategic Management Journal, 23*(2), 105-117. https:// doi:10.1002/smj.213

Schultz, M., & De Chernatony, L. (2002). The challenges of corporate branding. *Corporate Reputation Review*, *5*(2/3), 105-113. https://search.ebscohost.com/login.aspx?direct=true&db=bth&AN=7539206&site=ehost-live&scope=site

Schwaiger, M., & Raithel, S. (2014). Reputation und Corporate Success. *Management Review Quarterly, 64*(4), 225-259. https://doi10.1007/s11301-014-0106-8

Scott, I. (2009) The NHHRC final report: view from the hospital sector. *The Medical Journal of Australia, 191* (8), 450-453. https://doi:10.5694/j.1326-5377.2009.tb02884.x

Scott, T., Mannion, R., Davies, H., & Marshall, M. (2003). The quantitative measurement of organizational culture in health care: A review of the available instruments. *Health Services Research, 38*(3), 923-945. https://doi:10.1111/1475-6773.00154

Scott, S. V., & Walsham, G. (2005). Reconceptualizing and managing reputation risk in the knowledge economy: Toward reputable action. *Organization Science, 16*(3), 308-322. https://doi:10.1287/orsc.1050.0127

Seeger, M. W., Sellnow, T. L., & Ulmer, R. R. (2003). *Communication and organizational crisis.* Greenwood Publishing Group.

Shank, G. (2006). *Qualitative research: A personal skills approach*. Pearson Merrill Prentice Hall.

Shahian, D. M., Edwards, F. H., Jacobs, J. P., Prager, R. L., Normand, S. L. T., Shewan, C. M. & Grover, F. L. (2011). Public reporting of cardiac surgery performance: part 2—implementation. *The Annals of thoracic surgery, 92*(3), S12-S23. https://doi:10.1016/j.athoracsur.2011.06.101

Shamma, H., & Hassan, S. (2013). Customer-driven benchmarking. *Benchmarking: An International Journal. 20*(3), 377-395. https://doi:10.1108/14635771311318144

Shamsie, J. (2003). The context of dominance: An industry-driven framework for exploiting reputation. *Strategic Management Journal 24*(3), 199-215. https://doi:10.1002/smj.291

Shank, G. D. (2006). *Qualitative research: A personal skills approach*. Pearson Merrill Prentice Hall.

Shortell, S. M., Richardson, W. C., LoGerfo, J. P., Diehr, P., & Weaver, B. (1977). The relationships among dimensions of health services in two provider systems: a causal model approach. *Journal of Health and Social Behavior, 18*(2), 139-159. https://doi:10.2307/2955378

Silverman, D. (2019). *Interpreting qualitative data*. Sage Publications.

Simpson, D., Hamilton, S., McSherry, R., & McIntosh, R. (2019). Measuring and assessing healthcare organisational culture in the england's national health service: A snapshot of current tools and tool use. Healthcare (Basel), 7(4), 127. https://doi.org/10.3390/healthcare7040127

Singer, S. J., Falwell, A., Gaba, D. M., Meterko, M., Rosen, A., Hartmann, C. W., & Baker, L. (2009). Identifying organizational cultures that promote patient safety. *Health Care Management Review, 34*(4), 300-311. https://doi:10.1097/HMR.0b013e3181afc10c

Small, M. L. (2002). Culture, cohorts, and social organization theory: Understanding local participation in a Latino housing project. *The American Journal of Sociology, 108*(1), 1-54. https//doi:10.1086/345649

Smallman, C., & John, G. (2001). British director's perspectives on the impact of health and safety on corporate performance. *Safety Science, 38*(3), 227-239. https://doi:10.1016/S0925-7535(01)00003-0

Smircich, L. (1983). Concepts of culture and organizational analysis. *Administrative Science Quarterly, 28*(3), 339-358. https://doi:10.2307/2392246

Smircich, L. (2007). *Concepts of culture and organizational analysis.* (1st ed., pp. 255-274) Routledge. https://doi:10.4324/9781315241371-20

Smith, S. (2006). Encouraging the use of reflexivity in the writing up of qualitative research. *International Journal of Therapy and Rehabilitation, 13*(5), 209-214. https://doi:10.12968/ijtr.2006.13.5.21377

Somekh, B. (2009). *The SAGE handbook of educational action research*. Sage Publications.

