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ORIGINAL PAPER

Designing a Capability-Focused Strategic Management Model for a Turkish Public Hospital: Learning from Failure

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Abstract This study aims to depict a failed strategic change initiative in a Turkish public hospital by means of an action research and it strives to explain critical factors underpinning the failure, thereby proposing how such factors should be tackled with for similar initiatives elsewhere. The study calls attention to the recent challenges ongoing in the environment of hospitals, which urge them to take on a more strategic focus. In this vein, we discredit accreditation based systems, which emphasize monitoring resources and propose a capability-focused strategic management model for hospitals. A hybrid action research protocol, which combines both traditional and participatory action research methodologies in its design, is employed to formulate and implement the model in a public hospital. The phases of the project and obstacles faced during these phases are discussed. The findings suggest that although the model offers significant potential for competitive success and better resource efficiency, path-dependent characteristics of the public sector governance in Turkey have impeded the adoption of the model in our case. Both macro-systemic characteristics related mainly to the Turkish national culture and management of public institutions and situation-specific characteristics, such as top management's decision making orientation, professional norms and patronage relationships have blocked the way for the aspired transformation despite positive attitudes of and support from higher order public authorities and internal professional groups.

Keywords Turkey · Public hospital · Capability · Healthcare management · Strategic management

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Introduction

Transformation of healthcare institutions has become one of the hottest topics in the last two decades. Combined forces of economic and regulatory changes have compelled healthcare institutions to abide by a more strategic focus, which is characterised by increased economic efficiency motives. The hospital sector has been one of the most affected fields among other healthcare institutions, and has been exposed to substantial managerial reform processes on an international scale (Pettersen and Nyland 2006). Despite the intensity of these forces, the diffusion and adoption of strategic management practices across the hospital sector have become problematic even in the United States, where substantial incentives and relatively good administrative frameworks have already existed for hospitals (Swinehart et al. 1995). Other studies, conducted in the European context, had confirmed that the forces for market efficiency were pervasive and efforts to transform European hospitals became embedded in "The New Public Management" reforms (Hood 1995; Pettersen and Nyland 2006). Yet again, the attempts to implement strategic management in the European public hospitals were not problem-free, and significant inertia, and even rejections were observed. Apart from highly developed Western contexts, there seems to be a significant gap in the literature as to understand if these transformation efforts could be extended to less advanced settings, and if they did, what the basic elements of the strategic model of change would be. In accordance with this research need, this study aims to focus on a relatively less advanced setting, Turkey, to depict how macro-level forces of transformation make it possible to gain a strategic focus, but, at the same time, how local political and cultural factors impede sustained use of deliberate and articulated strategic practices in Turkish hospitals by means of an action research.

Theory about cross-national diffusion of management knowledge and practices suggests that the flow of knowledge is generally from more advanced countries to less advanced ones, because of the motivation of the latter to close perceived performance gaps and gain legitimacy (Arias and Guillén 1998). In accordance with this argument, recent studies explicitly have documented that Turkey had accepted "active consumer" role when it comes to Western practices and knowledge, especially in the field of business and management (Üsdiken 1996). Although, there were some cases where significant transformation of the content of incoming practices and discourses observed (Erçek and İşeri Say 2008/9), most of the time there was a relatively fast, easy and replicative transfer of business and management practices in various Turkish organization fields (Erçek 2009). However, we argue that replicative logic, that is to say, cloning an innovative management technique or practice, which has been proven to be successful in a Western setting, does not automatically guarantee successful adoption and entrenchment of innovative business practices in Turkey. There might be a significant need for re-contextualisation of the incoming management practice due to the "absorptive capacity" (Cohen and Leventhal 1990) of Turkish organizations and due to the attributes of the incoming innovative practices—i.e. complexity, adaptability, etc.—(Rogers 1964). Thus, when a participatory research proposal to design a system to abide by the Joint Commission International (JCI) standards, which were directly copied from the standards developed in the US and made compulsory by the Turkish Ministry of Health, came from a public hospital; we expressed our concerns about such an approach. Instead of exactly conforming to the demands of the Ministry, which impose an inert resource-based accreditation system, we stimulated a broader comprehension of the problem, based on the main causes of change and the prospective outcomes. Once a positive attitude has been displayed on the part of the management of the hospital, we engaged in an action research, which resulted in a dynamic

