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Abstract

This paper looks at hospitals' organizational structure through an institutional lens in order to examine how these organizations respond to the institutional complexity of the healthcare sector. Drawing on multiple and complementary sources of data, extracted from a focus group study, a statistical national database and a survey inquiry, we investigate one structural response of French hospitals to the emergence of a new managerial logic bringing more complexity in their field. We observe that this response, namely the implementation of management control systems, addresses this complexity by combining different institutional logics in a segmented system of actors, and that this arrangement of logics is not a strict homothetic translation of its correspondent field logic. We use the concept of hybridity to describe the distribution of institutional logics guiding organizational actors' behavior and conclude that cooperation within the system is related to the scope of action of most hybrid actors. We therefore contribute to the literature on institutional logics in healthcare by identifying organizational translation of field logics and hybrid actors' agency as key parameters in the structural design of hospitals' responses to institutional complexity.

Introduction

Healthcare systems face a high level of institutional complexity due to prescriptions from multiple institutional logics (Greewood et al., 2011). As a consequence, the conceptual framework provided by institutional logics scholarship has proved fruitful to explain profound transformations of these systems, like the rise of managed care as a new logic challenging the dominance of professional and state logics (Scott et al., 2000). Whereas managed care in the United States has strengthened both market and corporate logics (Nigam & Ocasio, 2010; Pouthier et al., 2013), evidence of a family (Heimer, 1999) or a community (Waldroff et al., 2013) logic can also be found in the literature.

If these approaches unveil the institutional complexity at play in healthcare as a field, less academic interest has been paid to the translation of this complexity at the organizational level. Although some empirical studies give illuminating examples of strategic responses to institutional complexity in hospitals (Heimer, 1999), or of strategic and structural responses by health authorities (Reay & Hinings, 2009), they posit competition as a *modus vivendi* between actors bearing each one a single logic. Further research on how actors driven by a plurality of logics interplay within organizational structures in a competitive or cooperative fashion is therefore warranted in the healthcare sector.

The purpose of this paper is to address this dearth of research by analyzing one of hospitals' structural responses to the institutional complexity of their environment. As central organizations in their field (Battilana & Casciaro, 2012) hospitals are particularly "exposed to the tension that multiple logics engender" (Greewood et al., 2011: 319). Their structural responses to complexity may accordingly serve as a paragon for the other organizations of the same sector.

One of these responses has been the flourishing of management control systems in the two thirds of French public and non-profit hospitals, with a 132% increase from 2009 to 2014 (*Source: French National Observatory on Analytical Accountings, 2014*). Two field-level reforms, fostering a "managerial approach in hospitals" (Engel et al., 2000), induced this development (Lartigau, 2009): the shaping of a more decentralized pattern of governance involving medical departments in corporate decision-making, and the implementation of an activity-based payment model for hospitals' stays.

These reforms embraced the same characteristics as the ones of the managed care logic in the United States, placing emphasis on efficiency in the delivery of medical services through technological imperatives, market reforms, and cost control mechanisms (Dunn and Jones, 2010). We will show that the adequacy of management control in this context relies on its capacity to combine, at the organizational level, these incipient logics with the long-prevailing state and professional norms of the clinical practice (Foucault, 1963).

Theoretical background

Like Waldroff et al. (2013), we used Thornton's (2004) inter-institutional system as an analytical framework to qualify the institutional logics at work in our scope of research. From this perspective, institutional logics can be defined as "the socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality" (Thornton & Ocasio, 2008: 101). Building on Friedland and Alford's (1991) notion of institutional orders, Thornton et al. (2012) derive seven ideal types of meta-logics at the societal level: Family, Community, Religion, State, Market, Profession, and Corporation. These macro institutional logics can be translated at the micro level of the individual as well as at the meso levels of the field or the organization.

The likelihood of a multiple translation of these meta-logics at each infra-societal level gave rise to the concept of "constellations of logics" (Goodrick & Reay, 2011) to designate the combination of meta-logics embedded in a specific individual, field, or organization. The relationships between the macro logics composing the constellation may be either competitive or cooperative. Goodrick and Reay (2011), as well as Waldroff et al. (2013), found two distinct forms of cooperative relationships in healthcare settings: facilitative relationships, in which a practice consistent with one logic may strengthen another logic; and additive relationships, in which "a particular work task reflects the influence of more than one logic" (Waldroff et al., 2013: 103). These findings therefore highlight the possibility of a hybridization of plural logics in work practice.

Associated with this potential of hybridization comes the notion of agency, meaning an actor's capacity to impact the social world by influencing rules, relation ties and distribution of resources (Scott, 2008). Waldroff et al. (2013) suggest that hybridization allows idiosyncratic arrangements of institutional logics at the micro level, and that this discretion provides agency for social actors. They also demonstrate that, while certain combinations of macro logics at the micro level may enable action, some others constrain it.

