Cultural consequences of cost control in public hospitals: An organisational level perspective

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ABSTRACT:

This paper explores the operationalisation of Activity-based funding (ABF) and its influence on organisational controls and the prevailing culture in public hospitals. Qualitative analysis of semi-structured interviews with fourteen senior managers reveals that ABF represents a decreed set of contractual obligations emphasising cost and efficiency, which are superimposed onto a pre-existing deeply entrenched culture that emphasises patient care. Organisational control systems which rely on high levels of bureaucratic and structural controls contribute to ongoing conflict between managers and clinicians resulting in a culture that is fragmented and adversarial. However control systems that emphasise commonalities in goals and vision are likely to result in a more integrated, collaborative culture where trust and mutual respect operate as the dominant control mechanism.

Keywords: Health policy; Healthcare management; Practice climate, culture, environment
BACKGROUND

Since the initial introduction of New Public Management (NPM) in the 1980s, ongoing health system reforms such as Activity-based funding (ABF) are increasingly aimed at controlling costs in public hospitals (Abernethy & Brownell, 1997; Duckett, Breadon, Weidmann, & Nicola, 2014). The gradual increase in managerial control and emphasis on cost and efficiency has resulted in a reduction in clinician autonomy and the decline of medical professionalism as the dominant culture (Freidson, 1988; Lewandowski, 2013). A such, healthcare provision has fundamentally shifted from a one-on-one relationship between patients and individual doctors, to a systems approach, which relies on multidisciplinary teams working together and collaboration between healthcare professionals and managers (Gittell, 2009; Kuhlmann & von Knorring, 2014). However, historical divisions between managers and healthcare professionals associated with imposing NPM ideology (managerialism) onto an existing deeply entrenched culture (professionalism), continues to cause tension between professional groups (Carvalho, 2014; Kuhlmann & von Knorring, 2014). Therefore, this research addresses the operationalisation of Activity-based funding in relation to the organisational control system, and its influence on staff behaviour, their interrelations, and “the way things are done”. In doing so, it also examines underlying theories around organisational control and organisational culture, and how these two constructs are linked.

Organisational control and organisational culture

On the one hand, organisational control is a system of control mechanisms designed and implemented by management to ensure employees are working towards achieving organisational goals (Abernethy & Chua, 1996, p. 573). On the other hand, organisational culture is considered to be a system of shared norms, values and beliefs that guide behaviour (Schein, 1996; Wood, Zeffane, Fromholtz, & Fitzgerald, 2006). The commonality between these two constructs is that they are both interested in behaviour; while control focuses on manipulating employee behaviour, culture is more of a lens for understanding behaviour. Both organisational control and organisational culture are well recognised as important elements which impact on organisational performance and productivity.
(Balthazard, Cooke, & Potter, 2006; Wilkins & Ouchi, 1983) however, the link between these two constructs and how they interact with one another remains unclear.

According to Ouchi’s (1980) modes of control framework there are three modes of control: Markets, Bureaucracies and Clans. More recently, these modes of control have been used to describe and assess an organisation’s culture. For example, Cameron and Quinn (2011) defines four types of culture; Hierarchy, Market, Clan, Adhocracy. Hierarchies are characterised by bureaucracy; Markets focus on transactions and the exchange of value; Clans rely on tradition, shared vision and goals; and adhocracy emphasises independence, flexibility, innovation and calculated risk. Using modes of control to assess the culture of an organisation assumes an inherent link between control and culture which suggests that if managers change the control mechanism within an organisation, this will in turn change the organisational culture. However, it is unclear if intentional changes to the control system will result in the type of culture that is desired by the organisation.

Another perspective is one that sees organisational control as a system of control mechanisms which work interdependently to encourage staff to work towards achieving organisational goals. For example, Flamholtz (2012) depicts three internal control mechanisms which operate within the external organisational environment. At the centre is the core control system, which are the administrative and financial controls, and performance measurement and reward systems. The core control system operates within the organisational structure, which is the formal structure and hierarchy that determines which roles have legitimate power over other roles. The third control mechanism is organisational culture which is the organisation’s value system, shared beliefs and assumptions. In this way, organisational culture is seen as a variable which is subject to design, and a product of management decision. As such the authors argue that managers can change the culture to one that is desired by the organisation by changing the organisational value system. To understand this better, Schein (1990) explains that there are three fundamental levels of culture; observable artefacts, shared values and common assumptions. Observable artefacts are the explicit behaviour patterns that a group displays. Shared values represent the set of coherent values that link members of an organisation together. Common assumptions are a collection of truths that members share based on
their experiences and which guide values and behaviours. Schein’s approach assumes that employees will share the organisational values, which will in turn create a culture that is desired by the organisation. Davies et al., (2000) argues however that while the more visible elements of culture such as artefacts and espoused values may be manipulated, the underlying assumptions, beliefs and attitudes of individual staff may be more difficult to change. This suggests that even though culture is often used as a component within an organisational control system, it doesn’t necessarily mean that culture is something that can be created and controlled through an organisational value system.