Spath, P. L. (2012). Error reduction in health care: a systems approach to improving patient safety. *Journal of Nursing Regulation*, 2(4), 60. https://doi:10.1108/ijhcqa.2011.06224haa.017

Stanford, N. (2014). Healthcare strategic management and the resource based view. *Journal of Strategy and Management, 7*(3), 251-264. https://doi: 10.1108/JSMA-06-2013-0040

Standifird, S. S. (2005). Reputation among peer academic institutions: An investigation of the US news and world report's rankings. *Corporate Reputation Review, 8*(3), 233-244. https://doi:10.1057/palgrave.crr.1540252

State of Queensland [Queensland Health] (2016) *Hospital and Health Services.* https://www.health.qld.gov.au/system-governance/health-system/hhs.

State of Queensland [Queensland Health] (2020) Hospital and Health Service Strategic Plan 2019-2023. Department of Health. https://www.health.qld.gov.au/system-governance/strategic-direction/plans/hhs-plan.

State of Queensland (Queensland Health) (2020a). *Queensland Health Performance and Accountability Framework 2020-2021*. Brisbane. https://www.publications.qld.gov.au/dataset/service-agreements-for-hhs-hospital-and-health-services-supporting-documents/resource/94ce3c3b-59dd-44d4-8d3c-ada71f6379bc

Staw, B. M., & Epstein, L. D. (2000). What bandwagons bring: Effects of popular management techniques on corporate performance, reputation, and CEO pay? *Administrative Science Quarterly, 45*(3), 523-556. https://doi:10.2307/2667108

Steering Committee for the Review of Government Service Provision (SCRGSP) (2017). *Report on Government Services 2017*, Productivity Commission, Canberra. https://www.pc.gov.au/research/ongoing/report-on-government-services/2017/community-services/rogs-2017-volumef.pdf

Stenvall, J. (2000). *From a commander to an actor. Developments in the value of the qualifications of central government officials from the beginning of the Grand Duchy to the 21st century*. (Publication No. 951-44-4852-9) [Doctoral thesis, University of Tampere]. Trepo.

Stevenson, W. B., & Bartunek, J. M. (1996). Power, interaction, position, and the generation of cultural agreement in organizations. *Human Relations, 49*(1), 75-104. https:// doi:10.1177/001872679604900104

Stokes, P., Baker, C., & Lichy, J. (2016). The role of embedded individual values, belief and attitudes and spiritual capital in shaping everyday post secular organizational culture. *European Management Review, 13*(1), 37-51. https://doi:10.1111/emre.12065

Strauss, A.L., (1987). *Qualitative Analysis for Social Scientists*. Cambridge University Press.

Strauss, A.L., & Corbin, J. (1990). *Basics of qualitative research: grounded theory procedures and techniques*. Sage Publications.

Sullivan, W., Sullivan, R., & Buffton, B. (2002). Aligning individual and organisational values to support change. *Journal of Change Management*, *2*(3), 247. https://doi: 10.1080/738552750

Sundaram, D. S., Mitra, K., & Webster, C. (1998). Word-of-mouth communications: A motivational analysis. *Advances in Consumer Research 25*, 527-531. https://www.acrwebsite.org/volumes/8208/volumes/v25/NA-25

Suomi, K., & Järvinen, R. (2013). Tracing reputation risks in retailing and higher-education services. *Journal of Retailing and Consumer Services, 20*(2), 207-217. https://doi:10.1016/j.jretconser.2012.12.003

Sutedjo, P., Budiman, C. & Teman, K. (2018). Effect of leadership strategic, entrepreneurship, organizational culture, and organizational reputation on performance Transformer Company in Indonesia. *International Journal of Advanced Research 6*(9) 1001-1011. https://doi:10.5281/zenodo.1466400

Swidler, A. (1986). Culture in action: Symbols and strategies. American sociological review, 273-286. https://doi.org/10.2307/2095521

Szwajca, D. (2018). Relationship between corporate image and corporate reputation in polish banking sector. *Oeconomia Copernicana*, *9*(3), 493-509. https://doi:10.24136/oc.2018.025

Szymaniec-Mlicka, K. (2014). Resource-based view in strategic management of public organizations – a review of the literature. *Management, 18*(2), 19-30. https://doi:10.2478/manment-2014-0039

Szymaniec-Mlicka, K. (2015). Assessment of the effectiveness of public organizations on the example of public hospitals - methodological aspects. *Science notebooks. Organization and Management. Silesian University of Technology*, (83), 651-660.

