From medico-economic performance management to service-based GHT's performance management

Du pilotage de la performance médico-économique au pilotage de la performance servicielle des GHT

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ABSTRACT

This communication raises the question of "*measuring the scope of the public hospital service within hospital organizations' territorialized networks*", to which the modelled forward-looking dashboard responds by assessing the Territory Hospital Grouping's overall performance. The research is based on an intervention-research case carried out from 2016 to 2018. The purpose of this case study is a GHT bringing together 9 public health facilities of heterogeneous sizes, of which an University Hospital Center is responsible for the management of missions and support functions by delegation since June 30, 2016.
The results obtained show that the collective intelligence of the territorial reorganization of the healthcare offer contributes to the public hospital service's territorialization. Concretely, these show that this paradigm shift results from the *customer-user*'s inclusion in a comprehensive open-ended response to the way of managing and financing their care needs, and thus in practice the transition from a logic of leadership to that of partnership. Modelling of overall performance indicators based on collective values, not just medico-economic data, allows this research to renew the design of management control in terms of service-based GHT'S performance management.

Key-words

The scope of the public hospital service; Hospital organizations' territorialized networks; Case study; Intervention-research; Service-based performance; Territory Hospital Grouping

RÉSUMÉ

Cette communication pose la question de « *la mesure de périmètre d'application du service public hospitalier au sein des réseaux territorialisés d'organisations hospitalières* », auquel le tableau de bord prospectif modélisé répond par l'évaluation de la performance globale d'un Groupement Hospitalier de Territoire. La recherche s'appuie sur un cas de recherche-intervention mené de 2016 à 2018. Cette étude de cas a pour objet un GHT regroupant 9 établissements de santé publics de tailles hétérogènes, dont un CHU assure par délégation de compétences la gestion des missions

et des fonctions supports depuis le 30 juin 2016. Les résultats obtenus mettent en évidence que la mise en intelligence collective de la recomposition territoriale de l'offre de soins contribue à la territorialisation du service public hospitalier. Concrètement, ces derniers montrent que ce changement de paradigme résulte de l'inscription de la prise en charge de l'*usager-client* dans une réponse globale décloisonnée des modes de gestion et de financement de ses besoins de soins, et donc en pratique au passage d'une logique de leadership à celle de *partnership*. La modélisation d'indicateurs d'évaluation de la performance globale basés sur des valeurs collectives, et non plus seulement sur des données médico-économiques, permet à cette recherche de renouveler la conception du contrôle de gestion à l'aune d'un pilotage serviciel de la performance des GHT.

Mots-clés

Périmètre d'application du service public hospitalier ; Réseau territorialisé d'organisations hospitalières ; Étude de cas ; Recherche-intervention ; Performance servicielle ; Groupement Hospitalier de Territoire

INTRODUCTION

The research work that we present here addresses the theme of the *overall performance of* ***hospital organizations' territorialized networks*** in the light of the traditional criteria's questioning for qualifying public hospital service. This theme falls within the field of ***New Public Management*** and ***inter-organizational management control***. By inter-organizational management control, we mean here, management control based on the relational approach, *i.e.*, based on trust or the social contract which considers that individual objectives can only be achieved by collective action, and therefore implies an understanding between the actors on the values and skills founding cooperation. In this case, this agreement will focus on **public service values**.

Its topicality is causally related to the ***Territory Hospital Grouping*** creation, whose goal within the meaning of the Tourraine law is to be an instrument for the public hospital service's renewal. In this context, focusing on the issue of assessing *the overall performance of hospital organizations' territorialized networks* amounts, on a theoretical level, to identify the criteria for assessing the quality of the patient's care pathway against the public service's founding principles, and therefore to move away conceptually **from medico-economic performance to enter a service-based performance model** (Meyssonnier, 2013).

The legitimacy of the chosen theme is based not only on the observations made directly from the field, but also on their echoes in the management literature. It is in the continuity of managerial reforms inspired by the theories of ***New Public Management***, that the recent hospital reforms have participated in the introduction of "*market-type mechanisms*" in the public hospital service management with the corollary of calling into question of the business model of the public hospital. Conceptually, this economic change has resulted not only in a change in the economic paradigm, which has resulted in the abandonment of the "*non-market compromise*" in favor of a healthcare system's market regulation, but also by the application of the agency model to health with the effect of the managerial logic's development, in other words a return in force of the State in the healthcare system management.

It has also laid the groundwork for a new organizational model of the public hospital, whose ambition is to reinvent the way the public hospital service is managed on a territory-wide basis (Ceuille, 2007). This is the "***hospital organizations' territorialized networks***" (Elhinger *et al.*, 2007) clearly enshrined in a logic of "clustering" like that advocated by Porter

(1998). This managerial innovation responds to the need to create an alternative model to the public hospital's medico-economic management **by repositioning hospital performance on collective values** (Lorino, 1999; Salgado, 2013).

The aim of this work, based on **an exploratory approach**, is to show that the networking of the hospital system helps to overcome the large opposition (*public / private sector*) on which public action was built, and thus contributes to the hybridization of the way the public hospital service is managed. From a theoretical point of view, this research work derives its raison for being from **the will not to accept that the public hospital service's modernization results from the public management's alignment with private management**. The challenge is to move beyond public/private opposition to a combination of public hospital service that can eventually be identified as a new management lever for the public hospital sector.

This hypothesis subordinates the optimization of the GHT'S strategic management to the validation of four prescriptive sub-hypotheses: the visionary partnership's development (**H1**); increasing the GHT'S attractiveness both in terms of the care pathway and the care chain (**H2**); planning of strategic objectives (**H3**); the implementation of internal audits (**H4**).

Based on the qualitative study (Yin, 2003) of an installation and operational implementation's case of a ***Territory Hospital Grouping*** bringing together 9 public health facilities of heterogeneous sizes, carried out in **an intervention-research behavior** (Moisdon, 2010), it involves questioning the criteria for assessing the quality of the patient's care pathway against the founders of the public service. The issue raised focuses more specifically to the impact of the shift from a medico-economic performance logic to a service performance logic on the management control's concept, in terms of management in the GHT sector.

This questioning leads first to a diagnosis of the networked functioning of the hospital system since the application of the modernization law of our health system from a single case of GHT, then to analyze considering the field results obtained the impact of GHT management in the sector on the management control's concept. **The first part presents the field of experimentation and the methodological approach** chosen. **The second part, the performance's theoretical framework** in *hospital organizations' territorialized networks*, before proposing an empirical dashboard for assessing *Territory Hospital Grouping*'s overall performance on the "*Balanced Score Card*" model. Finally, **the results obtained from the empirical case study, as well as their contributions and implications for management science research**, are communicated and explained in a third part.

1. RESEARCH PROTOCOL AND MODUS OPERANDI

Like the researchers from the Center for Scientific Management (CSM), the investigative approach used in this research is part of an intervention-research methodology using the case study *method*, *i.e.*, it is intended to be descriptive, explanatory, and prescriptive and is based on the development and validation of research hypotheses, scientific observation, and the collection of so-called field data (Plane, 2005).

In this exploratory phase, the aim is to **identify the cause of malfunctions reducing the *Territory Hospital Grouping* performance studied**, by analyzing concrete organizational practices in the field through the combination of around forty half-structured interviews, guidelines with direct observation in a strategic committee. Based on this observation, it is a question of operationalizing an empirical grid for assessing the overall performance of ***hospital organizations' territorialized networks***. A field of experimentation is the case analyzed in this work.

1.1. The study case presentation

The research scope is one of the 14 GHT in the Occitan region. This GHT has a coverage of 4,200 beds and places for 880,000 inhabitants and relies on 12,000 professionals. It was established by agreement on June 30, 2016. The GHT that is the subject of our study is made up of 8 satellite hospitals and 1 supporting public hospital, *i.e.*, a University Hospital Center also called a focal or a pivot firm.

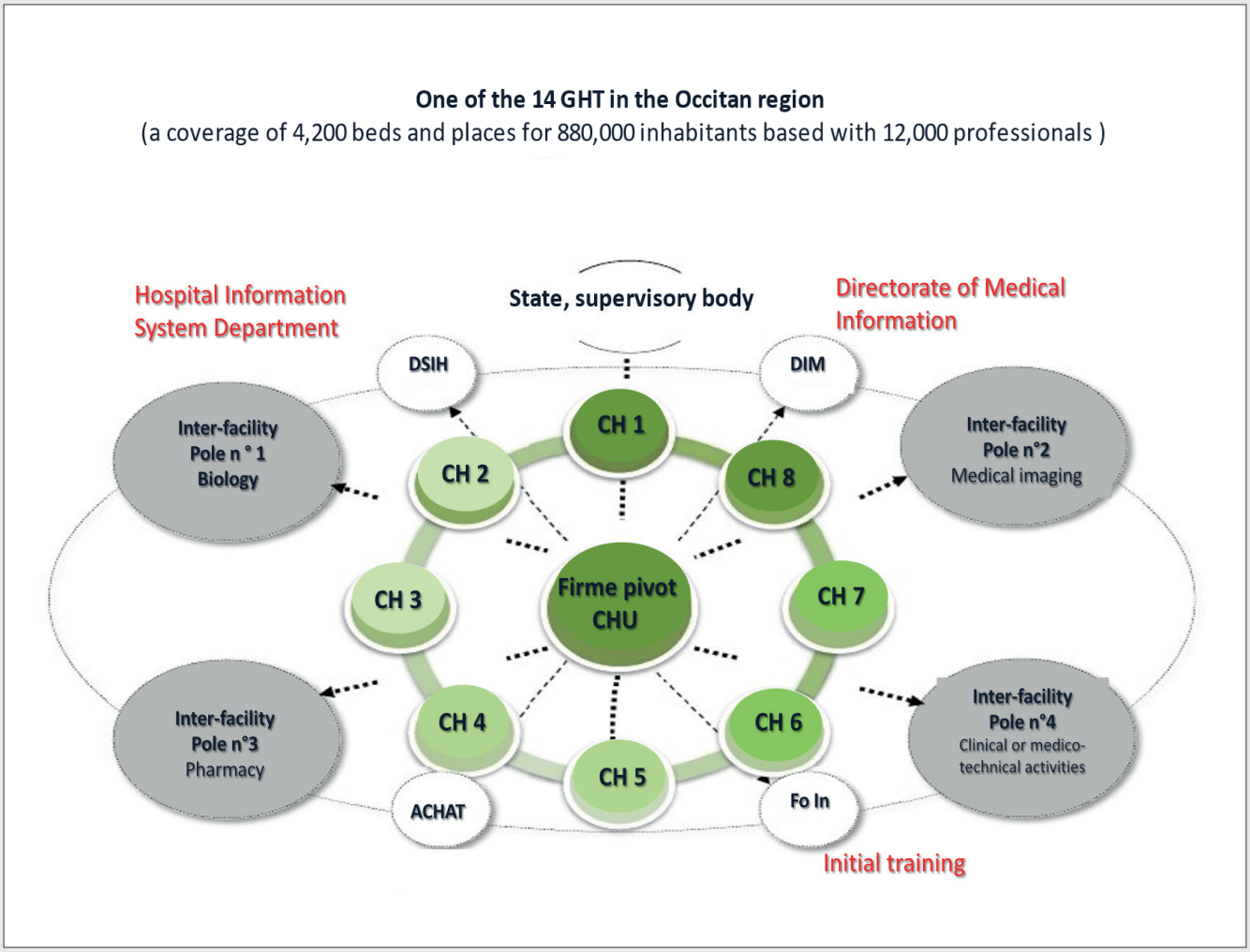

Figure 1 – Network representation of the studied hospital system
Source: Author Régine ROCHE

