

Performance Management and the Specificities of Public Hospitals

Fliliss Abdlhaq

Doctorate in economics and management, Faculty of Law and Economics, Fés.

Abstract

The aim of this article is to describe the specific features of public hospitals that hamper performance measurement. We conducted a literature review of several theses and articles, which enabled us to describe the specificities of public hospitals and their impact on hospital performance measurement and management systems.

Keywords: performance management, hospital performance, public hospitals, management control.

1. Introduction

The multi-dimensional nature of hospital performance, coupled with the specificity of care missions and the original principles of care facilities, make performance measurement a difficult task.

In this respect, several works in management control note that the use of performance measures within healthcare organizations is emblematic for several reasons, the complexity of these establishments, their typical missions and the pluralism of their professions. Combining the quest for productivity with consideration for patients' unique needs is a challenge for healthcare professionals¹.

The authors also point out that hospital establishments are divided into four different worlds, complicating the links between control and care missions. The criterion for distinguishing these four worlds is based on function: the world of "cure", whose main function is treatment, is represented by doctors. The second world is that of "care", whose main function is nursing, represented by nurses. A third world of control is led by administration. And finally, a fourth world of community. This divide fuels tensions between the four worlds and limits coordination within hospital establishments.

The patient is at the heart of care structures, because the hospital's main mission is to provide preventive, curative or palliative care. This care is intended for all people, and each patient must follow a care pathway from the moment he or she is admitted to the hospital until he or she is discharged. While the care pathway is unified, care differs according to a number of criteria, essentially duration, nature of care or intervention. Thus, hospital establishments receive patients who require urgent interventions, and others who suffer from chronic pathologies and need regular recourse to public hospital care. As a result, when introducing performance measures, doctors are faced with the dilemma of whether to provide the "right" care, or to give priority to quantification objectives¹⁸³. A number of studies have highlighted the impact of performance measurement on the quality and safety of patient care.

The impact of the introduction of performance measures cannot be the same for all in-house players, as teaching physicians in university hospitals are distinguished by a mission dedicated to scientific

¹ Weber, J., & Horner, K. (2012). *Introducing multilingualism: A social approach*. London: Routledge.

research. They are also involved in activities other than providing care, such as teaching and representing professional committees. Grima et al¹⁸⁴, consider that these doctors run the risk of being drawn into administrative tasks and focusing their activities on quantitative objectives, to the detriment of their other missions.

This search for coordination between market principles and the values of the public hospital service is supposed to be problematic. Several authors analyze this combination, which Thévenot¹⁸⁵ describes as paradoxical. Another major issue for hospital organizations is the impact of performance measurement on the autonomy of healthcare professionals.

2. The autonomy of healthcare professionals challenged by the introduction of performance measurement in hospitals.

A number of studies have concluded that accountability in hospital organizations, supported by the use of performance measures and the introduction of NPM principles², is confronted by a dominant medical and professional logic. Despite the reluctance of doctors, the use of accounting tools is finding its way into hospital organizations. As a result, doctors are required to account for their activities. In this sense, performance indicators are seen as a new way of controlling the medical profession, as well as guarantors of the quality of care provided to patients. The use of performance indicators can lead to a loss of medical autonomy based on peer control and professional values³.

This question of the autonomy of healthcare professionals in the use of performance measures has been widely debated, with Abernethy & Stoelwinder pointing out that the introduction of management control practices into professional organizations risks creating a culture shock. In the same context, a number of studies analyze the notion of hybridization of "converted" physicians into physician-managers⁴. The results of these studies leave room for ambiguity, as they reveal two contradictory postures: resistance and compliance on the part of doctors in the face of these managerial practices.

Doolin⁵, to carry out a study in New Zealand hospitals which showed that doctors who had become managers of their care units adapted to this new managerial culture. The same study showed that doctors intervened to absorb change rather than defend it, reflecting a conflict between the priorities of economic organizational survival in an increasingly competitive healthcare market and the maintenance of a negotiated internal order at the level of the work organization. This decoupling is seen as a form of resistance, where actors seem to accept change for the sake of external legitimization, but resist the use of these change practices internally.

A second study to address the notion of physician hybridization in the Finnish hospital context. So, for doctors who have acquired calculation management skills, this study reflects an appropriation of accounting tools by doctor-managers. But it does not enable us to understand the compromises made to accept these uses in the field.

²Thévenot, L. (2001): "Organized complexity: Conventions of coordination and the composition of economic arrangements", *European Journal of Social Theory*, 4 (4), pp. 405-425. DOI : [10.1177/13684310122225235](https://doi.org/10.1177/13684310122225235)

³Freidson E. The Reorganization of the Medical Profession. *Medical Care Review*. 1985;42(1):11-35. doi:10.1177/107755878504200103

⁴Kurunmaki, L. (2004) A Hybrid Profession-The Acquisition of Management Accounting Expertise by Medical Professionals. *Accounting, Organizations and Society*, 29, 327-347. [https://doi.org/10.1016/S0361-3682\(02\)00069-7](https://doi.org/10.1016/S0361-3682(02)00069-7)

⁵ Doolin, B. (2002). Enterprise discourse, professional identity and the organizational control of hospital clinicians. *Organization studies*, 23(3), 369-390

In 2009, a longitudinal study highlighted the successful integration of balanced-scorecard in Swedish healthcare facilities. However, this study did not specify the problems underlying this compliance, nor the behavior of managing physicians in the face of the tensions induced by the use of this performance management tool.

