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Organisational design choices in response to public sector reforms: A case study of mandated hospital networks

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ABSTRACT

In this study we investigate the design and control of public sector networks formed by government mandate. Specifically, we analyse how a range of antecedent factors influence the extent to which organisations within such networks effectively collaborate to unify their efforts. We examine the role of both formal and informal controls in promoting and co-ordinating activity and managing appropriation concerns among organisations of the network. We address these issues in the context of health sector reforms in Victoria, Australia, that resulted in the amalgamation of metropolitan hospitals into a number of hospital networks. While the reforms determined the particular aggregation of hospitals, management retained discretion as to the organisation and control of activity among hospitals of the network. We draw on Oliver's (1991) predictive model of strategic responses to institutional mandates to analyse how efficiency and legitimacy concerns, the influence of external constituents, and consistency between institutional and organisational goals influence resultant structural and control choices in three of these hospital networks. Specifically, we examine the extent to which structural and control attributes promote the integration of activity within networks by analysing the delegation and partitioning of decision rights, and the design and use of performance measurement systems, integrative liaison devices, and standard operating procedures. We also consider the implications of integration for network performance. In our empirical analysis of three hospital networks we observe tension in network design relating to the achievement of efficiency and legitimacy imperatives that underpin the mandate to form hospital networks. The networks differ in their potential to generate efficiency and legitimacy gains from collaboration, their commitment to the ideals underlying the institutional mandate, and their willingness to pursue effective collaboration in light of the influence of other external constituents. In turn they adopt structural and control system designs that reflect different levels of clinical activity integration, and different degrees of substantive acquiescence to the institutional mandate to collaborate.

1. Introduction

The management of economic activity relies increasingly on various forms of collaboration between organisations, such as joint ventures, partnerships, strategic alliances, networks and co-operative inter-firm relationships (Anderson and Sedatole, 2001). The management accounting and control literature explores control problems and solutions in these hybrid forms of organisation.

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However, our understanding of these issues to date is constrained largely to the study of vertical inter-firm (supply chain) relationships in private sector settings (Caglio and Ditillo, 2008; van der Meer-Kooistra and Scapens, 2008). In the public sector, collaboration between organisations is often the result of reform agendas introduced in an attempt to improve the efficiency and effectiveness of service delivery (Brown, 2000; Herzlinger, 1997; Lega, 2005; McMurchie, 2000; Reddy, 2002; Scott, 2005). The management and control requirements of such collaborations are likely to differ significantly to those observed in the private sector, given the highly institutionalised context in which these organisations operate and given that collaboration is typically horizontal rather than vertical in nature. In this paper we investigate the design of mandated public sector networks. We undertake a case study of metropolitan hospital networks[3] in Victoria, Australia, created as part of a series of reforms of health care sector activities. The central public funding authority in this setting initiated the formation of hospital networks in the expectation this would further efficiency and effectiveness imperatives. While the assignment of hospitals to networks was mandated, network management retained full discretion as to the nature of collaboration between hospitals. We draw on Oliver's (1991) framework of strategic responses to institutional processes to interpret observed network designs. We investigate the extent and form of integration within hospital networks and analyse concomitant control choices as well as the implications of these design choices for network performance.

This study contributes to the literature in a number of ways. First, we consider the design of public sector hospital networks as a strategic response to a mandate to form collaborative relationships. We know little of the factors that influence design choice when collaboration is imposed, rather than voluntary. The use of Oliver's (1991) framework allows us to relax the assumption that design choices are driven by pure economic rationality and incorporate institutional theory as a joint influence on network design. Institutional theory is a potentially important explanator of design choice, especially in public sector settings (DiMaggio and Powell, 1983; Meyer and Rowan, 1977; Scott, 1992).

Second, we study horizontal collaborations. Despite the increasing prevalence of horizontal inter-organisational relationships, we know little about the antecedents of structural and control system choices appropriate for such organisational forms (Caglio and Ditillo, 2008). There are particular challenges in the design and control of horizontal collaborations. While vertical inter-organisational activity tends to combine complementary capabilities, resources or processes across organisations, horizontal exchange of activity between organisations frequently combines potentially competitive or substitutable capabilities, resources or processes. This can result in complex inter-organisational interdependencies, and tensions between constituent and collaborative goals, which are quite distinct from those observed in vertical contexts (Mouritsen and Thrane, 2006; van der Meer-Kooistra and Scapens, 2008).

Finally, Chua and Mahama (2007) illustrate the importance of considering complex configurations of networks of inter-organisational relationships. Caglio and Ditillo (2008) note that while some studies are positioned as explorations of networks they in fact focus on dyadic inter-organisational relationships. In this paper we examine three networks of collaborative activity, collecting data from multiple organisations within each network.

Drawing on this interview and archival data we identify a range of factors that explain observed differences in the strategic responses of hospitals to mandated network formation. We consider variation in the response of hospital networks to reflect perceptions of the likelihood of efficiency and legitimacy gains, the influence of constituent stakeholders, and the level of consistency between institutional and organisational goals.[4] These antecedents impact on both the aims and the requirements of co-ordination, the potential for resource misappropriations and difficulties in aligning constituent and network objectives. Oliver identifies a range of strategic responses associated with these antecedent conditions – acquiescence, compromise, avoidance, defiance and manipulation. We assess the strategic response of hospitals and networks within this framework by focusing on structural and control system choices. The rationale for public sector hospital network creation was the achievement of efficiency and effectiveness gains and improved access to services through reduction in duplication and rationalisation of service offerings (Metropolitan Hospitals Planning Board, 1995). We examine the strategic response of organisations to the State-imposed efficiency imperative by exploring network integration. We consider how both formal and informal structural and control choices promote and manage integration between organisations of the network. We investigate design choices that include: the delegation and partitioning of decision rights; the design and use of performance measurement systems; the use of integrating mechanisms; and the use of standard operating procedures. These design choices reflect different levels of integration of core clinical activity, differential commitment to the ideals underlying the institutional mandate, and different strategic responses to institutional pressures. By examining the allocation of decision rights as well as operating and reporting processes, we are able: (i) to distinguish levels of commitment to integration from full network-level core service (clinical) integration from organisational designs which, in practice, privilege individual hospital authority and reporting structures; and (ii) to distinguish network-level integration from a façade of integration adopted to satisfy the demands of the State as a stakeholder. This distinction between appearances and

[3] We adopt the term network in this paper to be consistent with its use in our case context. We use the terms hospital network and health care network synonymously.

[4] In exploring the factors that explain the strategic response of organisations to institutional pressures we do not completely test the model specified by Oliver (1991). In ensuing sections we elaborate on the explanatory factors and strategic responses in Oliver's (1991) model that we are not able to address.