Szymaniec-Mlicka, K. (2017). The decision-making process in public healthcare entities – identification of the decision-making process type. *Management, 21*(1), 191-204. https://doi:10.1515/manment-2015-0088

Tan, C. (2019). The school as a learning organisation in China. *Journal of Professional Capital and Community*. https:// doi/10.1108/JPCC-09-2019-0024

Tarafdar, M., & Gordon, S. R. (2007). Understanding the influence of information systems competencies on process innovation: A resource-based view. *Journal of Strategic Information Systems, 16*(4), 353-392. https://doi:10.1016/j.jsis.2007.09.001

Tesch, R. (1990). *Qualitative research: Analysis types and software*. Routledge Falmer.

Tetrault-Sirsly, C. A., & Lvina, E. (2019). From doing good to looking even better: The dynamics of CSR and reputation. *Business & Society, 58*(6), 1234-1266. https://doi.org/10.1177/0007650315627996

Thorne, S. (1997). The art (and science) of critiquing qualitative research. In J. M. Morse (Ed.). *Completing a qualitative project: Details and dialogue* (pp. 117-132). Sage Publications.

Thorne, S. (2000). Data analysis in qualitative research. Evidence-based nursing, *3*(3), 68-70. http://dx.doi.org/10.1136/ebn.3.3.68

Thorne, S., Kirkham, S. R., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International journal of qualitative methods, 3*(1), 1-11. https://doi.org/10.1177/160940690400300101

Tischer, S., & Hildebrandt, L. (2014). Linking corporate reputation and shareholder value using the publication of reputation rankings. *Journal of Business Research, 67*(5), 1007-1017. https://doi:10.1016/j.jbusres.2013.08.007

Tobin, G. A. & Begley, C. M. (2004). Methodological rigour within a qualitative framework, *Journal of Advanced Nursing, 48*(4), pp. 388-396. https://doi:10.1111/j.1365-2648.2004.03207.x

Tolman, D. L., & Brydon-Miller, M. (2001). *From subjects to subjectivities: A handbook of interpretive and participatory methods*. New York University Press.

Tomak, S. (2014). Corporate Reputation and Financial Performance of Firms in Turkey. *Academic Review of Economics & Administrative Sciences, 7*(1). https://www.researchgate.net/publication/329512257

Tracy, S. J. (2013). *Qualitative research methods*. John Wiley and Sons.

Tran, M. A., Nguyen, B., Melewar, T. C., & Bodoh, J. (2015). Exploring the corporate image formation process. *Qualitative Market Research: An International Journal, 18*(1), pp. 86-114 https://doi.org/10.1108/QMR-05-2014-0046

Trice, H. M., & Beyer, J. M. (1993). *The cultures of work organizations*. Prentice Hall

Tsui, A. S., Zhang, Z., Wang, H., Xin, K. R., & Wu, J. B. (2006). Unpacking the relationship between CEO leadership behavior and organizational culture. *The Leadership Quarterly, 17*(2), 113-137. https://doi:10.1016/j.leaqua.2005.12.001

Tuck, J. (2012). *Reputation formation in the Australian mining industry: Stakeholder and industry effects* (Publication No. 3448) [Doctoral Thesis, University of Ballarat] Trove.

Turban, D. B., & Cable, D. M. (2003). Firm reputation and applicant pool characteristics. *Journal of Organizational Behavior*, *24*(6), 733-751. https://doi:10.1002/job.215

Turban, D. B., & Greening, D. W. (1997). Corporate social performance and organizational attractiveness to prospective employees. *Academy of Management Journal, 40*(3), 658-672. https://doi:10.2307/257057

Turner, S., & Risjord, M. W. (2007). *Philosophy of anthropology and sociology: A volume in handbook of the philosophy of science*. Elsevier. https://doi:10.1016/B978-0-444-51542-1.X5000-4

Tyler, T. R. (2006). *Why people obey the law.* Princeton University Press.