	Obstétrique et nouveau-nés (CMD 14 et 15)	Chirurgie (GHM type C)	Techniques peu invasives (GHM type K)	Séjours sans acte classant (GHM type M et Z)
GHT « Cévennes, Gard, Camargue »	66%	40%	36%	79%
GHT « Est-Hérault et Sud-Aveyron »	46%	33%	30%	65%
GHT « Gers »	98%	46%	31%	94%
GHT « Haute-Garonne et Tarn-Ouest »	37%	26%	21%	70%
GHT « Hautes-Pyrénées »	60%	51%	37%	80%
GHT « Lot »	100%	94%	86%	100%
GHT « Lozère »	100%	100%	100%	100%
GHT « Ouest-Audois »	98%	32%	42%	94%
GHT « Ouest-Hérault »	53%	17%	17%	65%
GHT « Perpignan, Prades, Narbonne, Lézignan-Corbières »	51%	20%	23%	62%
GHT « Pyrénées Ariégoises »	100%	100%	100%	100%
GHT « Rouergue »	100%	100%	100%	100%
GHT « Tarn, Revélois et Saint-Ponais »	84%	28%	20%	63%
GHT « Tarn-et-Garonne »	34%	22%	16%	62%
Ensemble de la région	**55%**	**33%**	**30%**	**73%**

Table 1 – GHT'S market shares for 4 activity healthcare categories in 2016
(Production of health facilities)
Source: PMSI MSO (secured access ATIH)

This is a GHT whose activity's strategic area is Medicine – Surgery – Obstetrics (MSO) and which regionally represents 43.5% of the hospital public sector's market share (**Table 1**).

This GHT looks like a holding company in that even if the management remains informal – the GHT has no legal status – the network administration is the responsibility of a focal firm responsible for meta-management through 6 strategic instances. This focal firm mobilizes the support functions, which it manages on behalf of the satellite public health facilities with an operating budget that must be separated from the budget of the member public health facilities, which they are intended to manage in their own right.

This powers' delegation (Houdart, 2015) is reflected in the case studied, by the management by the University Hospital Center, on behalf of member healthcare facilities, of a single quality account and an ancillary income statement (budget G) supporting pooled / transferred expenditure and proposed in a balanced budget, with a distribution keys' system. The prevailing way of managing is joint management: 50% of member healthcare facilities are legally attached to the University Hospital Center without having lost their autonomy.

This way of managing must be brought into line with the financial situation of the healthcare facilities that are the GHT'S members, insofar that more than one in two health facilities shows an operating deficit in the 2015-2016 financial years. This situation is to be causally related to a recent reduction in the authorized capacity of some member health facilities, and contributes to significantly burden their investment capacity, especially since the dilapidation rate of their real estate facilities is over 60 %.

Strategically, the unequal distribution of the population and health professionals in the territory – causally linked to its geography – immediately ruled out a total concentration of healthcare activities in favor of a group strategy based on a bipolar, or even tripolar pattern of community care and first-aid activities, hence a positioning of satellite hospitals in forward base.

8 care chains are thus identified and prioritized across the studied health area. For each of these chains, the GHT'S medical strategy is based above all on consolidation, but also on the development of a coherent public health organization, allowing equal access, quality, and safety of care to be reconciled for the benefit of the health population served.

The impact on the method of addressing patients will be all the stronger, as primary care medicine has been enhanced by resolving not only the problems surrounding the articulation between the city and the hospital, but also by developing advanced consultations in uncovered areas. The operational support development for territories, whether in rural areas or sensitive neighborhoods, is becoming an essential issue to prevent disparities in the supply and organization of care from being short-term barriers to the GHT'S territorial performance.

The use of public / private cooperation is a strategic management lever, even if the GHT officially displays a public group strategy. Because the financial fragility of the GHT is compounded by the fact that it finds itself in head-on competition with private clinics in its intervention's own area, being under-represented in certain health sectors at the infra and supra regional level.

1.2. Research Methodology

Organized over a discontinuous 18-month period, *i.e.*, in two steps, the intervention aims to develop a dashboard through the assessing of the GHT'S strategic management. The first step was conducive to carry out an analysis of the strengths and weaknesses of the organization management – insofar that it coincided with the GHT installation step. This diagnostic step was built: on the one hand, from an important work of collecting documentary data, carried out through access not only to internal documents, but also to communication platforms such as the FHF, Hospi Diag and ANAP (**Table 2**), on the other hand from the analysis of half-structured interviews conducted with 40 field actors selected from the GHT members directly involved in its strategic steering (**Table 3**), and direct observation at the height of a dozen meetings of the Strategic Committee.

The second step consisted of participating outside the formal framework of the strategic committee in working group meetings and feedback bringing together

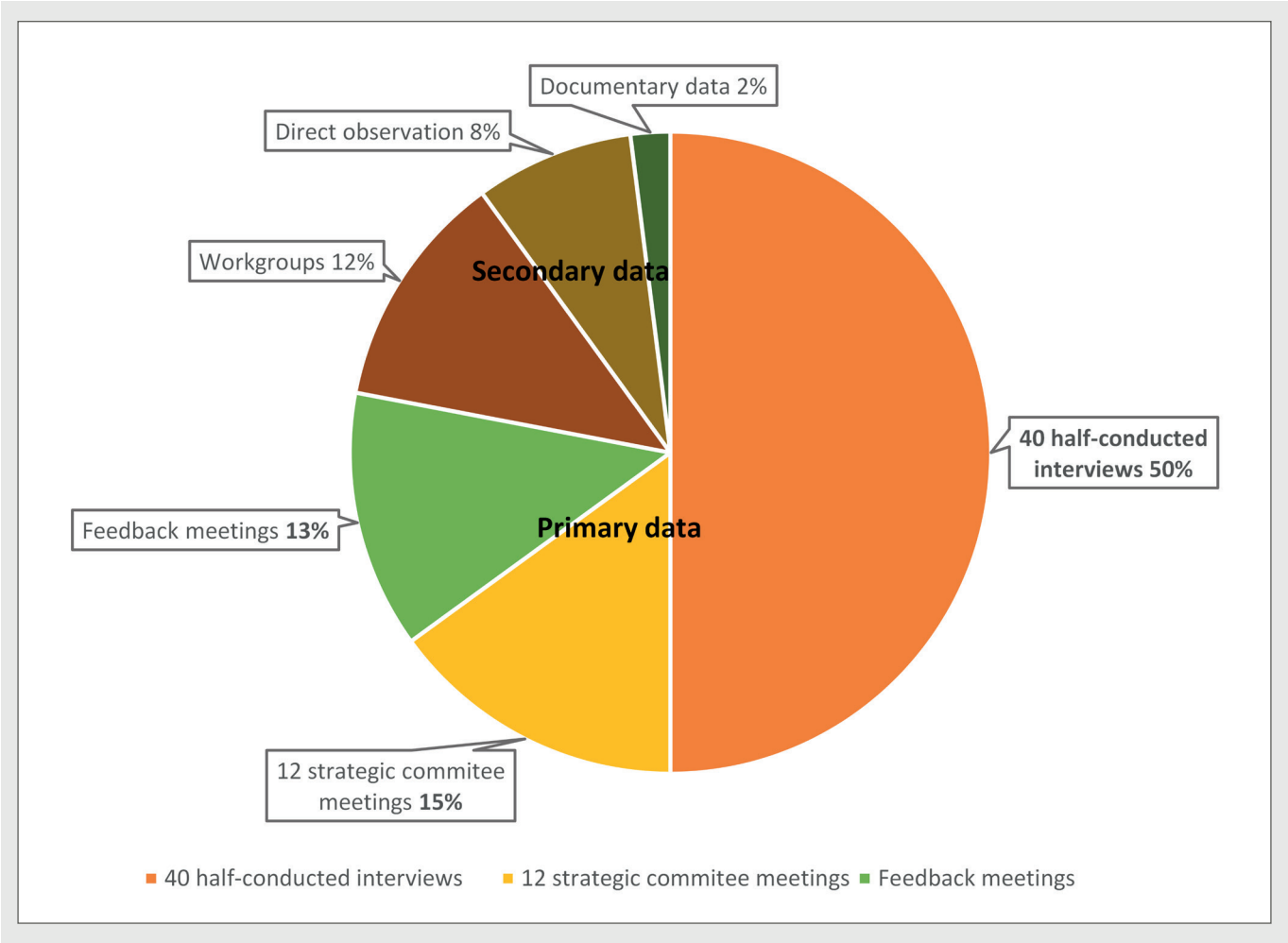

Table 2 – Experimental Database

the GHT various actors. They were an opportunity to present the progress of the work and obtain validation of the results as they emerged.

Interviews not exceedingly twice an hour and a half (**Table 3**) are sometimes carried out on site, sometimes in the premises of the field workers chosen for the study. The whole represents a sample of 40 selected people. This sample allows us to integrate the point of view different actors. When they agree, the interviews are repeated one month apart to identify and spot changes in their perceptions and interpretations.

The aim is to analyse the articulation between three control systems: **cybernetic management control** – setting of objectives, measuring, and providing incentives; **bureaucratic control system** – linked to organizational design or way to drive; and **cultural control system** – related to the socialization individuals and the organization values. With our tool, we intend to shed new light on the control activity.

The method of processing the data from the interviews uses the "*mirror effect*", *i.e.*, selection, and then the classification of witness or verbatim sentences in a tree structure made up of themes, subthemes, and key ideas (**Table 4**). This method allows us to compare the specific and contextual ideas of the actors in the field with the generic ideas that we can express during our investigations. The coding is open "*in vitro*", *i.e.*, it allows us to identify meaning units from the participants expression, formulated with our generic term. This technique, which we use during feedback meetings, allows us to obtain validation, invalidation, enrichment, or qualification of our results. It must be separated from the interpretative step of the results which helps to bring out several analysis levels of the GHT's piloting process (Zardet, Krief, 2013).

