

# Chapter 2

## Organizational Performance in the Italian Health care Sector

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**Abstract** The public sector performance management (PM) literature is particularly rich as this topic is one of the most appealing for public sector scholars (Pollitt, *J Public Adm Res Theory* 6:25–44, 2005). However, organizational performance (OP) has been neglected across the world (Andrews et al. *J Public Adm Res Theory* 21:i301–i319, 2011) as well as in the Italian public administration (Martin and Spano, *Public Money Manag* 35:303–310, 2015). This chapter investigates how OP is defined, measured, and evaluated in the Italian health care sector. Our analysis showed the limited use of performance management in Italian public health organizations and a high variability in the way OP is defined and measured. This makes it difficult to compare the results of different organizations. For this reason, future standardization could allow policy makers to improve the accountability.

**Keywords** Organizational performance · Health care · Italian public sector

### 2.1 Introduction

The issue of OP is of particular relevance in the healthcare sector, where the impact of health organizations on individuals' lives is significant and measures of OP are required to understand the extent to which these organizations are effective. Even though significant progress has been made in building more advanced performance measurement systems in the health care sector, more work is needed (Smith et al. 2008). In fact, the literature on performance management in the health care sector reports several cases of incorrect uses and, even misuses of performance measures and targets with the introduction of a kind of “governance by targets” and a

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consequent increased risk of gaming (Bevan and Hood 2006). Micheli and Neely (2010) also report a lack of coherence among the different actors involved in the setting of objectives and targets at different levels, from central to local, making performance measurement more complex.

Traditionally, performance in health care has been measured using specific indicators such as incidence of pathology, mortality measures, and measures of mortality after a specific treatment. Other measures are increasingly attractive, including those that focus on patient health status, which are often in the form of outcome measures (Smith et al. 2008). However, there is a limited “understanding of how performance measurement can be organized to support improvement initiatives in health care practices” (Elg et al. 2013).

In the Italian public sector, the role of OP has been largely neglected, and more importance has been given to individual performance (Martin and Spano 2015). As far as the healthcare sector is concerned, OP is attracting increased attention in Italy, but there is still a lack of extensive research on this topic. For example, there is a high variation in the way OP is defined and, consequently, measured. In particular, a comprehensive analysis of the current OP practices as measured by Italian health care organizations is still missing. For this reason, our research aims at addressing the following research questions (RQs):

RQ1: How do Italian health care organizations define OP?

RQ2: Is OP measured by Italian health care organizations, and if so, how?

This chapter is organized into six sections: (1) literature review on OP with specific reference to the health care sector; (2) the Italian health care system; (3) methodology; (4) results; (5) discussion; and (6) conclusions.

## 2.2 Literature Review

Although managing performance is a wider concept than measuring it, performance management systems need to be based on sound measurement systems (Martin and Spano 2015). The performance measurement literature lacks consensus on concepts and definitions as well as on how OP may be measured (Au 1996; Forbes 1998; Ostroff 1992). Neely and Platts (1995, p. 9) comment that “performance measurement is a topic often discussed but rarely defined.” They also tried to provide a more specific definition of three concepts: performance measurement (“the process of quantifying the efficiency and effectiveness of action”); performance measure (“a metric used to quantify the efficiency and/or effectiveness of action”); and performance measurement system (“the set of metrics used to quantify both the efficiency and effectiveness of actions”).

The problem with these definitions is that they are too specific and, as a consequence, they do not convey what is now being labeled “performance measurement” in the literature and in practice (Bourne et al. 2003). In fact, over the past decades, performance was mainly measured only in its financial dimension

(McCracken et al. 2011) via “simple outcome-based financial indicators that are assumed to reflect the fulfillment of the economic goals of the firm” (Venkatram and Ramanujam 1986, p. 803). Most recent studies suggest a multidimensional approach to performance measurement considering the organization’s strategies as well (Nuti et al. 2013).

Since the advent of New Public Management (NPM) in the early 1990s, the issue of performance management has gathered increased attention (Bouckaert and Van Dooren 2009; Talbot 1999) and has become a fundamental issue for improving public services (Nuti et al. 2013). One of the reasons for this increased attention is the fact that governments started to be accountable for the use of public resources and for the results achieved (Bouckaert and Halligan 2008).