Transposing this theoretical framework at the meso organizational level of the hospital implied considering the institutional logics guiding actors in their organizational behavior. As longitudinal studies of management control in French hospitals (Lartigau & Nobre, 2011; Bérard, 2013) had highlighted the systemic nature of that function, our first task was to construct a generic representation of the systemic interplay between organizational actors within hospitals, from the point of view of one of these actors: the management controller.

Methodology

Focus groups had previously proved to be a valuable research method in healthcare studies to generate data in the form of a collective representation by an occupational group (Liamputtong, 2011; Kitzinger, 1995). We seized the opportunity given by the creation of a community of practice dedicated to management control in French public and non-profit hospitals to prompt reflexivity among community members over their work practice (Schön, 1983). We asked them to detail all the tasks or roles they deemed necessary to implement management control systems in hospitals, and to identify the organizational actors who should, in their opinion, perform these tasks or roles.

We conducted this collective analysis through workshops where participants had to fill in and discuss factsheets describing their work practice. 15 focus group meetings were held from November 2012 to September 2014, involving 32 management controllers from 30 hospitals of various status, size, and activity, and 2 management controllers working in regional health authorities. In addition, the factsheets were debated and supplemented in 10 community meetings, to which all 71 community members were

invited. Eventually, printed versions of factsheets were reviewed by 14 community members, bringing final modifications and further materials.

Since focus group participants and other community members frequently pointed out their position in the organizational structure as a key determinant of their work practice, we looked for statistical data to verify this assertion. Although the National Observatory on Analytical Accountings (OCAH), run by the French Ministry of Health, indicated the positioning of management control's teams in 528 public and non-profit hospitals, no information was available to evaluate the impact of these different positions on management controllers' scope of action. We subsequently launched, in February and March 2014, an online survey, asking management controllers currently in office in public and non-profit French hospitals to weigh the pros and cons of their position in the structure of their organization. The survey was broadcast in and by the community of practice to 126 respondents. The results of the inquiry were analyzed and commented by 14 community members in a last focus group meeting held in December 2014.

Data analysis

The 242 tasks or roles mentioned in final versions of the factsheets were grouped by organizational actors and coded according to their underlying macro societal logics. Subsequently, tasks in relation with cost-efficiency, market share analyses, or profit maximization, were considered as reflecting the market logic. Similarly, bureaucratic roles or tasks embedded in a hierarchical form of control were seen as pertaining to the corporate logic. Tasks or roles giving responsibility to health professionals in the organization and control of their work, endowing them with autonomous corporate decision power or granting them discretionary resources, were deemed proof of the professional logic. Tasks or roles undertaken to comply with instructions from governmental or regional health authorities were linked to the state logic. Finally, tasks or role involving members of the local environment were judged in correspondence with the community logic. We found no evidence of a family or a religious logic in our dataset.

The tasks or roles of each organizational actor were coded using a linear numerical evaluation model, in which the score of each logic (y) comprised in a task or role is an inverted function of the number of logics (x) implied in that task or role, the regression

constant of the equation (a) being the total number of logics in the system: 5. The level of hybridity of logics in an organizational actor's behavior was measured by calculating the Relative Standard Deviation (RSD) between the scores obtained by this actor for each logic. A low RSD meaning a low cleavage between numerical values, it signals an organizational behavior homogeneously guided by all logics, and thereby a high degree of hybridity. Inversely, a high RSD indicates a relatively segmented, less hybrid, behavior.

Table 1 below shows the results of our initial coding, which will be completed in our full paper by multiple coding and inter-coder reliability analysis.

Table 1: Prevalence of Institutional Logics in each Actor's Behavior

| <i>Actors :</i> | Number of tasks / roles | Score of market logic | Score of corporate logic | Score of prof. logic | Score of state logic | Score of com. logic | <i>Relative Standard Deviation</i> |
|---|-------------------------|-----------------------|--------------------------|----------------------|----------------------|---------------------|------------------------------------|
| Management controller | 63 | 20% | 61% | 19% | 0% | 0% | 112,12% |
| Head of Medical Information Department | 27 | 34% | 43% | 23% | 0% | 0% | 87,79% |
| Medical departments' "managerial teams" | 54 | 10% | 26% | 63% | 0% | 0% | 118,36% |
| Chief Executive Director | 39 | 16% | 75% | 5% | 4% | 0% | 140,67% |
| Finance Director | 30 | 13% | 83% | 2% | 2% | 0% | 160,12% |
| Other Directors | 28 | 16% | 75% | 7% | 2% | 0% | 140,31% |
| Supervisory Board | 1 | 0% | 0% | 0% | 0% | 100% | 200,00% |
| Total | 242 | 20% | 61% | 19% | 0% | 0% | |
| <i>Prevalence of each logic in the system</i> | | 17,49% | 57,78% | 23,28% | 1,03% | 0,41% | |

Besides, our survey data proved to be consistent with national statics provided by the OCAH, since it showed the same three main structural positions of management

control in a similar distribution. 81 meaningful answers could be exploited to assess the most common position, under the Finance Director's authority, 17 to explore the association with the Chief Executive Director, and only 4 to address the segmenting of management control in a specific department, sometimes teamed with the Head of Medical Information Department (HMID). Examining these results in the last focus group meeting supplemented this data with respectively 8, 2 and 2 instances of each position. The synthesis of the benefits and limitations of each structural configuration of management control expressed by survey and focus group participants will be displayed in the full paper.