Segments Sample	Population	Phase n°1 – Diagnosis 30 interviews August 2016-April 2018	Phase n ° 2 - Project / Implementation / Assessing 10 interviews May 2017-June 2019
Direction of care offer [DOS1 – DOS2]	1 Project Manager - General Direction of the Care Offer 1 Director of care and autonomy - ARS	2 interviews	
Elected members of the territorial committee [CTE1 à CTE9]	1 Chairman of the Supervisory Board (Hospital support) 8 members of the regional committee of elected officials or their substitutes	9 interviews	
Executive members of the Strategic Committee [DGHT1 à DGHT17]	1 Chairman of the Users' Committee 1 Director IFSI / IFAS (Support health facility) 8 Hospital Center Directors, members of the GHT 1 DG of the supporting hospital responsible for the management of the GHT 1 Director of Regional Medical Information 1 Director of Financial Affairs and Information System 1 Director of Human Resources 1 General Nursing Coordinator 1 Director of Cooperation 1 President of the Medical College	17 interviews	10 interviews
Representatives Staff [RP1 à RP2]	1 Staff representative (CHSCT member) 1 Union representative of the management staff	2 interviews	
TOTAL	**40 interviews**	**30 interviews**	**10 interviews**

Table 3 – Study Sample

THEMES	SUB-THEMES
1. GHT'S organizational and managerial view	**1.1 Influence of the user's utilitarian / experiential behavior in choosing healthcare offer** 1.1.1 Quality of the Doctor / Patient relationship : quality of the social link, care ethic, care pedagogy, care coordination 1.1.2 Actions implemented to preserve the user's confidence in the hospital **1.2 Quality of the collective engagement framework** 1.2.1 Design, composition, and GHT'S organization 1.2.2 Way to manage the GHT
2. GHT'S attractiveness	**2.1 Degree of territorial visibility of the healthcare offer** 2.1.1 Quality of care delivered 2.1.2 Quality of the relationship with users **2.2 Social utility of participatory devices** 2.2.1 Quality of learning carried out jointly 2.2.2 Management of relational interfaces

Table 4 – Thematic Coding Grid

THEMES	SUB-THEMES
3. GHT'S strategic implementation	**3.1 Instead of the consensual size in the choosing healthcare offer** 3.1.1 Quality of information delivered to the patient 3.1.2 Progress, organization, and follow-up of care investigations by priority sector **3.2 Quality and timeframe for organizing the transfer of skills** 3.2.1 Partnership and autonomy of members hospitals 3.2.2 Management delegation
4. Cost transparency's organization and implementation	**4.1 Quality of the response to the user's care needs** 4.1.1 Support traceability 4.1.2 Management of adverse events **4.2 The added value of the alliance's success for member hospitals** 4.2.1 Productivity of care 4.2.2 Earnings for member hospitals 4.2.3 Control

Table 4 – Thematic Coding Grid

2. FROM INTEGRATED MANAGEMENT CONTROL TO THE COLLECTIVE INTELLIGENCE DEVELOPMENT: the challenge of moving towards a public territorial hospital service

From a theoretical point of view, our research is firmly in the field of ***New Public Management*** and interorganizational management control, which leads this research to focus on the meta-management **of hospital organizations' territorialized networks** "*Territory Hospital Grouping*". Measuring the scope of the public hospital service prompts you to first take an interest in the environmental factors that have led to the organization of public health facilities into integrated networks, then to give a definition of the criteria for assessing the overall performance of hospital organizations' territorialized networks, before identifying the determinants of their performance.

2.1. The group strategy to improve the service provided quality

Conceptually, the move towards an integrated approach to responding to the customer-user's care needs has helped make the quality of the care pathway an indicator of hospital performance.

2.1.1. An integrated design of the response to the patient's care needs

For a long time, silos were established in a field of health that was built around many bridgings: between health and social, between city medicine and hospital medicine, between public hospital and for-profit clinic, between CHU and CH, between somatic and psychiatric. *New Public Management* arises precisely against the professional bureaucracy (Mintzberg, 2012) which was built on *at first glance* trust in professional expertise and is based on two opposing principles: disappearance or weakening of the boundaries between the public and private sectors; the shift from procedural control to control by results. With the introduction of

activity-based pricing (Angele-Halgand, Garrot, 2014), it has led to a spatial and temporal fragmentation of the public healthcare offer, and far from reducing hospital performance to its purely economic dimension, contributed by refocusing hospital activity on the quality of service provided to the customer-user, to the move towards a unified notion of performance integrating the different meanings of the term.

This approach has resulted the redefinition of hospital's boundaries and thus the application scope of the public hospital service, and therefore makes the measurement of the public hospital service a management issue, insofar as the implementation of the response's integrated design to the customer-user's care needs fits strategically part of objectives of streamlining the supply of care and thus saving scale. The aim is to bring organizations and stakeholders in the health care system to meet common goals of care consistent with the principle of access to care's territorial equality (Dill, 1989; Park, 1996). With these networks, health facilities are grouped around joint projects with a strong relationship with the territory and the socio-economic environment (Barabel *et al.*, 2004), hence the term "***hospital organizations' territorialized networks***" (Elhinger *et al.*, 2007).

The use of the project method must then overcome the difficulties of bureaucratic functioning by proposing a hybrid political path (Courpasson, 2004). The challenge is not only to create the conditions for collective learning at the scale of the territory to maintain or even strengthen the logics of belonging and similarity which are at the heart of territorial development (Torre, 2011; Torre and Traversac , 2011), but also to break with the logic of sectoral and professional silos at the origin of the organizational dysfunction's risks.

2.1.2. The quality of the care pathway as hospital performance vector

Networking inevitably leads to a revision of the more established ways of regulating the health system on the silo operation of organizations and corporate entities (MSSS, 2002). The aim to bring actors to interact in a different way than on an ad hoc form inter-agency often associated with the goodwill of professionals. Functional or administrative and professional integration strategies essentially refer to integration tactics carried out at the level of the overall structuring of the network. These strategies act as support for clinical integration which is considered at the heart of the process (Gillies *et al.*, 1993).

Clinical integration aims for better coordination between stakeholders from different organizations and directly targets the user through a suitable device for continuous monitoring follow up: the care pathway. This integration is structured around the customer-user through the care path, according to the rule of becoming the consumer's owner. At the *Territory Hospital Grouping's level*, **the challenge will ultimately be the moving towards a health services platform**, at least in the way it operates. This service platform will only be designed to expand into some business segments. The aim is to better meet the needs of the customer-user, to improve the efficiency and relevance of the care system and the results relating to the health and well-being of the people in care. Improving the quality of service provided to the customer-user, allows us to go beyond the purely economic dimension of hospital performance to enter through the care pathway in a more values-oriented service-based performance model, which has the effect of making "*economy*" a quality instrument, and thus making it suitable for public hospital service.

2.2. The theoretical and practical aspects specific to overall performance measuring of hospital organizations' territorialized networks

The theoretical and practical aspects specific to the overall performance measuring of hospital organizations' territorialized networks (TNHO) lead to an interest in the issue of the hospital organizations performance, before addressing the debate on reducing organizational risks, *i.e.*, on the values control.

2.2.1. The concept of hospital organizations' performance

The question of organizational performance most often refers to the assessing's notion and therefore to indicators, which can be expressed quantitatively in

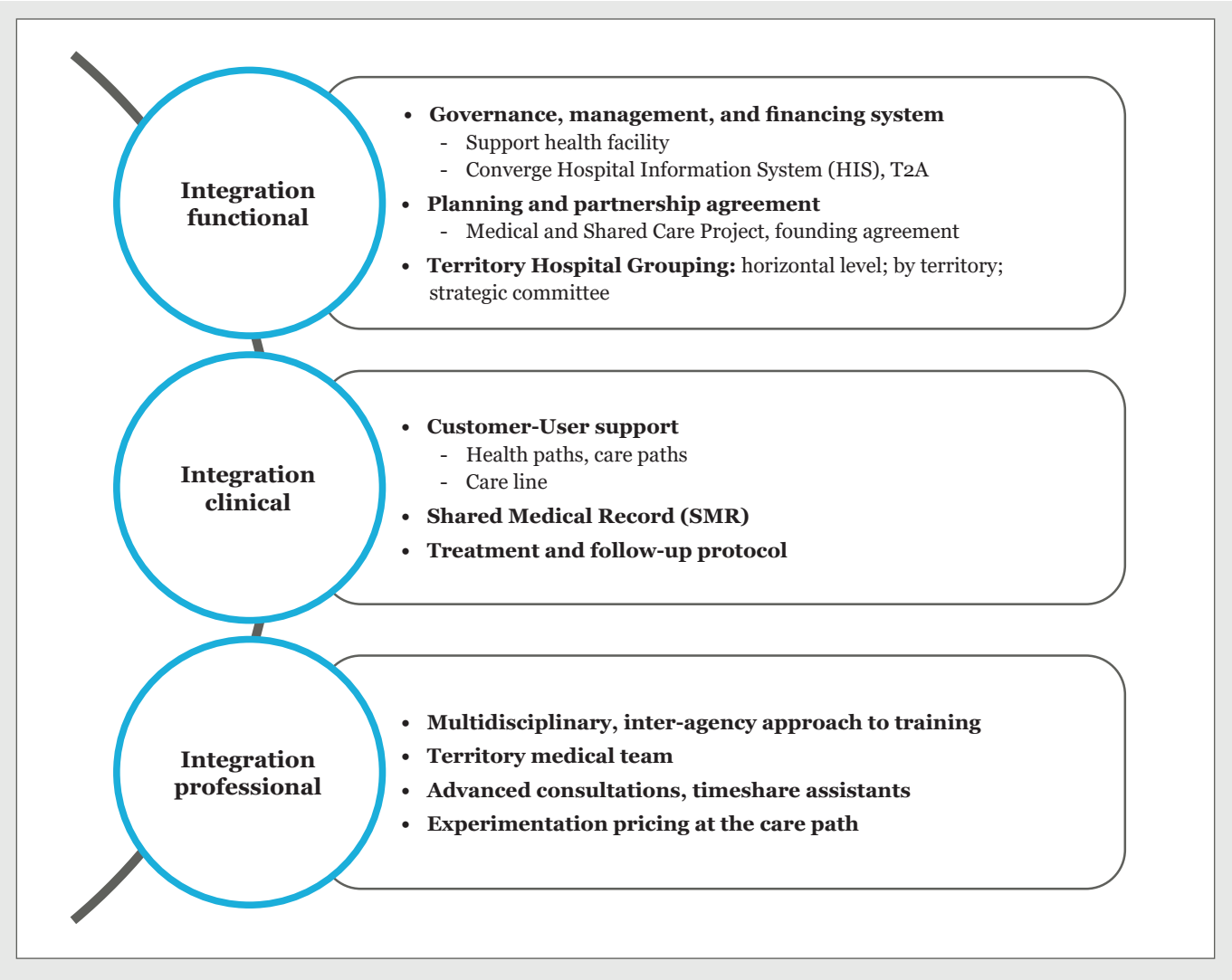

Figure 2 – Networked Health Institution Integration Strategy
Source: Author Régine ROCHE

the form of quantitative indicators, but also qualitatively in the form of a value judgment. In the hospital sector, the indicators often used to measure and compare the care quality that hospitals provide have the defect of focusing only on the performance 's medico-economic dimension, which is at odds with the goals of a public hospital service activity.