However, even though OP is particularly relevant to understanding why some organizations perform better than others, studies regarding OP in the public sector are not conclusive and there are different definitions of organizational performance (Andrews et al. 2011). In addition, several studies are based on perceived performance rather than on more objective measures, although there is evidence of a positive correlation between perceived OP and objective OP (Dollinger and Golden 1992). Both the reasons for measuring performance on the one hand and the process followed and the models used to measure it, on the other hand, are particularly important. With regards to the first aspect, Behn (2003) proposed eight purposes that public managers have for measuring performance: evaluate, control, budget, motivate, promote, celebrate, learn, and improve.

With regards to the second aspect, several authors describe how to design systems for performance measurement (Elg et al. 2013). For example, Kaplan and Norton (1992) consider that measures should be derived from strategy and represent different dimensions of an organization. Andrews et al. (2011) proposed a model for measuring OP in US federal agencies using three sets of measures: efficiency-related measures, effectiveness, and fairness. They identified five agency-level factors that may affect OP (organizational culture, human capital and capacity, agency support for the National Performance Review (NPR), leadership and supervision, and red tape) and four individual-level factors (structure of task/work, task motivation, public service motivation, and individual performance). They found that the most important elements that affect OP are effectiveness, teamwork, building human capital, structure of task/work, protection of employees, concern for the public interest, and task motivation. The main conclusion of this study is that OP is higher in organizations that adopt an involvement strategy—for both employees and other stakeholders.

In a similar Korean study, (Kim 2005) measured OP using a set of 12 items and provided evidence for the effect of individual-level factors on OP (such as job satisfaction, affective commitment, public service motivation, and organizational citizenship behavior). Kim (2005) investigated the link between OP and management innovation both directly and indirectly through performance management. In this study, OP was measured using a *core service performance score* constructed by the Audit Commission (2002) and based on six aspects of OP: quantity of outputs, quality of outputs, efficiency, formal effectiveness, equity, and consumer

satisfaction. Even though there is an established literature on this topic, the problem is that it remains a vaguely and loosely defined construct (Rogers and Wright 1998). In addition, several studies are based on perceived performance rather than on more objective measures, although there is evidence of a positive correlation between perceived OP and objective OP (Walker et al. 2011).

When discussing healthcare organizations, it is necessary to consider that they are complex adaptive systems (Anderson 1999; McDaniel et al. 2009) and, since the 1960s, complexity has been a central construct in the vocabulary of organization scientists (Anderson 1999). There are many ways in which this complexity can show itself (Daft 1992); however, even if the concept of complexity abounds in the public sector, the application of this theory is neither self-evident nor as straightforward as it might appear (Arnaboldi et al. 2015). In the specific case of health care organizations, the complexity relies on the phenomena's dynamism, which unfolds in unpredictable ways; these unfolding events are often unique, and it is interesting that a number of complexity theory advocates have identified health care as a suitable context for study (Arndt and Bigelow 2000). This complexity is also reflected in the way OP may be defined and measured. In fact, complexity theory has rich implications for the strategic management of organizations. Understanding this complexity to improve synergies among business units may improve OP. In the decades past, because of this complexity, measuring performance in the health care sector was uncommon and, in fact, it was believed that quality was not measurable. But today there is a higher interest in measuring and reporting performance in this sector, and in some cases there is the problem of having too many measures, some of which focus on outputs, outcomes, and processes, and others on single activities that have limited effect on overall health (Cassel et al. 2014).

Regarding the reasons for measuring performance in healthcare, according to De Vos et al. (2009), professionals use measurement for different purposes, i.e., evaluating, controlling, and improving clinical practice. Although there is little evidence that performance measures are actually used by practitioners to improve performance, Elg et al. (2013) suggest that "performance measurement may be a versatile method for driving improvement in healthcare organizations." In fact, performance measurement is recognized as a method with many utilization possibilities in health care (Elg et al. 2013). For example, implementing a transparent health care system is seen as a way to create external pressure and a sense of urgency for change (Elg et al. 2011). (Van der Wees et al. 2014) suggest that measures of quality are used by clinicians to evaluate the way they interact with patients and to measure quality improvement within their organizations; also, these measures may be used by health insurers to compare the performance of different providers. In addition, performance information may facilitate patients' decisions in choosing a provider.