Tzeng, H. M., Okpalauwaekwe, U., & Yin, C. Y. (2019). Older adults' suggestions to engage other older adults in health and healthcare: a qualitative study conducted in Western Canada. *Patient Preference and Adherence, 13*, 331. https://doi.org/10.2147/PPA.S182941

Tzeng, H. M., Okpalauwaekwe, U., Yin, C. Y., Jansen, S. L., Feng, C., & Barker, A. (2018). Do patients' demographic characteristics affect their perceptions of self-care actions to find safe and decent care? *Applied Nursing Research, 43*, 24-29. https://doi.org/10.1016/j.apnr.2018.06.020

Vancheswar, V., Batra, D. K., & Gera, R. (2015). Corporate reputation: A study of practitioners in the Indian context. *Corporate Reputation Review, 18*(3), 261. https:// doi:10.1057/crr.2015.7

Van de Walle, S. (2013). The role of trust in public services and public sector reform. In: C. Madureira, & M. Asensio, (Eds.), *Public Administration Handbook. Oeiras: National Institute of Administration,* (pp. 145-158). Sage Publications.

Van Maanen, J., & Barley, S. R. (1985). Cultural organization: Fragments of a theory. In P. J. Frost, L. F. Moore, M. R. Louis, & J. Martin (Eds.) *Organizational culture* (pp. 31–53). Sage Publications.

Van Riel, C. B., & Fombrun, C. J. (2007). *Essentials of corporate communication: Implementing practices for effective reputation management*. Routledge.

Varpio, L. & MacLeod, A. (2020). Philosophy of Science Series: Harnessing the Multidisciplinary Edge Effect by Exploring Paradigms, Ontologies, Epistemologies, Axiologies, and Methodologies. *Academic Medicine, 95*(5), 686–689. https://doi: 10.1097/ACM.0000000000003142

Veh, A., Göbel, M., & Vogel, R. (2019). Corporate reputation in management research: A review of the literature and assessment of the concept. *Business Research (Göttingen), 12*(2), 315-353. https://doi:10.1007/s40685-018-0080-4

Von Zugbach, R. G. L. (1988). *Power and prestige in the British Army*. Ashgate Publications.

Waeraas, A., & Byrkjeflot, H. (2012). Public sector organizations and reputation management: Five problems. *International Public Management Journal, 15*(2), 186-206. https://doi:10.1080/10967494.2012.702590

Waeraas, A., & Sataøen, H. L. (2015). Being all things to all customers: Building reputation in an institutionalized field: Being all things to all customers. *British Journal of Management, 26*(2), 310-326. https://doi:10.1111/1467-8551.12044

Walker, K. (2010). A systematic review of the corporate reputation literature: Definition, measurement, and theory. *Corporate reputation review, 12*(4), 357-387. https:// doi:10.1057/crr.2009.26

Walsh, G., Mitchell, V. W., Jackson, P. R., & Beatty, S. E. (2009). Examining the antecedents and consequences of corporate reputation: A customer perspective. *British Journal of Management, 20*(2), 187-203. https:// doi:10.1111/j.1467-8551.2007.00557.x

Wang, Y., & Berens, G. (2015). The impact of four types of corporate social performance on reputation and financial performance. *Journal of Business Ethics, 131*(2), 337-359. https://doi:10.1007/s10551-014-2280-y

Wartick, S. L. (2002). Measuring corporate reputation: Definition and data. *Business & Society, 41*(4), 371-392. https://doi:10.1177/0007650302238774

Wartick, S. L. (2016). Measuring corporate reputation. *Business & Society, 41*(4), 371-392. https://doi:10.1177/0007650302238774

Weerts, K., Vermeulen, W., & Witjes, S. (2018). On corporate sustainability integration: Analysing corporate leaders' experiences and academic learnings from an organisational culture perspective. *Journal of Cleaner Production, 203*, 1201–1215. https://doi.org/10.1016/j.jclepro.2018.07.173

Weigelt, K., & Camerer, C. (1988). Reputation and corporate strategy: A review of recent theory and applications. *Strategic Management Journal, 9*(5), 443-454. https:// doi:10.1002/smj.4250090505

Wernerfelt, B. (1984). A resource-based view of the firm. *Strategic Management Journal, 5*(2), 171-180. https:// doi:10.1002/smj.4250050207

Whetten, D. A., & Mackey, A. (2002). A social actor conception of organizational identity and its implications for the study of organizational reputation. *Business & Society, 41*(4), 393-414. https://doi.org/10.1177/0007650302238775

Wiedmann, K. P. (2017). Future research directions based on a critical assessment of reputation management in practice: A German perspective. *Corporate Reputation Review, 20*(3-4), 217-223. https://doi.org/10.1057/s41299-017-0028-1

Wiklund, J., & Shepherd, D. (2003). Knowledge-based resources, entrepreneurial orientation, and the performance of small and medium-sized businesses. *Strategic Management Journal, 24*(13), 1307-1314. https:// doi/abs/10.1002/smj.360