3. The perverse effects of using performance measures in hospital organizations.

In order to identify the negative effects of using performance measures in the hospital context, we have based ourselves on several works from specialist journals in a variety of disciplines: medicine, public management, nursing and management control.

One study looked at GHMs in French hospitals, and more specifically intensive care units⁶. These care units are dedicated to admitting critically ill patients requiring specific and specialized care. The central question of this study is to determine the impact of the introduction of GHMs on care practices, and they show that the use of GHMs can have serious problems in the specific context of intensive care units, as the revenue received by these units remains significantly lower than the costs actually incurred by the care provided to patients. This imbalance between revenues and costs leads hospital managers to make decisions such as creaming patients, dumping patients or reducing the number of intensive care beds⁷. Werner & Asch⁸, indicate that the communication of performance measures influences the quality of care. Although the aim of communicating performance measures is to improve transparency vis-à-vis stakeholders and improve quality rankings. However, this practice risks, on the one hand, pushing doctors to achieve target rates for care interventions even when this is not indicated for certain patients, on the other hand, encouraging doctors to avoid seeing certain patients in order to improve their quality ranking, and finally, neglecting patient preferences and clinical judgment. The authors believe that making performance measures public can have the opposite effect: reducing rather than improving the quality of care. For this reason, a re-evaluation of the role of performance measures is needed in the hospital context.

In 2012, a study identified twenty negative effects of performance measurement systems on hospital facilities⁹. The authors grouped these effects under four categories: poverty of measurement; misplaced incentives and sanctions; breach of trust; politicization of measurement systems. The twenty effects are as follows:

1. Inadequate choice of measures: managers focus on achieving the objective, rather than on what the measure actually means. In the example given by the authors, management decided to reduce the waiting time in the emergency department to five minutes, in order to improve the patient experience in this department. However, these measures prompted the nurses to adopt a very superficial greeting behavior, the aim of which was to validate the achievement of the objective. This behavior proved to be very costly for the facility, generating additional expenses without providing any benefit for patients. The authors believe that these adverse effects of performance measurement can be alleviated

⁶ Mannion, R., & Braithwaite, J. (2012). Unintended consequences of performance measurement in healthcare: 20 salutary lessons from the English National Health Service. *Internal medicine journal*, 42(5), 569-574.

⁷ C. Coulton et al. Discharge planning and decision making Health and Social Work (1982)

⁸ Werner, R.M. and Asch, D.A. (2005) The unintended consequences of publicly reporting quality information. *The Journal of the American Medical Association*, 293, 1239-1244. <http://dx.doi.org/10.1186/1471-2296-14-95>

⁹ Angelé-Halgand, Nathalie. (2014). Tarification au parcours ou au cycle de soins? *Revue Hospitalière de France*. 31-34. 10.3917/jgem.142.0141.

by involving front-line players - doctors and nurses - in the process of designing performance measurement systems.

2. **Tunnel vision:** is characterized by a concentration on certain dimensions of performance favored by a measurement system. In our example, focusing on the measurement of waiting times in the emergency department means neglecting the quality of care provided to patients.
3. **Myopia:** implies that managers focus on short-term problems and neglect long-term ones. The authors note that managers focus on measuring the performance of curative services and neglect the preventive aspects of care. To mitigate the myopic effect, the authors recommend setting medium- and long-term objectives;
4. **Ossification:** occurs when the hospital becomes paralyzed as a result of using a rigid performance measurement system. To reduce ossification, the authors recommend regularly updating the measures and data used to take account of technological developments, new procedures and rectified care paths.
5. **Irrelevance of the data collected,** specifically due to the time lag between data capture, processing, dissemination and use. To combat this problem, the authors recommend investing in performance measurement systems that minimize the time lag between data entry and dissemination;
6. **A focus on quantification is one of** the most widespread risks in hospital organizations. It can be defined as restricting complex problems to simple numbers, which leads to a loss of qualitative visibility of care, such as the patient experience or the working conditions of caregivers;
7. **Overcompensation:** occurs when performance incentives paid to professionals are too high in relation to the achievement of "mediocre" performance targets. These "over-dosed" incentives are given to the detriment of other aspects requiring these resources;
8. **Under-compensation:** occurs when performance incentives paid to professionals are very low or non-existent.
9. **Insensitivity:** is the risk of representing only poor performance to the detriment of good performance achieved in other departments. As a result, the whole organization is penalized while certain departments perform well.
10. **Widening inequalities:** this risk can arise when the funding of hospital organizations is linked to the performance achieved. This funding can be used to invest in services and improve the user experience for high-performing establishments. Non-performing hospital organizations, on the other hand, will find themselves less funded, and so performance inequalities will increase.
11. **Complacency** indicates disinterest in improving the non-performance of a service due to the perception of rankings linked to performance measures. For example, poor performance reflected in hospital rankings may prevent attempts to respond to incentives and seek further improvements.
12. **The attractiveness of** hospitals will be impacted, with nurses and doctors preferring to work with higher-ranked hospitals, while lower-ranked hospitals will find it difficult to recruit staff, thus increasing the performance gap between hospitals.
13. **Data manipulation:** staff make false declarations that differ from actual behavior. Several healthcare executives manipulate data linked to patient waiting lists to avoid penalties from health authorities, or declare false co-morbidities for patients to get higher compensation.
14. **Gambling is the** modification of behavior in order to gain a strategic advantage;
15. **Incorrect interpretations** are due to the difficulty of fully accounting for all the dimensions of performance. The authors support this observation with the example of the interpretation of readmission