Several studies have developed conceptual frameworks and models to help build effective OP measurement tools for the health care sector. For example, Arah et al. (2006) proposed a framework in which they present some common key performance dimensions for health care organizations. In building this framework, (Arah et al. 2006) considered other previous frameworks and the OP measurement systems used

in some jurisdictions (UK, Canada, Australia, USA, European Community Health Indicators, World Health Organization, and OECD) and created a list of performance dimensions in healthcare: effectiveness, appropriateness, safety, efficiency, continuity, accessibility, equity, responsiveness, patient-centeredness, timeliness, and acceptability. Some of these dimensions are consistent with the dimensions required by the Italian legislation, even if defined in a different way.

A recent study proposed a new model for measuring and evaluating health care organizations' OP using two main dimensions: outcome and delivery efficiency. The model is based on a "matrix of performance evaluation" (Elg et al. 2011) and includes 42 indicators, 24 concerning outcome and 18 on efficiency, and an additional area related to "management."

Studies on OP in Italian health care organizations are limited. Baraldi and Bocci (2009) analyzed the most common methodologies to measure OP of Italian health care organizations. In particular, they surveyed how Italian health care organizations measure their performance and observed the increased importance of the balanced scorecard that has been adapted to the features of the health care sector. In fact, even though financial indicators are still used—as in profit-oriented organizations—many nonfinancial indicators have taken center stage, and the balanced scorecard is useful to measure both financial and nonfinancial performance in health care organizations (Nuti et al. 2013). Bocci (2005) proposed a new model of the balanced scorecard for health care organizations based on four perspectives (community, internal process, financial resources, and learning and growth).

In 2005, the *Istituto Superiore Sant'Anna* of Pisa created and implemented in some health organizations in Tuscany a new OP measurement method based on the balanced scorecard model. This method is based on six evaluation dimensions (population health status, capacity to pursue regional strategies, clinical performance, patient satisfaction, staff satisfaction, efficiency, and financial performance) (Nuti et al. 2013). For each dimension, a set of indicators is defined ~130 indicators; the balanced scorecard approach is then used to evaluate OP. Since 2005, this method has been introduced in other organizations in Italy. In particular, eight other Italian regions and the Ministry of Health have adopted the S. Anna method to monitor levels of health services provided in the country (Nuti et al. 2013). This system is, as can be seen by the above description, a multidimensional performance measurement system and has been valued as particularly innovative and comprehensive.

However, as highlighted by Baraldi and Bocci (2009), the most common performance measurement methodologies in health care organizations are budgeting, cost accounting, and accounting for responsibility centers. These results show that Italian public healthcare organizations mainly focus on OP's financial dimension.

Broadly speaking, the OP literature in the Italian health care sector is limited, and there are few analyses of the actual measurement and evaluation systems. To fill this gap, this chapter focuses on organizational performance and concentrates on the Italian health care sector by addressing the following research questions:

RQ1: How do Italian health care organizations define OP?

RQ2: Is OP measured by Italian health care organizations, and if so, how?

## 2.3 The Italian Health care System

Italy's healthcare system (*Servizio Sanitario Nazionale* [SSN]) provides universal coverage free of charge at the point of service. The system is organized into three levels: national, regional, and local (Lo Scalzo et al. 2009). The general objectives and the fundamental principles of the health care system are guaranteed by the national level, while services are delivered at the regional level through local health organizations (Van der Wees et al. 2013) and public and private hospitals.

This system is based on public financing via general taxation. There are also private health organizations that provide health services. In particular, the percentage of hospital beds supplied by public sector organizations is 80.7%, with the remainder supplied by nonprofit and private organizations (Trincherio et al. 2013). The organizations that provide health care services are as follows:

- Local health authorities (*Aziende Sanitarie Locali*, ASLs)
- Public hospitals (*Aziende Ospedaliere*, AOs)
- Research Institutes for Hospitalization and Medical Treatment (*Istituto di ricovero e cura a carattere scientifico*, IRCCSs)
- Private accredited providers

The local health authorities are responsible for providing a selection of health services. Each region may have many ASLs, with each ASL responsible for providing healthcare to a given population. Initially, there were 659 ASLs, but several reforms occurred in the 1990s to modify their function and governance system. Their number was further reduced in 2015 to 139. The ASLs provide care directly through their own facilities and also buy services from external suppliers such as accredited private providers.