An alternative perspective is one that sees organisational culture as the organisation’s personality which is unique, organic and socially constructed and therefore cannot be controlled by management (Allaire & Firsorutu, 1984; Smircich, 1983). This approach is more interested in the symbolic meanings associated with explicit manifestations of culture including symbols, languages and actions (Parker, 2000) and emphasises context and the uniqueness of an organisation’s culture. However, Louis (1985) challenges this assumption arguing that organisational cultural boundaries are likely to be penetrated by external influences such as a staff member’s commitment to their professional identity. According to Martin (2002), multiple cultures may co-exist within an organisation and as such, it is important to examine culture from multiple perspectives. Organisational culture can be observed through three lenses: the integrated perspective which assumes homogeneity; differentiated perspective which assumes consensus within sub-groups; and fragmented perspective, which assumes a lack of consensus between individuals (Martin, 1992). As such, the degree to which the organisational values are shared throughout the organisation can be considered an indication of the type of culture (integrated, differentiated and/or, fragmented).

**Purpose of the research**

Much of the research around Activity-based funding (ABF) is focused on its impact on measureable outputs such as cost and efficiency (Sussex & Farrar, 2009), and quality indicators such as length of stay, re-admission and mortality rates (Farrar & Deckhee, 2009). However empirical studies which look at the broader impact of ABF on organisational culture are relatively scarce, particularly in Australia. Developing a better understanding around the cultural consequences of ABF
in public hospitals will assist managers in developing strategies designed to improve collaboration and cooperation, and overcome historical tensions between managers and clinicians. Therefore this research is interested in the senior manager’s perspective of ABF and how the organisation is responding in terms of its goals, control mechanisms, value system and the prevailing culture. As such, it explores the research question: “How do organisational control mechanisms shape organisational culture in the context of Activity-based funding?”

METHODOLOGY

Study design

This research is an exploratory qualitative study aimed at establishing an overall picture at an organisational level, of the dominant control mechanisms, type of culture, and how these are influenced by Activity-based funding and professional identity. It uses qualitative analysis of informant interviews and archival data (strategic plans, annual reports, websites etc.) to identify key issues and themes.

Setting and study population

This study was conducted within a public sector healthcare organisation in Australia. The study population is senior managers within the organisation who have a high level of decision-making power and budgetary responsibilities across administrative and/or clinical areas. Ethical approval was granted through the hospitals’ Human Research Ethics Committee (HREC) and the XXX University HREC.

Data collection and analysis

The interview questions shown in Table 1 were developed from two key bodies of literature being organisational behaviour/management, and organisational/financial control.

A snowball sampling method was used to recruit a total of 14 senior managers. Semi-structured interviews were conducted face to face between September 2015 and February 2016, and informed consent was obtained from all participants prior to conducting the interview. Interviews
were conducted in the offices or meeting rooms of the participants’ place of work and lasted 30 to 45 minutes. Open-ended questions initiated and guided discussion, and prompts were used to gain further explanation or clarification, and for more in-depth exploration of topics and issues raised. Interviews were recorded and transcribed verbatim, and detailed notes were also taken by the researcher with regards to observations made during the interview concerning the office setting, body language and communication style. Qualitative data analysis software QSR NVivo 10 was used to code the data, and develop a coding framework and conceptual model of the key themes that emerged. All interviews, coding and analyses were undertaken by the one researcher, however throughout this process, cross-coding verification was conducted with co-authors to ensure reliability of the coding and the conceptual model that emerged.

**FINDINGS**

The research findings are presented in three parts: Organisational goals and goal congruence; Organisational control system and performance measurement; and Value systems, organisational culture and the influence of professional cultural identity.

*Organisational goals and goal congruence*

Senior managers indicated that the organisational goals are very much aligned with those of the State Government Department of Health. Some participants felt there is a high degree of goal congruence downwards through the organisation as one senior manager explained:

“We have obviously the organisation-wide strategic plan, so those are health service planning documents that set the expectations, then they cascade down to the directorate level.” (Participant 13).