"*Hospital performance*", seen as economic efficiency raises the problem of the public hospital organization's economic profitability, public service missions' guarantor, and thus encloses its assessment in a pattern of competition with the private sector. The challenge **to move away from medico-economic performance is to move towards a broader view of performance more in line with the goals of a public hospital service activity**. This approach, however, implies that management control is based on measurement tools adapted to the specifics of the context and the organization itself. This is our methodological approach here.

Making available a GHT from the Occitan region during an **18-month off-season**, our mission is to participate in the co-design **of a tool for steering integrated activities of the GHT, to facilitate its management in chains**, and have therefore integrated the working groups set up as part of the GHT'S installation step.

The second immersion step was an opportunity for us to get closer to the financial management of the University Hospital Center and the territory's medical information service, to have

a comprehensive view the management delegation system as it can be identified within the GHT. This approach may seem more ambitious as the operating budgets' management of member public health facilities compartmentalized.

By the management delegation scheme's comprehensive view, we mean here: the setting of strategic goals through the Shared Medico-Care Project; the formal mechanism **for dividing and coordinating the member hospitals activity**; the system **for assessing and monitoring goals, based on common files** (Cofi), **ancillary income statements** (Ais), **forecast income and expenditure statements** (ES), **and financial indicators**.

The aim is to **first have a comprehensive view** of the budgetary impact of the care activities structuring within the GHT as well as of pooled activities based on the **Shared Medico-Care Project**. Secondly, it involves analyzing the **compliance with expenditure forecasts** with the multi-year commitments and the regional the wage bill development targets, while checking whether the members hospitals activity falls under either **return to financial equilibrium contracts** (RFEC), or **recovery plans** (RP) or **comprehensive multi-year financing plan** (CMFP). This review is coupled with a diagnosis of the activity fields, likely to be impacted by the staff's redeployment, to have an estimate of the social acceptability's level of the group strategy deployed by Occitan public hospitals.

In this context, **the "*Balanced Score Card*" model** (Naro *et al.*, 2010) has established itself, **to have an approach that is both benchmarking and by priority support chains**. Like Meyssonnier's (2011) work on the instrumentation of service delivery control, the focus has been more on the articulation's conditions of the BSC between the strategic and operational phases, in the light of GHT'S integrated steering (Lartigau *et al.*, 2011). To be completed, this analysis required revising the BSC'S usage reading grid (**Appendix 1**), from a service-based approach to the GHT performance.

This new approach, which offers a dynamic and interactive articulation of the strategic and the operational phase according to different intervention levels over time, goes as far as the contextualization of operational control in time and space. The aim is on the one hand to avoid the silos of the responsibility areas by ensuring the convergence of behaviors, on the other hand **to go beyond the tools of management accounting and budgetary control to appropriate the tools and methods dedicated to operational field control's some context** (Meyssonnier, 2013). Concretely, it is about building a shared view and developing a common action sense to be taken so that it becomes a social performance source, respectful of the life at work quality. The dynamic to achieve this is a transformation process of managerial practices based on co-responsibility and learning.

2.2.2. The inter-agency management control's contributions to the strategic management of hospital organizations' territorialized networks

We will see here, that if the moving towards a management in GHT sector is likely to introduce on the ground a qualitative change in the care nature, it will require to avoid a social crisis, to define **a social policy integrated** with the GHT in support of the Shared Medico-Care Project, and thus **to evolve towards a collective intelligence management**, more in line with the goals of GHT'S operational management.

In this context, the overall performance's concept will raise two great questions related to the GHT'S management and governance: What are the value creation sources? How to distribute the created value by GHT? In other words, what are the trade-offs to be made to distribute the created value (*ex post*) or to be created (*ex ante*) between GHT'S different stakeholders? This second question introduces the debate on limiting organizational risks, and more specifically on the control likely to be implemented to reduce the information asymmetry's risk between the agents contributing to the value creation and those who distribute it.

2.2.2.1 The value creation seen as the search for overall user satisfaction

The approach **to value creation in the public sector** (Lorino, 1999) has in recent decades devoted the transition from a research logic of productivity to a

logic of seeking flexibility and responsiveness. This new model, which has the corollary of transforming the hospital director into a public manager, tends **to evolve towards a business approach to public organization** more in line with the concept of "*improving the service provided to the user*". The study conducted by Cappelletti L. and Noguera F. (2012) highlights that the concept of creating public value is intrinsically linked to the standardization of public human resources management by the General Review of Public Policies (GRPP), whose aims the alignment of public human resources' consumption with that of the private sector in a logic of saving resources. In this context, identifying the value creation sources is tantamount to look at its assessing criteria and existence conditions, and therefore looking for key factors of success, identifying the different links in the value creation chain that contribute to increasing the value created, in this in our case to the value generated by the GHT.

In fact, it is no longer a question of considering value creation as the result of any strategy, but of assuming that the arrangement of organizational skills follows a logic of economic, social, and societal performance, which intimately links the organizational skills in management processes and in elements built around individual knowledge and know-how (Cappelletti *et al.*, 2012).

Here, the place given to the human resource has been considerably modified and the role of the public manager transformed. We move from a state where strategy is seen as adapting to the environment, to a state where it is seen as an opportunity to value the resources and internal skills accumulated.

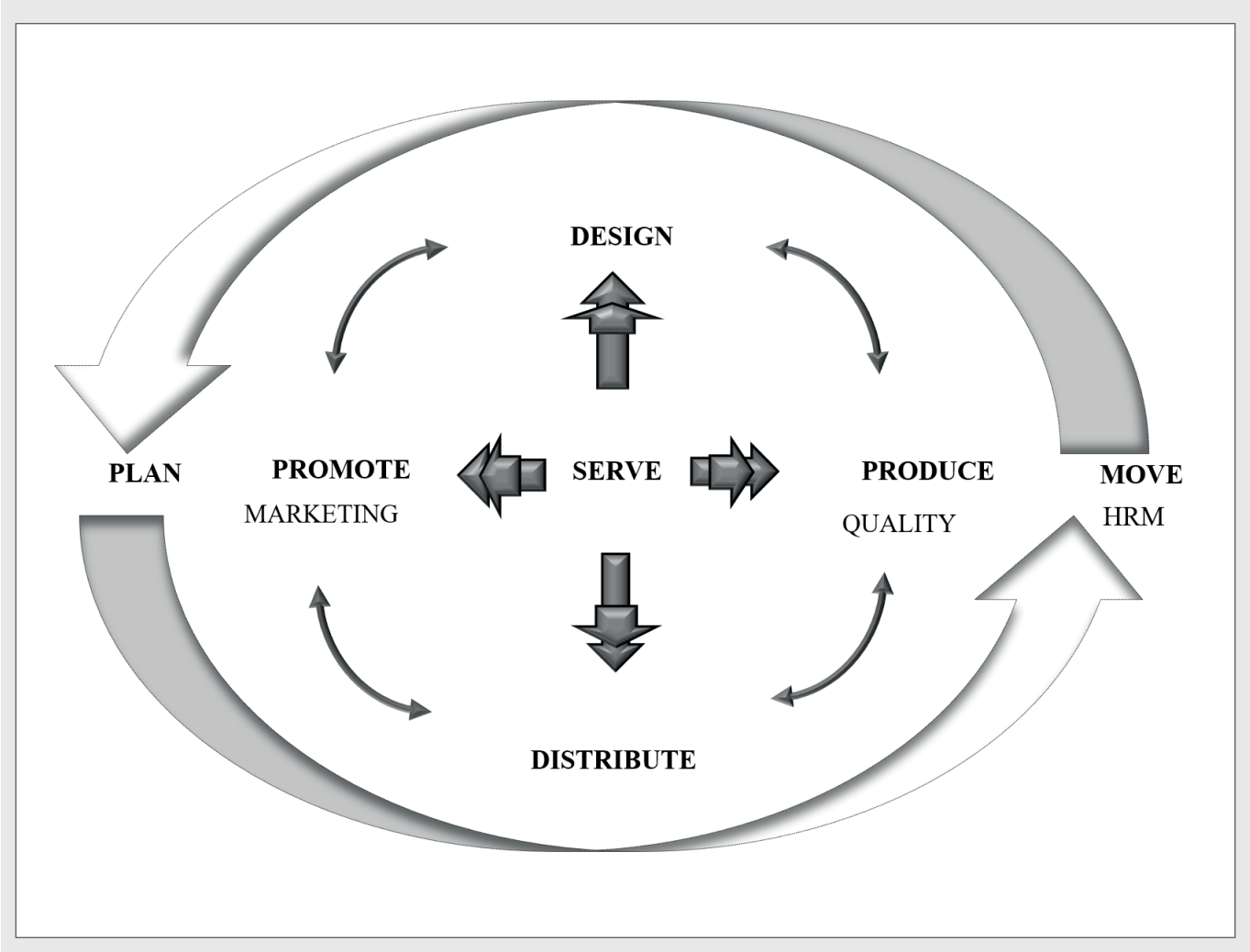

Figure 3 – "Closed" approach to M. Porter's value chain
Source: Adapted model for M. Porter's value chain

The position gives way to a contextualized, dynamic, localized work situation. The concept of qualification is fading in favor of that of skill. Therefore, it will be less a question of reasoning according to the arbitration "*forecasting expenditure / forecasting the human resource deployed*", than of thinking about valuing **a portfolio of resources and skills** (Rouby *et al.*, 2011).

On this last point, the various strategic analysis models (*Porter's analysis, portfolio analysis methods, resource approach*) show that performance can be improved either by increasing products or reducing visible or "*hidden*" cost (Savall and Zardet, 2015).

The diagram (**Figure 3**) proposed above shows the seven generic actions that make up any value chain (Meier, 2015); including information-making, feedback, and transformation decisions. From an economic point of view, **the GHT has similarities with the network of companies** (Capiez *et al.*, 2004), insofar as **the "*production lines*" can be assimilated to those of the patient pathways**. The concept of "*product*" then has a special meaning, since each patient presents a unique health problem, which must be treated in an appropriate and personalized way. In this context, the value chain developed by Michael Porter allows us **to analyze the contribution of each of the care stream to achieving the goals of the GHT by breaking down each patient journey into a care process**.

A "*closed*" or "*in-circuit*" approach to the value chain, *that is*, integrating feedback at all levels of the GHT, allows us to analyze not only the relationships between each process, including the necessary feedbacks, but also to assess their impact on achieving the GHT'S results, *i.e.*, its ability to innovate, to quickly adjust to a moving environment, and its agility. This norm-real-deviation-corrective action circuit is typical of top-down feedback, or single-loop learning (Argyris and Schôn, 1978).

Value creation cannot be understood here as a search for financial profit (Pestiau and Gathon, 1996), but rather as the search for the overall user satisfaction. In this context, **the work is conceived as a place of direct expression of the intelligence and initiative of all employees, which implies a good interpretation and translation of user expectations.** For if value creation refers expressly to public service laws, known as Rolland's law, *that is*, equal access to care, continuity of service and adaptability of supply, it is dependent on user's behavior, insofar as user satisfaction and perceived value do not depend on the actual quality of the service provided (measurable by precise and "*hard*" internal indicators), but on the user's subjective perception of the adequacy of the service lived with his expectations, measurable only by external and "*soft*" indicators (Meyssonnier, 2011).