Public hospitals, established by Legislative Decree No. 502/1992 and defined as quasi-independent agencies, enjoy financial and operating autonomy. In 1995, many preexisting hospitals were transformed into 82 AOs. This was further reduced to 77 in 2015. There are three necessary conditions to obtain AO status: "a divisional organizational structure; the existence of at least three clinical units; and a complete emergency department with an intensive care unit" (Lo Scalzo et al. 2009, p. 76). AOs provide healthcare to all residents in a region, while ASLs serve a portion of the population. Also, AOs are financed based on the diagnosis-related group (DRG) system, while ASLs are financed based on per capita transfers.

The IRCCSs are research-oriented hospitals operating at the local level with competences in research and treatment of important diseases. In 2008, 13 of the 20 Italian regions had 42 IRCCSs divided into 18 public and 24 private institutions. As of 2015, there are 21 public and 27 private IRCCSs in Italy. The scientific activities of the hospitals are monitored by the Ministry of Health, which is also responsible for establishing new IRCCS.

Since 1990, Italy's health care system has seen several reforms introduced by different pieces of legislation (Law N. 833/1978, Legislative Decrees N. 502/1992, N. 517/1993, and N. 229/1999) that have changed its structure and established the procedures now in use.

With regards to the issue of OP in the Italian health care system, Legislative Decree 150 of 2009 introduced the following eight dimensions:

1. Implementation of active policies for satisfying citizens' needs;
2. Implementation of plans and programs;
3. Customer satisfaction;
4. Modernization and qualitative improvement of public organizations and employees' professional skills and the capability to implement plans and programs;
5. Improvement of relations with citizens and other stakeholders;
6. Efficiency in the use of resources, with particular reference to cost reduction;
7. Quality and quantity of services; and
8. Equal opportunities.

Our analysis focused on the effective use of these and additional dimensions of OP by health organizations.

## 2.4 Methodology

The research looks at the way organizational performance is (1) defined and (2) measured by Italian healthcare organizations. The data collection methods include document analysis and semi-structured interviews with key informants. To investigate the ways in which the healthcare organizations define OP and measure it, we performed an in-depth analysis of the content of the documents prepared by a sample of Italian public health care organizations. In addition, we analyzed the performance documents of the seven Italian health care organizations that are accredited by the Joint Commission—an independent, not-for-profit organization that accredits and certifies top performing health care organizations and programs in the USA and across the world (Joint Commission International 2016). In Italy, there are seven accredited public health organizations:

1. AO *Santa Maria degli Angeli*;
2. ASL 3 *Alto Friuli*;
3. AOU *Santa Maria della Misericordia*;
4. *Ospedale Cattinara*;
5. *Istituto Giannina Gaslini*;
6. *Presidio Ospedaliero Oglio-Po*; and
7. *Ospedale Santa Chiara*.

Content analysis is a research method that “classifies textual material, reducing it to more relevant, manageable bits of data” (Weber 1990, p. 5). In particular, we used an inductive approach, starting with data and then creating specific categories that can explain the general phenomena. The qualitative data were organized with the process of “open coding” according to which notes and headings were written in the text while reading it. Only after this analysis was the categories created.

The analyzed documents include the following: the evaluation system, the performance plan, and the performance report. Each of these documents has specific functions, and it is important to consider all of them in the analysis. The evaluation system sets the guidelines by which performance at both individual and organizational levels is measured and evaluated. The performance plan shows what performance dimensions, objectives, and indicators have been selected, consistent with the evaluation model defined by the system. The performance report provides evidence of the results achieved and of the way the performance measurement process worked. These are the specific documents requested by the legislation on performance management in Italian public organizations (Legislative Decree 150/09).

The census of Italian public health care organizations is composed of 237 units. These organizations are divided into 139 ASLs, 77 AOs, and 21 IRCCSs. For analysis, a random sample of 20% was extracted via stratified samples. In this way, the study was conducted through a sample of 50 health care organizations and was subdivided in 30 local health authorities (ASLs), 16 public hospitals (AOs), and four research institutes (IRCCS). A set of substitutes was randomly extracted as alternatives. During the first step of the extraction, we replaced some selected organizations that had not published their performance plans on their Web sites. These included nine healthcare organizations (18% of the overall sample) that had not published performance plans and were subdivided in four local health authorities (13% of the 30 extracted authorities), four public hospitals (25% of the 16 selected hospitals), and one public National Institute for Scientific Research (25% of the four selected institutes). These organizations have been replaced with other organizations that did publish a performance plan. This way, the sample is composed only of organizations with officially published performance plans.