According to participants, this cascading, multi-level goal-setting and strategic planning is achieved through a collaborative process which is driven from the ground up. Despite this however, some senior managers suggested that some clinical staff don’t really connect with the strategic goals because the goals are ambiguous and don’t represent what clinicians do in their day-to-day work. The
lack of relevance of the strategic goals in the routine work of clinical staff makes them difficult to implement at an operational level as one senior manager explained:

“In my current role it’s very much about getting that message across and aligning all of our work across all of those areas, but it’s difficult trying to implement those goals into day to day practice” (Participant 9).

Overall, these findings suggest there is a lack of congruence between the strategic goals, the operational goals, and the goals of the health professionals; and that different groups tend to prioritise different goals. Even though recent restructuring at a State level has given the organisation an increasingly higher level of autonomy to set their own policies and procedures, the strategic goals are strongly influenced by the political environment within which it operates and reflect how the organisation is expected to be perceived by its key stakeholders including the Department of Health and community. The operational goals however are more aligned to the way performance is measured, and the goals of health professionals are focused on providing appropriate treatment to all patients who present.

Organisational control mechanisms and performance measurement

Findings suggest that the organisational control system is primarily focused on monitoring and reporting against key performance indicators (KPIs), counting costs, and ensuring compliance with policies and procedures. This is largely in response to externally imposed controls associated with the Service Agreement with the state government under ABF. The Service Agreement specifies the pre-determined amount of resources allocated to the different areas of health service delivery based on the predicted level of activity. Senior managers explained that there is often a mismatch between the predicted level of activity and the number and type of patients seeking treatment, and ABF essentially passes any risk of increased expenditure onto the healthcare organisation. Therefore one of the biggest challenges is managing demand for healthcare which exceeds a constrained supply:

“Most organisations have a budget in health to live within and most organisations face demand for their services that if met would potentially cost the organisation more than its
budget. So the fundamental challenge is dealing with the demand for health within the financial resources allocated by the State” (Participant 11).

While the organisational control system is focused on measuring performance in terms of measureable activity and cost, senior managers indicated that professional subgroups also have their own sets of controls which are primarily in relation to clinical standards and quality indicators. While some professional controls are consistent with those of the organisation, some are discipline specific and have more of an emphasis on quality, rather than quantity and cost, which suggests there is a moderate degree of ambiguity in performance measurement.

According to Ouchi’s modes of control framework (Ouchi, 1980), where there is a moderate degree of goal incongruence and a moderate degree of ambiguity in performance measurement, the most efficient mode of control is bureaucracy. Indeed, the organisational control system was perceived as being highly bureaucratic with one senior manager describing it as being characteristic of a highly centralised system, which relies primarily on structural and bureaucratic controls to ensure compliance with rules, regulations, policies, procedures, and governance framework. Some participants felt it is necessary to have a high level of bureaucratic control especially in response to previous incidents whereby employees did not comply with policies and procedures. Others however suggested that the level of bureaucratic control is somewhat excessive and unnecessary, and slows the system down. In addition, senior managers indicated that staff, particularly clinicians do not like high levels of bureaucratic controls, and that increasing levels of bureaucratic controls is not an effective strategy for overcoming issues as one senior manager explained:

“Managers bring in control measures to address issues can alienate clinical staff so they are scared to behave in a certain way for fear of reprimand. [Example] broke down trust and respect, and changes in attitudes were seen. A better way is to talk the clinicians’ language and find out why this issue is happening rather than bringing in a big stick” (Participant 12)

These findings suggest that the high level of bureaucratic control is causing conflict between the managers at the strategic level of the organisation and the clinicians at the operational level of the organisation. As such, improving the alignment of the strategic and operational goals, and the way
performance is measured, may reduce the need for such a high level of bureaucratic control, and in turn, create the opportunity to build stronger relationships amongst staff between professional groups and hierarchical levels.

Value systems, organisational culture and the influence of professional cultural identity

The organisational values were perceived as being extremely important and well communicated. It was generally felt that staff in the executive team can relate to the values and usually demonstrate them through their behaviour and interrelations with other executive level staff. As such, at the strategic level the organisational values seem to be well shared, however participants indicated that staff at the operational level often don’t really connect with the strategic values:

“The values feel very Government, ‘public sectory’, and a lot of people in healthcare delivery organisations find that they are not people-focused enough, not soft enough, or don’t quite sit with their service delivery ethos. So they think the values are just not grounded in where they really are” (Participant 1).