2.2.2.2 From bureaucratic management control to management control through organizational values and skills

Traditionally, the hospital is characterized as a weakly coupled organization (Weick, 1976), where the "*caregivers*" at the heart of the activity are clearly distinguished from the "*administrators*". The asymmetry of expertise is all the stronger there as it opposes a technostructure responsible for the financial, administrative, and regulatory environment, to autonomous care units in the organization and realization of their production. In the case of these organizations with a strong identity, where "*the staff feel that they belong to a group or are one with the organization*" (Ashforth *et al.*, 1989), as is the case in the public hospital sector, **managerial theory advocates value control or predominant cultural control** (Ouchi, 1977), insofar as physicians have difficulty identifying with the health management design that accompanies the implementation of management control at the hospital (Ogien, 2000).

This raises the question of the application of control based on the results or cybernetic control, planned, and obtained, within a GHT. Indeed, management control tools meet different purposes (*convergence of goals, strategy variation, assurance of the effectiveness and efficiency of actions carried out*), some of which can be ensured by "*shared organizational values*". This can be a sufficient means for the supportive health facility to be assured that the activities of the GHT are carried out with performance (*economy of means, efficiency in resources and effectiveness in objectives*).

In its classical understanding, management control is based on "*the notion of organizational risk*" (Alvarez, 2000). From this perspective, **management control focuses on the means of compliance control**, compliance of individuals' actions and behavior with the "*scheme*" previously devised by organization's leader. Control then plays **a risk-limiting role**. It is part of a perspective that requires "*questioning the meaning of practices, articulating management control with strategic dynamics and thinking of complex, multiple, labile organizations, open to their environments and mobilizing actors belonging to several of them*" (Cauvin, 1999).

We may therefore ask ourselves **what concept of management control should emerge if organizational risk is no longer the major risk to be managed?** In our case, the scope of HRM goes beyond the borders of hospital and must move towards partnership and flexibility and pooled human resources.

Going towards a chain piloting means for the GHT to go beyond the simple distribution of activities between the different sites and will therefore require coordination at the interfaces of the levels of recourse, **and therefore tools, both communication and information, but also to manage integrated activities**. Indeed, the challenge of an effective coordination in the sectors calls – beyond the pooling of support functions – to conceive of the strategy development process as a multi-managerial activity, interweaved on different levels and sub-processes, and thus **to look outside the physical and symbolic perimeter of the public hospital to take advantage of new management levers.** From this perspective, the general processes, within the purview of higher hierarchical levels, will tend both to determine the structural context and the strategic context while **finding their foundations in the operational cycle.** In this organizational scheme, local managers are no longer mere relays for supporting hospital, and will find themselves, in fact, at the heart of the feedback loops between the strategic level and the operational level.

This necessary decentralization of decision-making processes will then generate internal risk-taking which will not necessarily lead to coordinated action (Mintzberg *et al.*, 1999). Because the "*by way*" approach will enshrine the hospital strategy on the territory, in "*a continuum with partners*", and will therefore put at the expense of managers a responsibility that goes beyond what is prescribed. In this reading, management control, using accounting information provided by the business-based accounting techniques (ABC), **will incorporate a complementary dimension: that of the construction and meaning-sharing** (Lorino, 1995; Fiol and Lebas, 1999). The ongoing interactions between the central and regional level will therefore give management control a role of understanding all the processes with **the aim of reducing "*behavioral risk*" by maintaining consistency between these two levels**.

The first step will therefore consist **in developing collective intelligence**. In this case, the thinning of the decision-making chain and the creation of short circuits will enable the needs of the teams to be effectively met and thus to restructure the management of human resources around the care path, which leads to at the heart of the hospital organization the agents who work as close as possible to the patients (Fulconis *et al.*, 2012). The challenge is not only to enable the GHT to be steered by monitoring indicators and making the actors concerned more responsible, but above all **to make it a tool for anticipating restructuring**.

By collective intelligence we mean here, the bringing together of all the tools, methods and processes that allow to network, to cooperate individual intelligences to achieve a common goal, carry out a mission or a project. For, in a sociological context where the professional dimension takes precedence, "*management control is only relevant if it is fully anchored in this sociological reality: this means **placing the professional practices of the actors at the heart of the scheme**, linking them to the generation of costs at the same time as to the strategic value produced for the user within the framework of a given resource allocation*" (Cauvin, 1999).

The proposal for matrix positioning of Collier and Meyer's services (1998) linking two concepts: the nature of the customer's request and the method of delivering service provided by the company, can come by analogy to complete this analysis, and enrich our indicator base. Because the GHT aims to manage not only relationships as well as operations, but also **to co-build the service with the user** (Edvardsson *et al.*, 2005) in the same way as a health facility.

We can already the groundwork of our empirical model. This model (**Figure 3**) is based on a service-based approach to assessing the GHT's overall performance. This approach makes the user a co-producer of the care service and favors the process / care chain approach to network management, hence two levels: **territorial performance** (*by reference to the value created for the customer-user through their trajectory/care path*); **collective performance** (*by reference to the value created for stakeholders through the group*).

These two levels are evaluated by key action variables that link:

- **the territorial performance** to the influence of the customer-user utilitarian / experiential behavior in the choosing healthcare offer; the degree of visibility of the healthcare offer; the place of the consensual dimension in the choosing healthcare offer; the quality of the response to the patient's care needs.

- **the collective performance** to the quality of the collective engagement framework; to the social utility of participatory devices; to the quality / timeframe for organizing the transfer of skills; to the added value of the alliance's success for member hospitals.

3. THE COLLECTIVE INTELLIGENCE OF THE CARE ORGANIZATION at the service of an open-ended comprehensive response to the patient's care needs

[Results of central hypothesis] In our interviews, we sought to show that in hospitals, the performance low often observed stems mainly from the lack of overall consistency between prescribed work and actual work. The sample of field actors interviewed for our survey allowed us to identify the precise causes of the GHT'S organizational dysfunctions and to confirm our central hypothesis. Among the most disruptive and costly dysfunctions, were first the imperfections of the territorial diagnosis carried out ahead of the launch Shared Medico-Care Project, then the deleterious effects of the decline of the public hospital service on the exercise of the GHT's territorial governance studied, and finally the brakes placed on the joint support of a social policy integrated with the GHT.

The results obtained show that the consolidation of **the organization of the public hospital service and the strengthening of its attractiveness to health professionals** require **the user to become a determining variable**, not only in the process of obtaining quality, but also the GHT's overall performance. Insofar as the "*satisfied-patient*" approach will mobilize energies on their core business, generate an interest in acting together, which will facilitate the transgression of sectoral and disciplinary boundaries, and thus in practice the transition from a logic of leadership to that of partnership. To facilitate this cultural change, management **control must be used to build a common framework for action.**

3.1. Promoting a collective approach to the provided service

[Prescriptive hypothesis results] The use of the "*Balanced Score Card*" model (Kaplan, Norton, 1992; 1993) (**Appendix 2**) has become the appropriate tool for a process approach to the GHT'S strategic management. It was an opportunity to ask not only the priority areas care, but also the key organizational factors. Methodologically, this approach follows an approach centered both on the patient by reference to a decentralized management of care and on inter-agency cooperation, hence the importance of a territorial diagnosis, identifying the existing territory offer, analyzing the addressing logic, identifying orientation errors in care and the disruption causes in the patient's path.

The use of PMSI data has also identified performance levels and quality criteria which they will be defined. **Four main areas of performance** adapted from the *BSC* (Dreveton, 2014) have thus been identified: **the Patient-User axis** (*by reference to the GHT'S missions*), **the organizational learning axis** (*by reference to the offer's attractiveness*); **the internal process axis** (*by reference to shared collective values*), **the financial axis** (*by reference to internal control*).

For each of these axes, **two sub-areas of performance were defined**: **territorial performance** (*by*

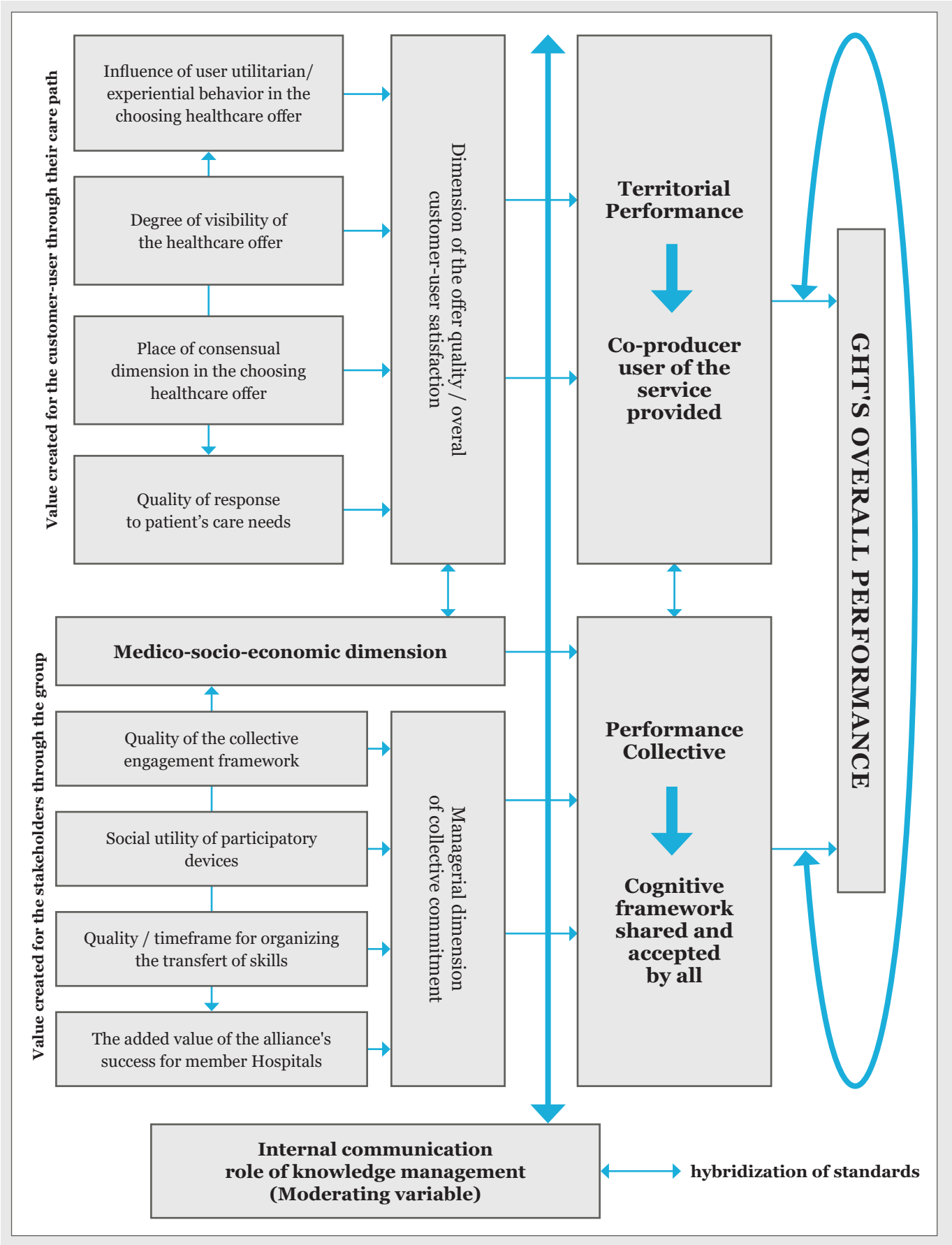

Figure 4 – Modelling a grid to assess the GHT'S overall performance

Source: Author Régine ROCHE

reference to the value created for the customer-user through its care trajectory) and **collective performance** (*by reference to the value created for stakeholders through the grouping*). Two sub-areas that link the GHT's performance to the characterization of the territory and its patient base, to the quality of the current care offer in its capacity dimensions, activity authorization, equipment and style of patients supported, analysis of patient pathways and market shares in the sectors selected in the Shared Medico-Care Project.