Presentation and discussion of main findings

Considering the hybridity of logics in the overall management control system, the constellation of logics (Goodrick & Reay, 2011) described in Table 1 comprises five macro societal logics, of which one is more influential. The corporate logic, totalizing 57% of all actors' scores, is significantly more prevalent than the professional (23%) or the market (17%) logics. The state and community logics appear as residual, with a respective prevalence of 1% and 0.4%. Management control systems in French public and non-profit hospitals therefore fall into the first of the three types of constellations identified by Goodrick and Reay (2011): to wit, a constellation characterized by one dominant logic. For the purpose of this short paper, we wittingly limited our analysis to the macro-societal logics identified in our theoretical framework. Nevertheless, as early institutional approaches in hospitals revealed the presence of other societal logics, like law (Heimer, 1999), the comprehensiveness of this framework will be questioned in our full paper.

This dominance of the corporate logic in hospitals' management control systems reveals the impact of organizational embedment over the implementation of field logics. Indeed, whereas the French "managerial approach in hospitals" (Engel et al., 2000) emphasized, at the field level, the market logic, and aimed at promoting more professional logic in hospitals' governance, the main organizational embodiment of that logic in hospitals' structure, namely management control, is primarily guided by a corporate logic. As a result, it can be asserted that structural responses of

organizations to institutional complexity are not always strictly homothetic translations of the constellations of logics promoted at their field level.

Considering the hybridity of logics at each actor's level, the system forged by management control in hospitals looks rather segmented, as all of the actors present high RSD of logics. Whereas directors, including the Chief Executive, are unambiguously marked by the corporate logic, imbuing at least 75% of their organizational behavior, medical departments' heads and nurse coordinators remain mostly pervaded (at 63%) by the professional logic, in spite of their corporative function within the organization. The community logic, marginal in the system, is supported by only one actor: the Supervisory Board. This high level of segmentation within the system of management control supports Greenwood's (2011) definition of the hospital as a structural hybrid, meaning that differentiation of logics is clearly visible in the organizational structure.

The synthesis of the survey and focus group participants' answers about the benefits and limitations of their positions in hospitals' structures enables us to single out hybrid actors' agency as a cooperative factor in that context. Indeed, both survey and focus participants highlighted that the isolation, in a segmented compartment of the structure, of the two actors displaying the lowest RSD, namely management control and the HMID, was the position granting these actors the largest scope of action, and, at the same time, allowing the best linkage between medical departments and administrators. Structural configurations binding management control to directors were depicted as detrimental to cooperation within the system, as management controllers were in these cases perceived by medical departments as serving only the corporate logic.

Although the relative impact of cooperative and competitive structural patterns on organizational performance is yet to be determined, these findings already reflect at the organizational level Waldroff et al.'s (2013) observations on the relationships between combinations of institutional logics and action. For instance, our results confirm that additive relationships between logics constrain organizational action, especially in those configurations where a hybrid actor is associated with a less hybrid one. Similarly, transposing at the organizational level the mechanisms enabling action demands relevant structural designs: as examples, strengthening alternative logics means empowering the actors bearing these logics, and favoring facilitative

relationships between logics requires win-win solutions like profit-sharing between organizational actors.

Conclusion

As a whole, our results highlight that the translation of a constellation of logics in an organizational context implies considering how this arrangement of logics is reflected within the organizational structure. If the structure is segmented, as in the case of hospitals, the cooperative or competitive nature of the relationship between institutional logics will be shaped by the structural configurations linking organizational actors. Hybrid actors play a key role in these configurations since their hybridity allows them to bridge gaps between segmented actors. However, the performance of this intermediation in both cooperative and competitive arrangements should be looked upon in our full paper, in order to assess the relevance of the different configurations of management control as structural responses to institutional complexity.

Besides, further research would be warranted, and probably continued beyond our future full paper, to include privately-owned clinics, as previous works have underlined that hospitals' ownership may affect the prevalence of logics in these organizations under certain circumstances (Goodrick and Salancik, 1996). International comparison would also be justified, since comparative studies have shown that constellations of logics may vary from one country to another in responding to the same healthcare issues (Waldroff et. al, 2013). Finally, other types of structural responses to institutional complexity in hospitals could be explored, like liaison structures, which have already been observed at the field level (Reay & Hinings, 2009).

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