While most participants indicated that they tried to impart the organisational values onto staff at the operational level, they said it was difficult, and that staff behaviour is quite inconsistent:

“There are some days where [the values] are very tangible, very visible, that there are shared values and staff embody values. Then there are other days where it’s very clear that our staff have no interested in, or knowledge of the values and whose behaviours are inconsistent with the organisation’s values” (Participant 12)

Some participants suggested that when work situations became stressful or confrontational the organisational values tended to disappear. One senior manager explained that some clinicians feel that they do not need to answer to managers, but rather to senior clinicians within their discipline. Another suggested that some staff just seem to have a blatant disregard for the organisational values and think they can get away with inappropriate behaviours. These findings suggests that the organisational values may only have a limited influence over the behaviour of staff at the operational level, and that the behaviour of clinicians may be more strongly influenced by the connection they have with their
professional identity. This challenges the assumption made by Flamholtz (1995) that organisations can create and control organisational culture through the organisational value system, and is more consistent with Louis (1985) who argues that organisational boundaries are permeated by professional cultures, and Martin (2002) and J. Fitzgerald (2002) who argue that multiple cultures co-exist within an organisation. Indeed senior managers indicated that each clinical discipline has its own deeply entrenched professional culture with their own hierarchical systems and practice standards, which is constantly reinforced by their peers and professional institutions. For example, in relation to nurses:

“If they wanted to move on their career ladder they have to have the body of evidence to submit to a panel who review their portfolio and decide whether they are going to be professed or not and if they can move on to be recognised as an expert. So that’s another way of instilling professionalism within the profession” (Participant 8).

Senior managers acknowledged that cultural differences are causing fragmentation between professional groups and within multi-disciplinary teams, and are generally the root cause of a lot of issues which arise. The general attitude of the senior managers was that clinicians need to develop more of a business sense, and have a better understanding of the managerial/financial side of healthcare delivery. Therefore there is a strong push from some senior managers to try and improve the culture and a number of strategies are being put in place to improve relationships and show commonalities of purpose and vision. These strategies include monitoring and assessing culture through staff surveys, creating hybrid positions (clinical and management responsibilities), and the development of a Relational Co-ordination Program. They acknowledged however that it is difficult to change the culture, and most seemed unsure of how to address cultural differences.

Overall, staff at the strategic level of the organisation have a strong connection to the organisational values, which indicates an integrated, fairly homogenous culture. However, staff at the operational level have a stronger connection to their professional cultural identity which indicates a more differentiated or fragmented culture. As such, professional cultural controls can at times undermine or override bureaucratic controls and the organisational values, and increasing levels of bureaucratic controls are likely to further alienate staff and increase the gap between the strategic and
operational levels of the organisation. Therefore, one of the most important challenges for managers is to balance the demands placed on them from externally imposed controls such as ABF and the Service Agreement, with creating an internal environment that is built on trust, mutual understanding and a common vision, rather than relying on high levels of bureaucratic controls.

**DISCUSSION**

This paper aims to explore how control mechanisms shape the organisational culture in public hospitals in the context of ABF from an organisational level perspective. Findings indicate that the organisational environment is strongly influenced by external factors which are causing a moderate level of incongruence between the strategic goals, operational goals and the goals of health professionals. Differences in the prioritising of competing goals between professional groups and hierarchical levels create a moderate degree of ambiguity in the way performance is measured. As such, the organisation relies on a highly bureaucratic organisational control system, which is causing conflict between managers and clinicians, and a disconnect between the strategic and operational levels of the organisation. These findings are consistent with much of the literature in relation to managing healthcare organisations (Glouberman & Mintzberg, 2001a, 2001b), the introduction of new public management (NPM) and ABF (Abernethy & Chua, 1996; Carvalho, 2014), and professionalism (J. Fitzgerald, 2002; L. Fitzgerald & Ferlie, 2000; Freidson, 2001). Current literature suggests that the continued application of New Public Management ideology and high levels of bureaucratic control emphasising cost reduction, are likely to perpetuate ongoing conflict between managers and clinicians, therefore organisations need to find a new approach to rebuilding this relationship (Kuhlmann & von Knorring, 2014; Lewandowski, 2013).