To answer the first research question, we noted in each document whether and how OP is defined. We also clustered the definitions to identify recurrent aspects and which organizations comply and do not comply with the legislation. We also searched for innovative ways to define and measure OP.

To answer the second research question, we studied the measurement systems regarding OP, focusing on both methodological and practical aspects. This analysis was made among the ASLs, AOs, and IRCCSs. In addition, all performance reports were clustered using three criteria: strategic areas, objectives, and performance dimensions.

We also identified congruence among the three different analyzed documents. In particular, the study focused on the performance dimensions used in the measurement process. During the analysis of their congruence, we considered whether, in every document, the same performance dimensions were reported. Broadly speaking, we studied whether each document fulfilled its tasks.

To strengthen the results of the document analysis, 30 qualitative semi-structured interviews were conducted between May and August 2016. Two general directors, three administrative directors, and 25 organization and control managers were interviewed. The interviews lasted about 40 min and were recorded and transcribed. With regards to the regional distribution, nine interviewees belong to organizations that are located in the northwest of Italy, 10 in the northeast, three in the center, and



eight in the south and the islands. The interviewees were asked to answer questions related to the performance management systems used in their organizations and were also allowed to add other comments about the specific performance dimensions measured. The interviews provided a deeper understanding of the ways in which Italian healthcare organizations effectively measure their OP, strengthening the results of the document analysis or, in some cases, highlighting the differences.

2.5 Results

Our research revealed that just 34% of the organizations (ranging from 25% of AOs and IRCCSs to 33.3% of ASLs) published the evaluation system and a 78% published the performance reports on their Web sites (ranging from 50% of IRCCSs to 83.3% of ASLs) (see Table 2.1). If we consider the initial extraction of the sample, before the substitutions, 18% of the organizations did not publish the performance plan (13% of the local health authorities, 25% of the public hospitals, and 25% of National Institutes for Scientific Research). This means that just 87, 75, and 75%, respectively, published the performance plan (Table 2.1).

The first RQ describes how OP is defined by Italian health care organizations. The results show that there are many differences among Italian public health organizations in the way OP is defined and measured. In addition, not all organizations explicitly provided a definition of OP. In particular, 62% did not provide any definition at all (57% of ASLs, 69% of AOs, and 75% of IRCCS). The remaining 38% of the organizations explicitly defined OP. Of the organizations providing a definition, 79% (15 out of 19 organizations) used the very same definition provided by the legislation (60% of ASLs, 60% of AOs, and 100% of IRCCS): “The contribution that a subject generates through its action to achieve the purposes and the objectives, and to satisfy the needs for which the organization has been created” (Delibera Civit 89/2010). In three cases only, different definitions were chosen. For instance, one organization defined OP as “the performance obtained by the firm as a whole and by each organizational unit.” In some cases, even if there is not a specific definition of the performance dimensions, the definition itself has been derived from the strategic areas as defined in the performance plan (this is true for 6 out of 30 ASLs and 2 out of 16 AOs) or from the objectives (3 out of 30 ASLs). The interviews confirmed these results. In fact, most interviewees did not provide an explicit definition and told us that no specific dimensions are used to measure OP. Respondents reported the way that OP was

Table 2.1 Published performance documents

	Evaluation system (%)	Performance plan (%)	Performance report (%)
ASL	33.3	87	83.3
AO	25	75	75
IRCCS	25	75	50

measured, regardless of its definition. When a definition was given, it was the same as the legislation. In some cases, strategic areas are defined in a way that is consistent with the OP dimensions as defined by the legislation. For this reason, the performance plans of the organizations in the sample were analyzed and contrasted according to two elements—strategic areas and objectives—to understand the underlying performance dimensions.

With respect to whether and how OP is measured by Italian healthcare organizations, after analyzing the performance documents, we then focused on specific performance dimensions, and we contrasted the dimensions used by the organizations with the eight dimensions provided by the legislation (Article 8 of Legislative Decree 150/2009). By analyzing all published documents (evaluation system, performance plan, and performance report), we verified the specific dimensions that health organizations actually use to measure and evaluate OP (Table 2.2). This analysis shows that the evaluation systems report just a minority of the eight dimensions of OP introduced by the legislation listed above. They range from 50% of the cases for “quality and quantity of services delivered” to 0% of the “qualitative and quantitative development of relationships with the relevant stakeholders” (see Table 2.2; Annex 1). Only 56% of the organizations specified the performance dimensions used in the measurement process in their performance plan (11 ASLs, 13 AOs, and 4 IRCCSs). In the performance report, the presence of the OP dimensions ranges from 64% for “efficiency in the use of resources” to 15% for “equal opportunities.” The performance plans show the highest percentage of the presence for all the dimensions with a range from 78% for “efficiency in the use of resources” to 20% for “equal opportunities.”