rates, which may be the result of patients being discharged early, but also of poor management during the hospitalization process.

16. Intimidation often observed in an environment where staff are under pressure to perform better.

17. Declining confidence occurs when the local population expresses a low level of confidence in the services offered in care facilities, following a performance evaluation.

18. Psychological and psychological effects can occur in employees as a result of poor performance;

19. Politicization of performance data occurs when political parties, the media and other stakeholders use performance measures to score points, leading to an increase in the negative image of hospital organizations.

20. Political diversion: instead of reforming their healthcare systems, governments under pressure will seek to implement a new performance measurement system with the promise that this solution will bring the necessary improvements to healthcare organizations.

In a case study focusing on the measurement of post-surgical 30-day mortality, the authors demonstrate the negative effects of performance measurement in the American hospital context. Measuring this indicator leads ICU nurses to postpone comfort care for patients in need, in order to achieve the required rate. These practices have negative effects, as they generate financial costs associated with unnecessary care. These findings confirm the effects described by Smith¹⁰ including tunnel vision, myopia and gaming.

Aryankhesal et al¹¹ list seven perverse effects inherent in the introduction of performance measurement systems in Iranian hospitals. These dysfunctional aspects are: misrepresentation of data by hospitals; anxiety and stress among hospital employees; tunnel vision; increased financial pressure on poorly-ranked hospitals; incentives to purchase unnecessary equipment; loss of user confidence; and restriction of access to hospital services for certain patients. The authors conclude that the pay-for-performance system has made it difficult for poorly-ranked hospitals to improve their performance.

The emergence of T2A: activity-based pricing in French hospitals, has led to an increased focus on activity¹². The authors show that T2A encourages managers to give priority to quantitative indicators: revenue from the department or activity cluster, number of stays, number of GHMs treated, DMS ...). This race and determination to quantify activity generates exhaustion, stress and tension within and between healthcare managers.

Franco-Santos & Otley¹³, publish a review of the literature on the effects of the use of performance measures on healthcare establishments. According to the authors, these perverse effects are the norm rather than the exception in hospital organizations, driving managers to adopt "inappropriate" practices such as lying to escape pressure. The authors point out that few studies provide explanations of how and why these effects occur.

All the studies analyzed show that the value of using performance measurement systems in hospital organizations remains to be proven. These studies provide a detailed account of the perverse effects asso-

¹⁰ Smith, G. T., & McCarthy, D. M. (1995). Methodological considerations in the refinement of clinical assessment instruments. *Psychological Assessment*, 7(3), 300.

¹¹ H. M., Aryankhesal, A., & Haghani, H. (2015). The relationship between the managerial skills and results of "performance evaluation" tool among nursing managers in teaching hospitals of Iran University of Medical Science. *Global journal of health science*, 7(2), 38.

¹² KLETZ F. and MOISDON J.-C. (2015): Metabolizing an economic incentive: expected and unexpected effects of new modes of financing the hospital system. *Revue Sciences de Gestion - Management Sciences - Ciencias de Gestión*, n°106.

¹³ Franco-Santos, M., & Otley, D. (2018). Reviewing and theorizing the unintended consequences of performance management systems. *International Journal of Management Reviews*, 20(3), 696-730.

ciated with the use of performance measurement, but do not help us to understand either why or how these effects arise in a particular context: healthcare organizations.

The use of performance measurement systems was the subject of a systemic review by Klassen et al¹⁴, the main findings of which show the existence of over 100 performance measurement frameworks identified in the health, education and social services sectors.

4. Conclusion

There's no denying that hospital performance is a major issue in the healthcare sector, and management control plays an essential role in measuring and improving it. Hospital performance is not limited to financial aspects, but also encompasses operational dimensions, quality of care, patient satisfaction and many others.

However, it is important to emphasize that hospital performance measures must be chosen with care, and must be aligned with the facility's strategic objectives. A balanced approach, integrating both financial and non-financial indicators, is necessary to gain a global view of performance and avoid potential biases. Hence the importance of the Balanced Scorecard as a tool for measuring hospital performance.

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¹⁴ Klassen, R. M., & Chiu, M. M. (2010). Effects on teachers' self-efficacy and job satisfaction: Teacher gender, years of experience, and job stress. *Journal of Educational Psychology*, 102(3), 741.

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