



Examining the joint effects of strategic priorities, use of management control systems, and personal background on hospital performance

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ABSTRACT

This study aims to respond to recent calls for a better understanding of the factors that support the effectiveness of formal control practices in hospitals. Based on survey data from 117 top-level managers in Belgian hospitals, the study investigates the performance effects of the alignment between the use of performance measurement systems (PMS), strategic priorities, and the particular role top-level managers' personal background plays in this context. The quantitative results suggest that it is the top-level managers' personal background that brings to life the benefits of the alignment between the use of PMS and strategic priorities in hospitals. Specifically, this paper shows that when the emphasis on partnership or governance strategic priority is high, the effect of the interactive use of PMS on hospital performance is more positive for top-level managers with a clinical background than for those with an administrative background. This study offers value for practitioners in that it supports the argument that hospitals can benefit from involving physicians in the top-level management team.

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1. Introduction

Hospitals face growing regulatory and competitive pressures to develop management control systems (Cardinaels and Soderstrom, 2013). However, formal management control systems (MCS) are seen to be problematic in hospitals (Aidemark and Funck, 2009). Questions about the use of monetary incentives for goal congruence, the power of physicians and nurses over operational processes, various priorities imposed by a large diversity of influential stakeholders, and austere budgets that constrain expansion and restructuring combine to create unparalleled complexities for the effective use of MCS (Abernethy et al., 2007). Previous research in management accounting thus calls for a better understanding of MCS in hospitals (e.g., Bai et al., 2010; King and Clarkson, 2015), especially factors that influence the effectiveness of formal performance measurement systems (PMS) (Ballantine et al., 1998; Cardinaels and Soderstrom, 2013).¹

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¹ Management control systems are defined as "formal, information-based routines and procedures managers use to maintain or alter patterns in organisational activities" (Simons, 1995, p. 5). Formal performance measurement systems are an

Over the past two decades, the literature on MCS in hospitals has emphasised the importance of aligning the use of MCS with hospital strategies (e.g., Aidemark and Funck, 2009; Ballantine et al., 1998; Chilingierian and Sherman, 1987; Wardhani et al., 2009), an alignment that should lead to positive organisational outcomes, such as hospital performance (King et al., 2010). Inherent in these arguments is the implicit assumption that the individual behaviour of clinicians dominating the core operations of a hospital can be controlled towards the successful achievement of hospital strategies. However, several management accounting studies (e.g., Abernethy and Stoelwinder, 1991, 1995; Jones, 2002) report that regular conflicts between the professional objectives of administrators and clinicians curtail the effectiveness of MCS. Coombs (1987, p. 391) notes that bureaucratic control mechanisms attempted by administrators have "the potential to substantially affect the motivations and practices of a relatively cohesive and powerful occupational group who frequently defend their professional autonomy quite effectively". Therefore, our knowledge of how PMS are effectively used to support hospital strategies remains incomplete and fragmented.

In the hospital management literature, significant attention has concentrated on the role of "doctor managers" (i.e., managers

essential aspect of formal management control systems (Chenhall, 2005; Henri, 2006).

with a clinical background) in the management team and the implications for hospital effectiveness (Bai and Krishnan, 2014). Previous empirical findings suggest that greater participation of doctors in management teams is positively associated with increasing engagement in quality improvement initiatives and improved strategic decisions (Veronesi et al., 2013). In contrast, there are relatively few empirical studies in the management accounting literature that assess the effectiveness of PMS used by doctor managers, despite clear evidence that the use of bureaucratic control mechanisms in hospitals differs according to the top-level managers' personal background (Abernethy et al., 2007). This paper aims to fill this gap.

We suggest that the involvement of doctor managers in the use of PMS is likely to affect dialogue between top-level managers and clinicians and is one potential solution for an effective use of PMS in the support of certain hospital strategies. These top-level managers with a clinical background, educated and socialised with different values and perspectives than top-level managers with an administrative background, would preserve freedom in professional and medical judgement and at the same time address the financial and organisational concerns of the physicians. Therefore, this paper seeks to extend previous studies at the interface between MCS and hospital strategy and to explore how top-level managers with different personal backgrounds (i.e., clinical vs. administrative) use PMS to successfully support hospital strategies.

In line with previous studies on MCS-strategy relationships in a healthcare setting (e.g., Abernethy and Brownell, 1999; Naranjo-Gil and Hartmann, 2007), we explore two dimensions of the use of PMS, namely, diagnostic and interactive, which have been extensively described by Simons (1995, 2000). A diagnostic use of PMS entails formal, information-based routines and procedures that emphasise the development of critical performance variables to translate the organisation's intended strategy, identify pre-set performance targets, measure deviations, and implement corrective actions. In contrast, an interactive use of PMS (e.g., Henri, 2006; Marginson, 2002; Widener, 2007) involves top-level and operating managers using formal, information-based routines and procedures to debate face-to-face, with a focus on strategic uncertainties, in a non-invasive, facilitative, and inspirational manner (Bisbe et al., 2007).