The most recurrent OP dimensions are “efficiency in the use of resources” and “quality and quantity of delivered services” (Table 2.3).

In just one case, OP was actually defined and measured using all eight dimensions provided by the legislation (as emerged from both the performance plan and the performance report). The other organizations measured only some of the dimensions requested by the legislation. In almost 60% of cases, the organizations introduced additional dimensions not required by the legislation. In particular, the most recurring performance dimensions in the performance report that differ from the legislation are appropriateness, risk management, processes, research, and teaching (Table 2.4).

Appropriateness is divided into two elements: clinical appropriateness and organizational appropriateness. “Clinical appropriateness” applies to cases in which

**Table 2.2** % of OP dimensions present in the performance documents

	Performance dimensions							
	1	2	3	4	5	6	7	8
ES (%)	25	13	31	31	0	38	50	6
PP (%)	48	30	36	44	26	78	74	20
PR (%)	44	21	28	38	23	64	62	15

*ES* Evaluation System, *PP* Performance Plan, *PR* Performance Report

**Table 2.3** Most recurrent OP dimensions

Type of perf. document	Efficiency				Quality and quantity			
	ASL (%)	AO (%)	IRCCS	Overall (%)	ASL (%)	AO (%)	IRCCS	Overall (%)
ES	13.3	12.5	–	12	16.7	18.8	–	16
PP	73.33	81.25	100%	78	66.7	81.3	100%	74
PR	47	69	50%	50	43	56	50%	48

*ES* Evaluation System, *PP* Performance Plan, *PR* Performance Report

**Table 2.4** OP dimensions present in the performance report not listed in the legislation

Performance dimensions	ASL	AO (%)	IRCCS
Appropriateness	30%	44	0
Research and teaching	7%	6	75%
Risk management	1%	12	
Processes	0	31	0

healthcare interventions occur in such conditions that the probability of benefits outweighs the potential risks in terms of safety for the patient and economy of resources (Scaletti 2014). “Organizational appropriateness” refers to the fact that health care interventions must be provided at the proper level of assistance. For instance, patients that may be treated in a day hospital center should not be admitted to hospitals. Most organizations use organizational appropriateness rather than clinical appropriateness as a measure.

Focusing on the performance report (which shows what is actually done in terms of performance measurement and evaluation), 22% of the surveyed health organizations did not report any OP dimensions. In fact, 11 out of the 50 surveyed organizations do not mention OP measurements in their performance report at all. In another 18% of cases, the OP measurement is limited to a small number of dimensions. As a consequence, just 60% of the organizations in our sample make some sort of OP measurement using one or more of the eight performance dimensions required by the legislation.

2.6 Discussion

Measuring and reporting performance in health care is recognized as an important tool to improve the quality of the services delivered by health care organizations (De Vos et al. 2009; Elg et al. 2013). However, the actual use of performance measurements in the health care sector is also limited because of a lack of understanding of how these measures must be used in practice (Elg et al. 2013). More generally, performance information allows governments to monitor health care systems’ performance (De Vos et al. 2009).

The results obtained in the research raise some areas of concern. First, we found that just a limited percentage of the organizations (34%) published the evaluation system on their Web sites. Although it is not compulsory under the current legislation, we believe that such reporting of the methods for evaluation is not fully consistent with the principle of transparency that aims to provide citizens and other stakeholders with all the relevant information needed to learn the results achieved and hold these organizations accountable.

Second, the majority of organizations (62%) did not provide any definition at all of OP and those that did, used the very same definition provided by the legislation, which is very general and even vague. A lack of clarity in the way OP is defined does not help in understanding the actual results achieved and does not give a sense of direction to the people working in the organizations.