Wilkins, A. L., & Ouchi, W. G. (1983). Efficient cultures: Exploring the relationship between culture and organizational performance. *Administrative Science Quarterly, 28*(3) 468-481. https://doi.org/10.2307/2392253

Willems, J., Jegers, M., & Faulk, L. (2016). Organizational effectiveness reputation in the non-profit sector. *Public Performance & Management Review*, *39*(2), 454-475. https://doi:10.1080/15309576.2015.1108802

Williams, E. N., & Hill, C. E. (2012). *Establishing trustworthiness in consensual qualitative research studies.* In C. E. Hill (Ed.), *Consensual qualitative research: A practical resource for investigating social science phenomena* (p. 175–185). American Psychological Association. https:// https://psycnet.apa.org/record/2011-09578-013

Williamson, O. E. (2008). Outsourcing: Transaction cost economics and supply chain management. *The Journal of Supply Chain Management, 44*(2), 5-16. https://doi:10.1111/j.1745-493x.2008.00051.x

Wittenberg-Lyles, E., Goldsmith, J., & Ferrell, B. (2013). Oncology nurse communication barriers to patient-centered care. *Clinical Journal of Oncology Nursing, 17*(2). http://dx.doi.org.libraryproxy.griffith.edu.au/10.1188/13.CJON.152-158

Wolcott, H.F. (1994). *Transforming Qualitative Data: Description, Analysis and Interpretation*. Sage Publications.

Wolcott, H. F. (2008). *Ethnography: a way of seeing*. Rowan & Littlefield Inc.

Wood, J. M. (2004). *Organisational behaviour: A global perspective* (3rd ed.). John Wiley & Sons.

Wood, R. E., Roberts, V., & Whelan, J. (2011). Organizational psychology. In P. R. Martin, F. M. Cheung, M. C. Knowles, M. Kyrios, L. Littlefield, J. B. Overmier, & J. M. Prieto (Eds.), *IAAP handbook of applied psychology* (pp. 233–268). Wiley Blackwell. https://doi.org/10.1002/9781444395150.ch10

Wynia, M. K., Papadakis, M. A., Sullivan, W. M., & Hafferty, F. W. (2014). More than a list of values and desired behaviors: a foundational understanding of medical professionalism. *Academic Medicine, 89*(5), 712-714. https://doi: 10.1097/ACM.0000000000000212

Yahanda, A. T., Lafaro, K. J., Spolverato, G., & Pawlik, T. M. (2016). A systematic review of the factors that patients use to choose their surgeon. *World Journal of Surgery, 40*(1), 45-55. https://doi:10.1007/s00268-015-3246-7

Yang, Y., & Konrad, A. M. (2011). Understanding diversity management practices: Implications of institutional theory and resource-based theory. *Group & Organization Management, 36*(1), 6-38. https://doi:10.1177/1059601110390997

Yin, R. K. (2017). *Case study research and applications: Design and methods*. Sage publications.

Yusuf, N. A., Mustaffa, C. S., & Mohamad, B. (2018). External perception of organisational culture and customer based corporate reputation: the mediating role of transparent communication. *The Journal of Social Sciences Research,* (SPI6), 638-645. https://ideas.repec.org/a/arp/tjssrr/2018p638-645

Zhang, R., & Rezaee, Z. (2009). Do credible firms perform better in emerging markets? Evidence from china. *Journal of Business Ethics, 90*(2), 221-237. https://doi:10.1007/s10551-009-0038-8

Zheng, X. (2018). *Antecedents and Outcomes of Downwards Trust in Organisations* (Publication No. 12553) [Doctoral dissertation, Durham University]. Open Access Theses and Dissertations.

Ziemba, J. B., Allaf, M. E., & Haldeman, D. (2017). Consumer preferences and online comparison tools used to select a surgeon. *JAMA Surgery, 152*(4), 410-411. https://doi:10.1001/jamasurg.2016.4993

Ziemba, J. B., Arenberg, S., Reustie, H., Allaf, M. E., & Haldeman, D. (2019). Consumers' association of hospital reputation with healthcare quality. *Journal for Healthcare Quality, 41*(4), 251-258. https://doi:10.1097/JHQ.0000000000000167

Zyglidopoulos, S. C. (2005). The impact of downsizing on corporate reputation. *British Journal of Management, 16*(3), 253-259. https://doi/full/10.1111/j.1467-8551.2005.00460.x