In this study, we build on management control theory, mostly focused on healthcare organisations, to develop and test two research models: (i) a preliminary MCS-strategy fit model detailing the joint effect of strategic priorities and use of PMS on hospital performance, and (ii) a more comprehensive model detailing the joint effect of strategic priorities, use of PMS, and personal background on hospital performance. The first research model aims to examine whether adopting a contingency-based perspective helps predict the effectiveness of PMS in the healthcare sector. The objective of the second research model is to explore the role of top-level managers' personal background, identified as important in understanding behaviour in hospitals, in MCS-strategy relationships. We test the two research models with survey data from 117 top-level hospital managers in Belgian hospitals.

Our study contributes to the extant management accounting and healthcare literatures by producing empirical evidence on the use of MCS by healthcare managers. This research improves our understanding of factors that influence the effectiveness of PMS in hospitals, recognising different strategic priorities and the tensions that emerge when doctors engage in management. Additionally, our findings shed more light on the complex relationships that exist between individual, structural and contextual variables and hospital performance. Specifically, we propose and present quantitative evidence that the personal background of top-level managers is an important moderator of the relationship among the use of PMS, strategic priorities, and organisational effectiveness in healthcare. Hence, this research calls for caution in generalising

the expected effects of MCS on hospital performance and identifies scenarios for reconciling different perspectives on how PMS should be effectively used in hospitals through the explicit consideration of personal background. This study also extends previous research by developing a more comprehensive and integrated model specifying the background of the performance information user under which PMS use and strategic priorities will produce favourable outcomes. There has been relatively little empirical evidence on this relationship in the literature to date.

The remainder of this article proceeds as follows. After we review the literature on hospital strategy, the styles of PMS use, the effects of strategy and PMS on performance, and top-level managers' personal background, we formulate and explain the research hypotheses. The subsequent section presents the research design, variable measures, and validity analyses. This section is then followed by the presentation of results. Finally, we provide conclusions, limitations, and some research extensions.

2. Literature review

2.1. Hospital strategy

Empirical research in management and accounting notes the implications of strategic orientation for managerial practices (e.g., Chenhall and Langfield-Smith, 1998; Ittner et al., 2003; Mintzberg, 1990; Porter, 1980) and other elements of the control systems in hospitals (Abernethy and Lillis, 2001). A relevant stream of literature (e.g., Abernethy and Brownell, 1999; Naranjo-Gil and Hartmann, 2007) uses Miles and Snow's (1978) strategic patterns, classified as prospectors, analysers, and defenders. Others use Porter's (1980) framework to examine strategy contributions to control system designs (e.g., Pizzini, 2006).² However, there is general congruence between Miles and Snow's and Porter's categories (Langfield-Smith, 2007; Shortell et al., 1990), although Porter's (1980) framework is difficult to adapt to professional service organisations because of its central focus on product characteristics (Chenhall, 2005), limited representation of multidimensional organisational strategies (Ittner and Larcker, 2001), and inability to discriminate cost leaders from differentiators in quantitative empirical research (Langfield-Smith, 2007).

Previous literature also offers healthcare-specific strategic frameworks (e.g., Goldstein et al., 2002; Nath and Sudharshan, 1994; Wells and Banaszak-Holl, 2000). Zelman and Parham (1990) characterise four strategies hospitals use to define their business focus (i.e., generalist, market specialist, service specialist, or super specialist). Recognising that each business can undertake a strategic orientation, Butler et al. (1996) also synthesise Miles and Snow's (1978) pattern with hospital-specific strategic orientations: pacesetter hospitals are at the forefront of medical knowledge and technology, pacemaker hospitals are at (or near) the state of the art in every department offered, and provider hospitals are usually small and emphasise operations management and cost control as key to their competitive strategy.

However, hospitals often use multiple strategies simultaneously rather than adopting a single set of stable practices focused on a sole strategy (Goldstein et al., 2002), largely because of the coercive influences of various powerful stakeholders with diverse and complex objective functions and work methods (Abernethy et al., 2007; Chenhall, 2007; Eldenburg and Krishnan, 2007). These stakeholders include local authorities, central governments, public

² According to this framework, firms have two strategic priorities, representing two extreme points on a spectrum: low cost production to be a cost leader or superior product quality, flexibility, customer service, delivery, and design to achieve differentiation leadership (Chenhall and Langfield-Smith, 1998).

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