Third, the analysis of the performance documents highlighted that Italian public health organizations are only partially complying with the legislation. For example, there is a difference between what is said in the evaluation system, in the performance plan, and in the performance report regarding the measurement of OP. In fact, the evaluation systems and the performance plans promise more than the performance reports deliver. These data may be explained by considering that health organizations have set the evaluation systems in a very generic way and have used the performance plan to better specify the content of the OP dimensions and how to measure them. To some extent, it seems that they tend to underestimate the difficulty in measuring and evaluating OP. As a consequence, when it comes to reporting what dimensions of OP have actually been measured and evaluated, the reported percentages are lower. Fourth, public health organizations did not find in the legislation a model that fits with the peculiar features of the healthcare sector. We found that 58% of the sample uses dimensions of OP different from those in the legislation—mainly appropriateness and risk management. In particular, appropriateness is particularly relevant in the health care sector. The interviews showed that appropriateness is a dimension used by all organizations to which interviewees belong, but it is reported in only one-third of the analyzed documents. Given the very nature of the health care sector, risk management is also very important—as demonstrated by its presence among the performance dimensions.

Not surprisingly, IRCCSs make extensive use of the research and teaching dimensions, given their specificity. In fact, IRCCSs are research-oriented hospitals in which research and teaching dimensions are fundamental.

Broadly speaking, it appears that the actual measurement and evaluation of OP by Italian health organizations is limited, and those that actually perform it use only a limited number of performance dimensions. In addition, there is significant variability in the content of OP and in the process of measuring and evaluating it.

To have a clearer picture of the Italian health care situation, we analyzed the performance documents of the Italian public health organizations that are accredited by the Joint Commission (Joint Commission International 2016). The Joint Commission's accreditation is a guarantee of quality of the health care services provided by the accredited organizations. In fact, the validation process is based on international standards of excellence in performance and organization to guarantee

security and high quality of the services. The analysis of the content of the performance documents of the organizations accredited by the Joint Commission shows a similar situation compared to the sample. In fact, all the accredited organizations published their performance plans on their Web sites. Six out of the seven published their performance reports, but only two (30%) published the evaluation system. Even for the most advanced public health organizations, the importance of publishing the evaluation system is apparently low. We compared the performance dimensions required by the legislation with the performance dimensions actually used by the accredited organizations. The analysis shows some differences with regards to the most used OP dimensions versus the sample. In fact, all accredited organizations consider in their performance plans two specific dimensions: the “implementation of plans and programs” and the “modernization and qualitative improvement of public organizations and employees’ professional skills and the capability to implement plans and programs.” In the organizations studied here, we found that the most commonly used performance dimensions are “efficiency” and “quality and quantity of services.” The additional dimensions used by the accredited organizations are the same cited previously (appropriateness, risk management, and research). Some of the interviewees are from organizations accredited by the Joint Commission. What emerged is that the only difference in comparison to the nonaccredited organizations is a higher attention to the quality of the performance:

Some objectives are connected to the quality of the performance because the Joint Commission asks us to maintain and to show specific standards of quality. (Interviewee 17)

In fact, the accreditation program requires some qualitative parameters to be met, so the healthcare organizations must measure these aspects with more attention than others to make sure that they meet the required levels of quality.

The semi-structured interviews showed some other interesting results. All interviewees recognized the importance and the relevance of the performance measurement system in place. All of them said that having a good performance measurement system is a necessary condition to effectively manage their organization—particularly with regards to complex organizations like those in the health care sector. The interviews showed that in most organizations, the performance measurement system is not sufficiently embedded into the organizational structure and is continually being changed and improved over time:

If I look at the first performance plan, it looks really embryonic; but year after year we improved it. Maybe if I look at the present performance plan in three years, I will realize it has been done in the wrong way. (Interviewee 19)

In particular, the first relevant issue is about the role of regional legislation in defining the performance objectives of the health care organizations. Broadly speaking, each regional government defines some performance objectives that have to be achieved by every health care organization in that region. Thus, the starting point of every performance measurement system is the regional legislation. Another interesting common element is the role of the director general and his influence in structuring the performance measurement system and its operation.

The interviewees highlighted that the presence of a director general sensitive to the issue of performance measurement positively influences the effectiveness of the performance system itself, as reported by one interviewee:

In this moment the top management focuses only on financial aspects, and I am sorry about it, because with the previous director general the OP measurement system was more complete. (Interviewee 2)

Broadly speaking, if the director general pays attention to the ways in which OP is measured, then the organization as a whole is more likely to have a more effective performance measurement system; on the contrary, if the director general does not care about this issue, then measuring OP will be neglected with negative consequences for the organization as a whole. In two cases only, the interviewees reported that the system was already well structured when a new director general not attentive to OP measurement came in. This did not hamper the functioning of the systems itself.