The stages' qualitative analysis in the building of territorial care pathways, then led to favor "*the patient-path tracker's methodology*" implemented by the High Authority for Health (*Working Group Meeting, Finding, 06/16/2018, 07/04/2018 and 03/29/2019*), and thus to assess the collective value created by the GHT, which has led to refinement of the relevance of its indicators, by integrating the **human capital (HC)**, **organizational capital (OC)** and **relational capital** sub-areas **(CR)** in the proposed dashboard. These dimensions are used to measure intangible capital. By intangible capital, we mean here, an organization's ability to create value from its knowledge's stock (Poincelot, Wegmann, 2005). Two main approaches have been mobilized to the assessment of intangible capital (IC) into the forward-looking dashboard. The field data collected allowed, in fact, to define for each component of the GHT'S intangible capital, the impact it has on the performance areas measured by the *BSC*. They also identified the intrinsic mechanisms for creating value through intangible capital.

3.1.1. Developing a visionary partnership (H1)

On the customer-user axis, the operational objectives focused on verifying the adequacy of the GHT'S development trajectory with the objectives of a public service activity.

This strategic action which involves:

> "*Everything that can be done locally will be done nearby and as soon as the patient's state of health no longer requires treatment in a referral center, the patient returns to a facility closest to his place of residence or his family*" (Hospital director member of GHT, working Group Meeting, Finding, 06/16/2018, 07/04/2018 and 03/29/2019) puts into action a strategy variable, which can be evaluated by **an outcome indicator such as the rate of deployment of advanced consultations**.

Insofar as our dashboard meets the needs of change management by the value of the service provided to the customer-user, in the sense that the territorialization of the care path makes eligible not only:

> "*The user has access to the right doctor, at the right time, in the right place, with quality care, quality equipment, without wandering in his care path, but also stakeholders in the sharing of expertise between hospitals, in search of productivity gains, as well as the enhancement of administrative and technical professions among all professional communities in a new territorial organization*" (Working Group Meeting 06/14/2018), we had to take into account takes into account **the value generated respectively by the intangible capital of the stakeholders and the customer-user**.

The quality of the care path will therefore be measured by putting of the patient's care path under pressure as soon as the patient is referred by the attending physician, regarding a target model. Its quality will not only help strengthen patient confidence, but also increase the attractiveness of the offer delivered by the GHT:

> "*While the GHT foreshadowing work undertaken by the Regional Health Agency has proven useful, it must not impose itself on the actors on the ground or risk locking them in forced marriages*" (Hospital director member of GHT, Working Group Meeting, Finding, 06/16/2018, 07/04/2018 and 03/29/2019).

The relational capital that impacts the performance of the GHT at the level of the **customer-user axis** allows to introduce in the assessment of its performance, taking into account the asymmetry of information between health professionals and patients (*respect for the patient's free choice*), and thus the actions taken

by the GHT to rehabilitate the request by making the patient an actor in its care, which can be measured by an outcome indicator such as **the percentage of patients who have been aware of the hospital patient's charter.**

3.1.2. Strengthening attractiveness of the hospital care offer (H2)

On the organizational learning axis which refers to the "*value created for stakeholders through the grouping*", the operational objectives, resulting from the interviews **concern the strengthening of the attractiveness of the GHT.** This strategic action, in this case the implementation of a social policy integrated into the GHT, is based upstream on a diagnosis of the field of activities impacted by the territorial reorganization of the hospital care offer, and downstream on the preventive measures taken by the manager, namely the GHT member Hospital:

> "*To avoid a social crisis likely to slow down the GHT'S territorial performance, the strategic committee questioned whether to develop a common policy to prevent psychosocial risks that would allow: the identification of fields of activity impacted by the GHT; measuring and controlling psychosocial risks; measuring changes in HR productivity; implementing an active HR monitoring policy*" (Hospital director member of GHT, Working Group Meeting, Finding 06/16/2018, 07/04/2018 and 03/29/2019).

The key action variable is the "*adaptability and innovation*" of Hospital mobilized to reduce psychosocial risks, which can be assessed by outcome indicators, such as the percentage **impact of preventive measures taken. Human capital** allows the specificities of HRM to be considered in the evaluation of participatory devices produced by the GHT. The social relevance of the GHT lies in the fact that it can be used as a tool for anticipating restructuring.

Two strategic objectives are thus identified. The first directs the scope of the GHT'S social policy towards supporting health facilities facing plans to restore balance. The second focuses on the statutory decompartmentalization of HRM practices, with a view to facilitating inter-agency mobility. The challenge is to harmonize recruitment practices through the formalization of a job and skills repository that focuses on both needs analysis and the gateways to facilitate skills transferability.

The implementation of a social policy integrated with the GHT allows us to assess the sustainability of the organization through:

- the hybridization of organizational standards, which links collective performance to the assessment of **the deployment rate of the trades and skills repository**.
- improving the level of territorial development, which combines collective performance with the measure of **the implementation rate of forward-looking management approach for trades and skills**.
- the development of democratic experimentalism, which links territorial performance to the assessment of **the part of patients hospitalized in their residence municipality**.

3.1.3. Implementing strategic planning (H3)

Organizational capital, linked to the internal process axis, which refers to the "*value created for stakeholders through the grouping*", **allows to consider on the one hand the support functions' delegation, and on the other hand the sharing of resources and pooled skills**, in other words the convergence of hospital information systems and the sharing of hospital practitioner / assistant positions within the framework of the implementation of advanced consultations.

Insofar as the formalization of the skills delegation procedures and the access methods of members hospitals to shared skills and resources allow us **to assess the quality not only of their level of expertise, but also of the offer delivered**:

> "*The hospitals must work to build pooling in the seven areas set by law, namely the converging SIH, the Department of Territory*

Medical Information, the purchasing function, coordination of schools training and continuous professional development (CPD) plans, but also medical biology, imaging, and pharmacy activities" (Hospital director member of GHT, Working Group Meeting, Finding, 06/16/2018, 07/04/2018 and 03/29/2019).

3.1.4. Organizing internal controls (H4)

On the financial axis, the operational objectives relate to the methods for carrying out internal control of the GHT. This procedure's implementation which **involves the evaluation the added value of the alliance's success for members Hospitals puts into action an activity variable**, which can be assessed by a result indicator such as **the cumulative contract completion rate to return to financial equilibrium at the May's end N.**

The impact of intangible capital on the financial axis are indirect: the productivity gains of members hospitals are improved by the quality of the skills transferred, themselves improved by the users' confidence in the facility, leading to a diversification of the hospital activity's spectrum, and thereby a reduction in costs through synergy in the joint production of the various medical sectors.

3.2. The emergence of a new paradigm of collective intelligence management

As we have seen, the quality and consistency of the response to the patient's care needs are conditioned by **the policy implementation of strengthening and upholding the medical staff.** The social relevance of such a policy is not only based on the right sizing of the Shared Medico-Care Project (*coherent response to health needs, gradation of care, size of teams, quality of the technical platform, organization of on-going care, information systems' convergence, harmonized professional practices...*) and a real recognition of the territorial exercise and the associated hardship, but above all on appropriate management tools.

The proposed management tool was involved in defining the scope of the public hospital service within the GHT. A conventional framework could thus be formalized not only from a mapping of GHT'S sectors generated by the University Hospital Center's PMSI database, but also from a mapping of pooled activities / functions. **A target model or care common base concentrating the GHT'S main patient flows has in fact been designed and recognized by conventional means by the various stakeholders** as being the cognitive target framework. 8 care sectors have been identified and prioritized.

These care sectors revolve around emergencies and critical care, oncology, follow-up and rehabilitation care, care for women / mothers / couples / newborns / children, chronic and metabolic diseases, elderly and aging, mental health and psychiatry, and palliative care. The field concerns a large population that goes well beyond the definition of long-term conditions.

It has also enabled us to provide an answer to the issue of decompartmentalizing patient care and verifying the credibility of our investigative hypotheses, highlighting the contradictions of the GHT'S management strategy. Indeed, the GHT'S strategic objective is to support the rise in power or preservation of first resort for chronic diseases.

As a result, this strategy involves integrating the private sector in its response to care needs. The private sector has positioned itself so far, only in specialties with actions to be carried out, and less so, it seems, on episodes built around the patient's health journey.

This approach may seem paradoxical, in that the GHT is intrinsically part of a public group strategy. Thus, our management tool served as a common thread for an assessing process, which can be studied as the implementation of "*the patient-path tracker's methodology*" on the GHT's scale, insofar as it measures the adequacy of the GHT development trajectory with the objectives of a public service activity, by energizing the patient's care trajectory as soon as he is referred by the attending physician, in relation to a target model.

It is a performance approach that we are studying at the GHT's scale, not only by the value created for the customer-user at the level of his care trajectory, but also by the value created for the stakeholders through

the recognition of a support common base. In fact, it helps **to subordinate the user's overall satisfaction and his confidence in the institution**, to the request's mastery, which can be assessed by behavioral intention and his adherence to therapy. This leads in terms of strategy and territorial governance to the solutions' implementation to avoid **disruptions in the continuity of service, to reduce the leakage rate; to achieve common goals of specialization.**

The question of measuring the scope of the public hospital service makes the collective values mobilized by the GHT'S governance framework an important issue in measuring its performance, insofar as the assessing of the GHT performance does not only address the question of the participatory devices effectiveness contributing to the management of the network, but takes into account **the participatory component's importance of these devices, in other words their contribution to local democracy according to the collective building's methods of territory shared projects.** From this point of view, for the governance system is to strengthen **the logics of belonging to the territory and similarity to the shared repositories and values in order to promote the territorial intelligence's processes.**

The hybridization of the way the public hospital service can be seen in this context as a solution to back up a care response in geographic areas with low medical demographics. For this reason, that the GHT makes public-private partnerships one of the main levers of action in the group strategy deployed in rural areas with low medical demographics. Not only is it a matter of working together to improve the care system (*coordination and pathways*), but it is also a matter of collaborating by pooling material means and medical resources (*cooperation / partnership*), thus transforming the borders of facilities and medical teams. The government's desire to limit health spending combines with the changing hospitals and their environment to foster new organizational models based on inter-institutional cooperation.