Key findings from this study indicate that values may be the critical link between control and culture. The figure presented below identifies dominant value systems at the strategic and operational levels of the organisation which link the dominant control mechanisms (external and internal) with the dominant type of culture.
As shown in the figure, at the strategic level of the organisation, the dominant external control mechanism is a politically managed market which relies on a high level of internal bureaucratic control. The dominant value system which drives staff behaviour at this level is the organisational values and the prevailing culture is integrated. At the operational level, the dominant external control mechanism is professional cultural identity and the dominant internal control mechanism is clan. Therefore, professional or personal values are the dominant values systems which guide behaviour resulting in a culture that is differentiated or fragmented. This suggests that imposing a new set of values and high levels of bureaucratic control over a pre-existing culture will only have a limited impact on influencing behaviour and can lead to a fragmented culture. Yet it is important to acknowledge that many of the professional values are actually consistent with the organisational values, and it may be the symbolic meaning that different professionals and individuals attach to the managerial language and approach that is causing the conflict. As such managers need develop new and innovative ways for the organisation to support and promote synergy between the strategic and operational levels of the organisation by focusing on goals and strategies which emphasise commonalities between value systems (Kuhlmann & von Knorring, 2014; Noordegraaf, Schneider, Van Rensen, & Boselie, 2015). In order to achieve this however, organisations need broader support from both the side of the government as well as professional institutions. According to Kirkpatrick, Jespersen, Dent, and Neogy (2009) Governments can facilitate this through reform strategies which provide incentives for doctors to engage with management, and professional institutions need to encourage clinicians to actively seek and engage in management strategies.

CONCLUSION

Organisational control mechanisms play a critical role in shaping the organisational culture. ABF represents a decreed set of rules and regulations that emphasise cost and efficiency, which are superimposed over a pre-existing deeply entrenched culture that emphasises patient care. As such, the internal organisation control system, which is comprised of the organisational goals, structural and core controls, and the organisational value system, can be seen as the interface between these two opposing ideologies and can therefore serve as a means for integration. While organisations cannot
directly create and control the organisational culture, the control system they construct and implement will have a major influence in shaping the culture. Control systems which are designed around differences and the authority of one group over another are likely to cause greater disparity between managers and clinicians, resulting in a culture that is fragmented and adversarial. However, control systems which emphasise commonalities and actively promote trust and mutual respect will help to unite the two groups. This approach is likely to result in a more integrated, collaborative culture where staff are working towards a common goal and vision, without forsaking traditional values and beliefs. In order to achieve this however, organisations need broader support from both the side of the government as well as professional institutions.

Apart from the inherent limitations associated with a qualitative methodology (Creswell, 2009), there are two other limitations. Firstly, this study was conducted in only one organisation, which means that caution should be taken when considering transferability of the findings. However, the key issues examined in this study are not site-specific and therefore the results may be extrapolated and tested for relevance in other public sector healthcare organisations which operate within similar external control environments and high levels of bureaucratic control. Secondly, the study presents senior manager perspectives only, which may not accurately represent the perspectives of operational staff. Therefore the application of these findings at the operational level should be exercised with caution. As such, ongoing research needs to explore this topic from the operational perspective in order understand how clinicians actually feel about ABF and the managerial response in terms of the organisational goals, control mechanisms, values and culture.
REFERENCES


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### Table 1: Interview questions

<table>
<thead>
<tr>
<th>Interview Question</th>
<th>Source</th>
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<tbody>
<tr>
<td>1 Please tell me about your role within the organisation?</td>
<td>(Glouberman &amp; Mintzberg, 2001a, 2001b; Johansen, Olsen, Solstad, &amp; Torsteinsen, 2015; Kirkpatrick et al., 2009)</td>
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<tr>
<td>2 Please tell me about the organisational goals and you perception of how well they align with the goals of Queensland Health and the goals of your department?</td>
<td>(Duncan, 2014; Ouchi, 1980)</td>
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<td>3 Please tell me about the organisational values and your perception of how shared they are throughout the organisation?</td>
<td>(Carvalho, 2014; Davies et al., 2000; Freidson, 2001; Louis, 1985; Martin, 2002; Schein, 1990)</td>
</tr>
<tr>
<td>4 Please tell me about the key organisational control mechanisms and your perception of how effective they are in ensuring employees are working towards achieving the organisational goals?</td>
<td>(Flamholtz, 1995; Malmi &amp; Brown, 2008; Ouchi, 1980)</td>
</tr>
<tr>
<td>5 Please tell me about the funding model and how resources are allocated? Also please tell me about some of the challenges and some of the good things about these.</td>
<td>(Canadian Health Services Research Foundation, 2013; Covaleski, Dirsmith, &amp; Michelman, 1993; Duckett et al., 2014)</td>
</tr>
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#### Figure 1: Values linking control and culture

- **Organisational level**
  - Strategic
  - Operational

- **Dominant external control mechanism**
  - Politically managed market

- **Dominant internal control mechanism**
  - Bureaucracy

- **Dominant value system**
  - Professional / personal values

- **Dominant type of culture**
  - Integrated
  - Differentiated / fragmented