## 2.7 Conclusions

The healthcare sector in Italy has traditionally been at the forefront of the innovations and reforms that took place in this country. For example, in the early 1990s, health organizations were the first to introduce accrual accounting and management tools.

Although OP is a particularly relevant topic, it is still neglected in the Italian public sector, which has focused more on individual performance than on organizational performance (Agasisti and Arnaboldi 2011). The Italian healthcare sector is not different, and often neglects OP. In fact, our analysis shows that 40% of organizations in our sample do not appear to measure and evaluate OP. The remaining 60% undertake some form of measurement and evaluation of performance at organizational level.

Our research provides evidence of a significant variance in the way OP is defined and measured, with subsequent comparison problems. In some cases, this variance may be, at least in part, explained by the different types of organizations, i.e., local health authorities are different from public hospitals and from research institutes for hospitalization and medical treatment. However, there is also a significant variance among organizations of the same kind. Although this difference is, to some extent, normal, it shows a limited alignment of performance measurement systems among Italian health organizations. It also shows the difficulty deriving from implementing a top-down performance management system enforced by law (Micheli and Neely 2010). In addition, the research confirms the persistence of two traditional problems of the Italian public sector. One refers to the limited attention given to the role and importance of performance management (Martin and Spano 2015). The second is the false conviction that changes can be introduced by law.

Our study tried to fill the gap in the literature related to OP in the Italian health care sector by providing an in-depth analysis of the way OP is defined and measured. Some implications emerge from this research. First, the cited limited

compliance with the legislation, in a country where formal respect of the legislation is paramount (Martin and Spano 2015), needs to be better analyzed and understood. In fact, the strong presence of OP dimensions that differ from those listed in the legislation confirms one of the most criticized aspects of the existing legislation, which is that the legislation is the same for every kind of public organization regardless of differences in typology, size, specific context, and the like (Giovanelli et al. 2015). For example, none of the eight cited dimensions is specifically suitable for the health care sector. Thus, it is not surprising that a significant portion of the organizations in this sector decided to complement the legislation with other dimensions that are perceived to be more useful in capturing what OP is in this specific context. In fact, the legislation sets the general rules that are the same for all public organizations in Italy, regardless of the many existing differences among the different types of organizations, e.g., municipalities and health organizations. This emphasizes the need to adapt the set of OP dimensions prescribed by the legislation to the specific context. Thus, it is no surprise that in the case of the healthcare sector, some organizations select different dimensions from the ones provided by the legislation. Consequently, the overall framework that imposes the same rules to all Italian public authorities and agencies needs to be revisited.

Second, our data show that there is limited actual use of performance measurement by Italian public health care organizations, and a significant portion of the surveyed organizations do not measure OP. The limited attention to the definition of OP and its measurement has been confirmed, to some extent, by the analysis of the health care organizations accredited by the Joint Commission, i.e., those organizations that should represent the best practices in terms of organizational performance. Nevertheless, even accredited organizations do not measure all the performance dimensions required by the legislation; they measure just a portion. While the most common OP dimensions of the organizations in the sample are “efficiency” and “quality and quantity of services,” accredited organizations more often use two other dimensions: “implementation of plans and programs” and “modernization and qualitative improvement of public organizations and employees’ professional skills and the capability to implement plans and programs.” While it is no surprise that quality improvement is of paramount importance for accredited organizations, it would be interesting to better understand the reasons underlying the different importance given to the other OP dimensions. In addition, accredited organizations use the same additional dimensions introduced by the other organizations in the sample, such as “appropriateness” and “risk management.” This confirms on the one hand that these two elements are very important in the health care sector, and, on the other hand, that there is a need for a general cultural change to foster a stronger commitment to measuring and evaluating performance and a realization that a centralized approach is not always the best choice (Micheli and Neely 2010).

Third, there appears to be a shortfall in designing and implementing performance management policies and frameworks that are homogenous across the Italian regions and that flow from the national to the regional and local levels, creating what are considered 20 different health care systems (one for every Italian region) (Bertin and Cipolla 2013).





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