In conclusion, the added value of this research work is threefold. On the one hand, it highlights that cross-cutting management driven by **process-based management contributes to the decompartmentalizing the response to the patient's care needs, insofar as it contributes in practice to the transition from a logic of leadership to that of partnership.** This managerial approach is the prerequisite for the GHT to mobilize the ability of a group to understand all the dimensions of a complex problem, to succeed in asking questions and seeking answers together to reach a collegial decision. On the other hand, it suggests that the overhaul of hospital governance leads the renovation of the human resources function, insofar as that it tends to seek public-private partnership (Dumez *et al.*, 2003) to remove financial and organizational constraints. Finally, it reinforces the idea that rehabilitating user request is an economic asset for the GHT in its relationship with the latter.

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APPENDIX 1

Analysis of the main phases and dashboard control levels with a view to GHT's operational management

Empirical control system	Articulated control phase	Control levels	Goals	Tools	Indicators	Nature of control
Balanced Score Card **(Case 1)**	Strategic / Operational (separate phase control)	- Diagnostic - Interactive	Minimization of organizational risk (the control provided by the central level is articulated with the regional level)	Expense forecast / forecast performance of deployed HR (Planning and reporting tool)	Result indicators	ABC-type budget control[1]
Balanced Score Card + Value creation indicators **(Case 2)**	Strategic (long cycle) Operational (short cycle) (interactive and dynamic phase steering in different cycles of intervention over time)	- Diagnostic - Interactive - Operational and Contextualized (in time and space)	Search for the modalities of collective action ➔ Real-time implementation of the strategy / permanent adaptation, activation, and field completion of processes (the control provided by the central and regional levels follows different cycles)	Portfolio of resources and skills to be developed → Competitive advantage of the organization comes from the endowment of resources and skills (control levers and feedback loops)	Result indicators Leading and local indicators	ABM-type management activity control[2]

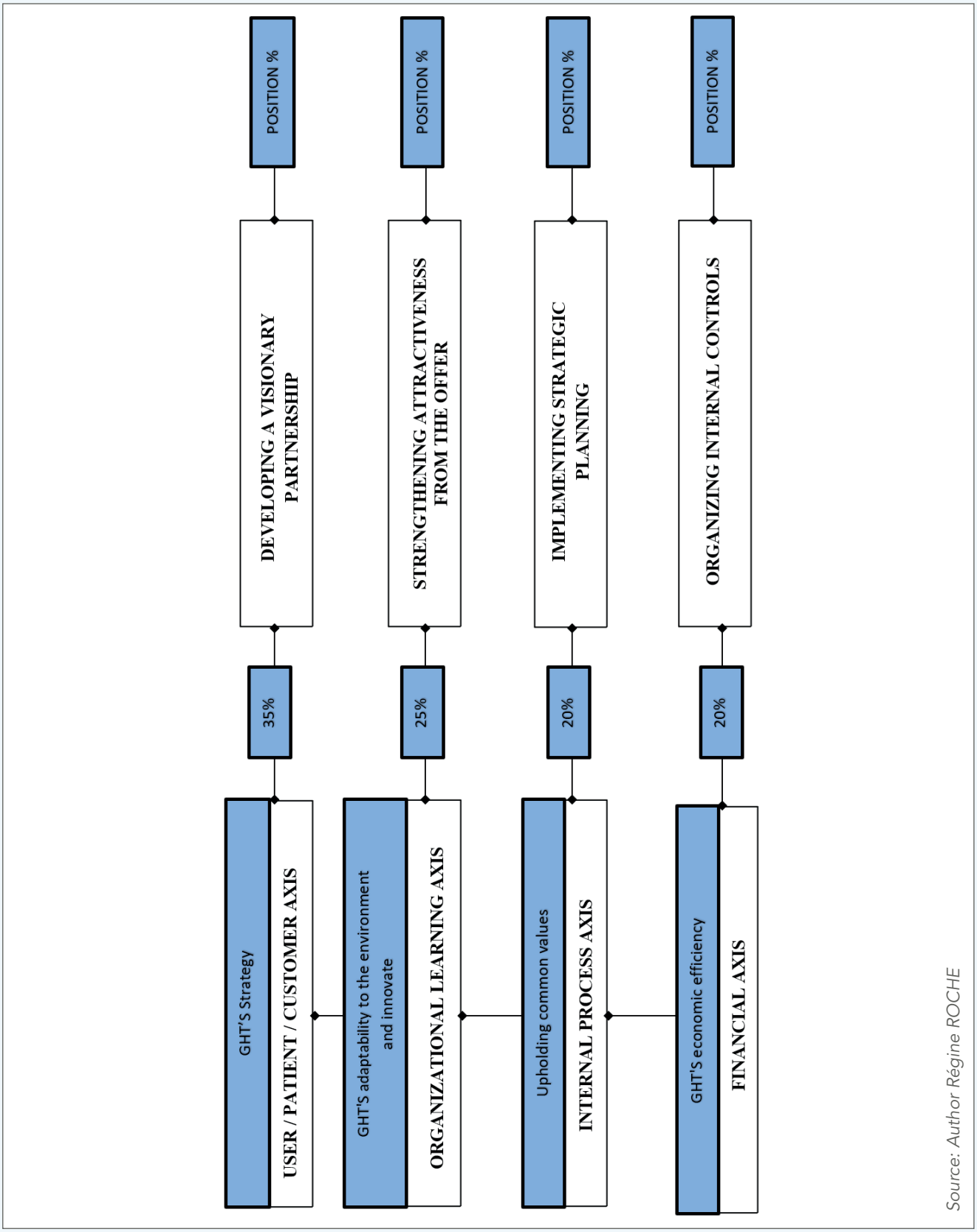
1 Activity Based Costing (*Contrôle bureautique*).

2 Activity Based Management (*Contrôle par les valeurs et les compétences organisationnelles*).

APPENDIX 2

Balanced Score Card (case 2)

GHT's strategic objectives

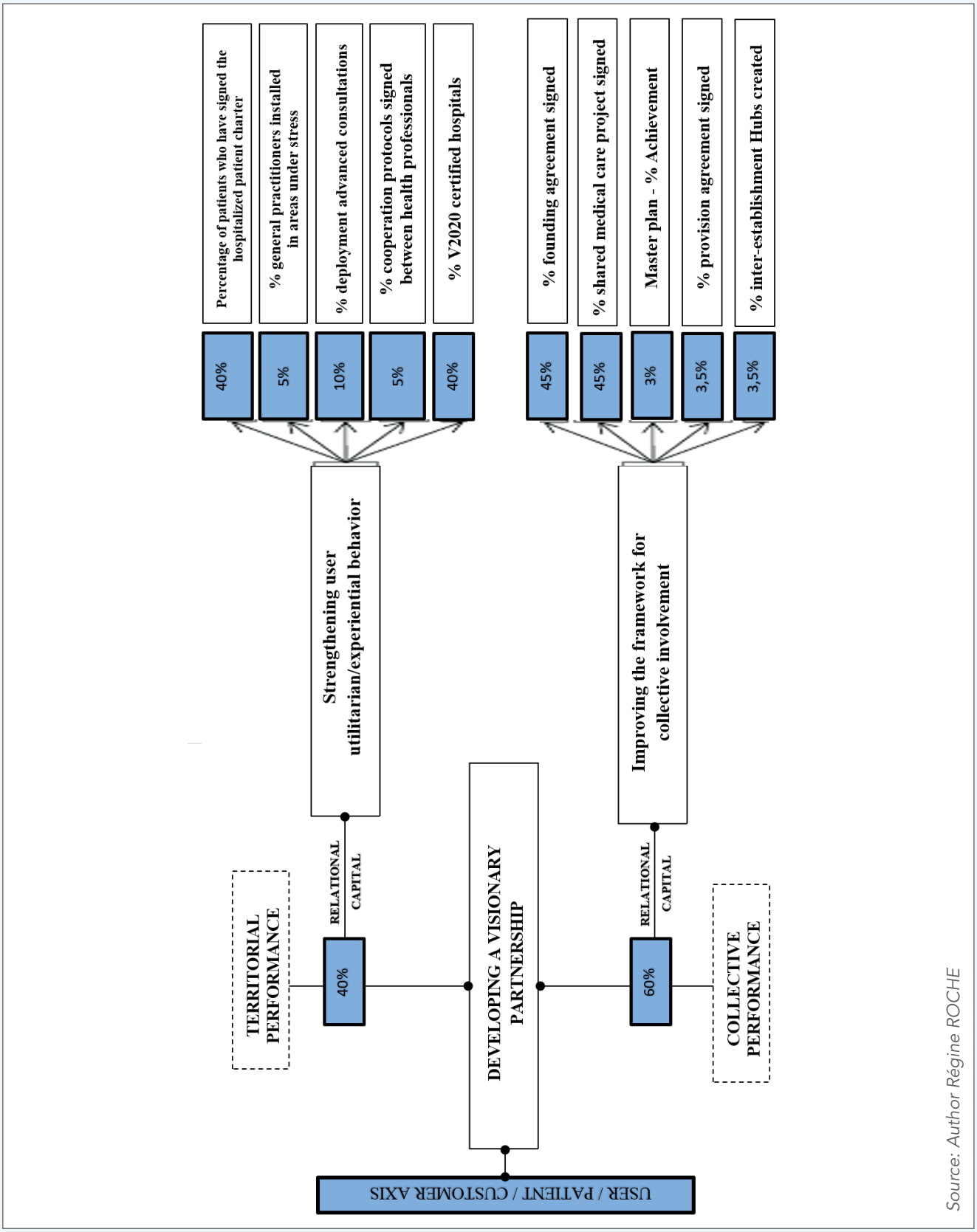


Source: Author Régine ROCHE

APPENDIX 2

GHT's strategy

Declination in strategic and operational objectives and performance indicators

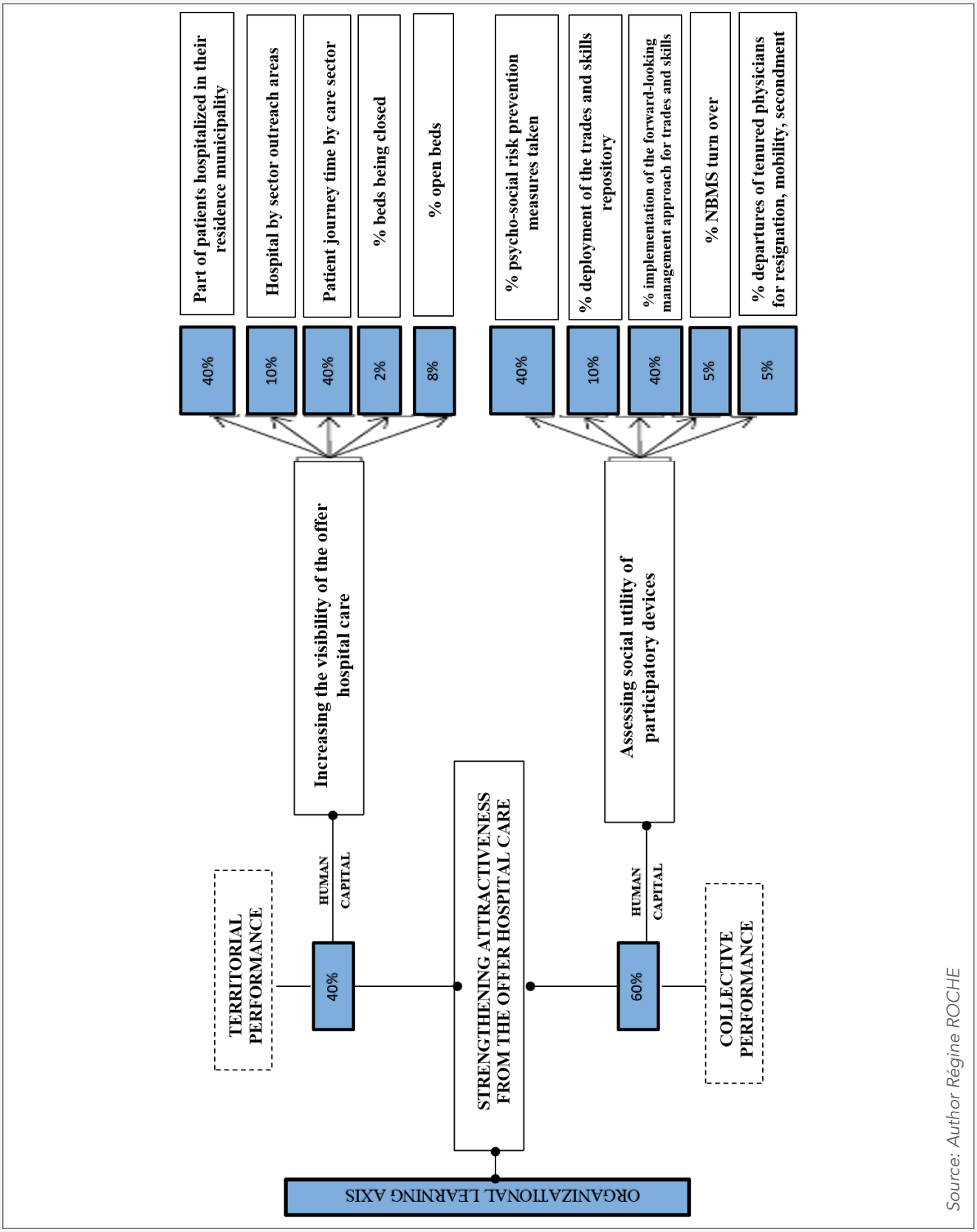


Source: Author Régine ROCHE

APPENDIX 2

GHT's adaptability to the environment and innovate:

Declination in strategic and operational objectives and performance indicators

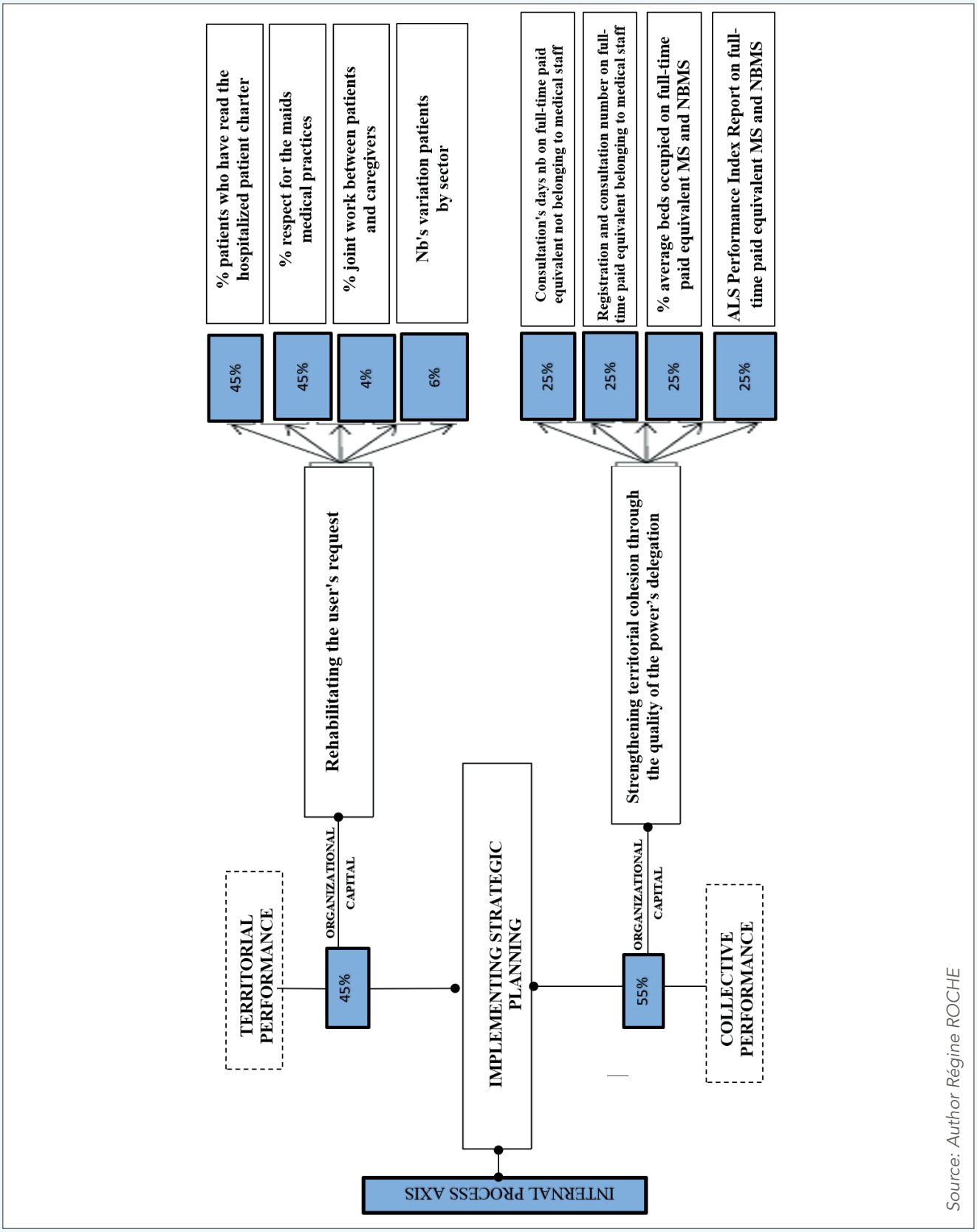


Source: Author Régine ROCHE

APPENDIX 2

Upholding common values:

Declination in strategic and operational objectives and performance indicators

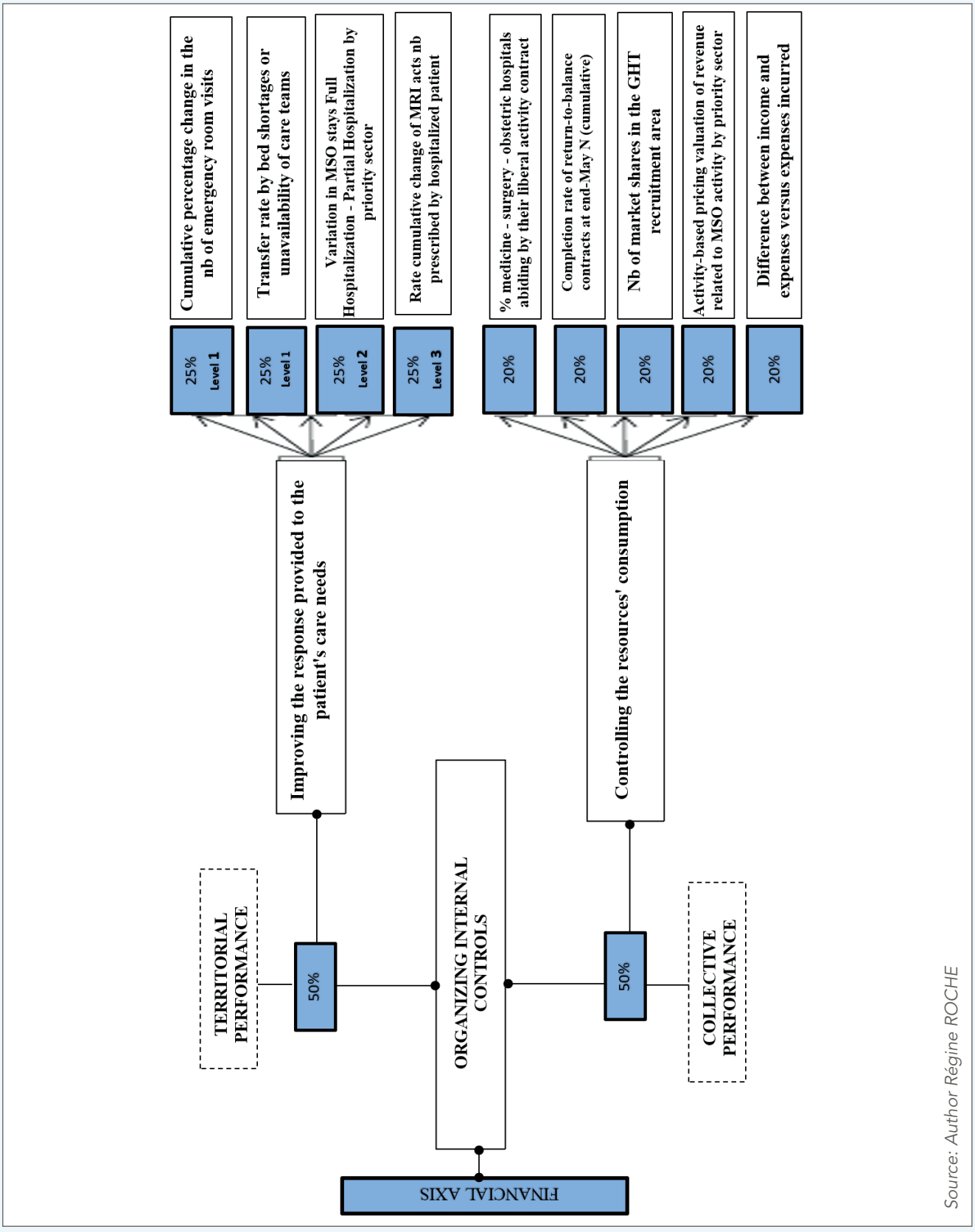


Source: Author Régine ROCHE

APPENDIX 2

GHT's economic efficiency:

Declination in strategic and operational objectives and performance indicators



Source: Author Régine ROCHE