capability-focused strategic management model for the public hospital. Furthermore, study has achieved to develop the blueprints of a Business Intelligence system, which can automate the processes concerning the reception, filtering, computing and summarising of the key performance indicator (KPI) metrics. Yet, due to path-dependent characteristics prevailing in the Turkish public sector, the continuous evolution and sustained development of our model was impeded. Top manager of the hospital, displaying initially a positive, subsequently a laissez-faire attitude toward the project, retrieved his support, and furthermore, discouraged the last stage of the implementation. Thus, the implementation and entrenchment stage of the model turned out to be a failure. Nonetheless, we believe that the failed model not only helps to improve our understanding of the strategic management of hospitals especially concerning capability focused on learning and monitoring, but also empirical evidence gathered from the deployment process can still add significant value to our discernment of the critical factors of successful acceptance and use.

The study is composed of five consecutive parts. In the first part, we describe the relevant issues of the context of Turkish hospital sector and the major impetuses for the shift to a more strategic focus in managing public hospitals. In the second part, we define the methodology of our research, in which we have incorporated a hybrid action research protocol. Subsequently, we introduce a model of strategic change and management for Turkish hospitals, theoretical roots of which were based on resource-based-view (RBV) and specifically, capabilities. The following part describes the iterative cycles of implementation of the model in a public hospital and delineates how specific targets and measures for performance were operationalised. In the last section of the study, we discuss the merits of this model and specify the reasons of a failure in a more systematic basis.

The Context: The Transition of Turkish Hospital Sector

Concomitant to the transformation of healthcare systems in Western settings, the foundations of change in Turkish hospital field were laid in the beginning of 1990s, when a small number of high quality private hospitals began to emerge. The emergence of private hospitals was important because hospital sector of Turkey had traditionally been a public domain and strongly controlled by the state or state-controlled authorities (Aksoy 2007). In the beginning, these private hospitals were focused on a niche in the hospital market, which involved a relatively small segment of patients with high income and high expectations of service quality. The emergence and rapid dissemination of these private hospitals signalled that a new business model other than publicly controlled hospitals—either governed by the Ministry of Health, public universities or charity foundations—was viable. Yet, the major impetus of change for the field of hospitals was after 2001, when a major economic crisis hit Turkey. Like other less advanced countries with a high trade deficit and high overall national debt, an orthodox economic retrenchment policy was introduced in 2002 with the aids from World Bank (WB) and International Monetary Fund (IMF). Since Turkish public healthcare system was diagnosed by the WB and IMF experts as the most problematic field in terms of economic efficiency, a set of directives have been launched to correct this deficiency. As a result of this initiative, the "Healthcare Transition Project" was launched in 2003 under the auspices of 59th cabinet and with approximately 50 million € financial support from the WB (World Bank 2004).

For the health transition project to be successful, government needed a novel approach to transform public hospitals. The latter were highly bureaucratised structures, which were epitomised by their lack of administrative performance standards. Being

controlled by the state apparatus and governed by the civil servants legal framework, the positions in public hospitals offered life-time employment. Even though, at the first glance, this could be regarded as a fundamental advantage for public hospitals, incorrect and/or politically guided selection of staff could—and usually did—bring about serious inflexibility and disadvantages. To be sure, public hospitals recruited reputable and talented medical doctors, especially in urban areas. Yet, absenteeism was common among these staff, since they were forced to work freelance because of the amount of their salaries, which were relatively low. No strategy existed for public hospitals, even at the informal level, and therefore, they did not have a clear set of objectives. Due to all these factors, the level of service quality in public hospitals was incredibly low, not standardised, and was tied to idiosyncratic professional norms. Therefore, the Turkish Parliament proceeded to a new reform plan that all hospitals—including the private ones—had to adopt a unitary performance system. The first meeting about this project was held on September 23, 2004, and after a short time Ministry of Health signed a collaboration agreement with Joint Commission International (JCI) (Aydın 2008; World Bank 2004). JCI, is a not-for-profit organisation, the roots of which were laid as early as 1913 by the American College of Surgeons in order to prepare minimum standards for hospitals (The Joint Commission 2009). After a long historical journey, JCI has substantially expanded its boundaries and now became an international accreditation and counselling body for health-care organisations. The international standards of JCI for accreditation of hospitals accrue to 1,200 items are categorized under 14 major topics, which serve as check points in self studies and third-party assessments (JCI 2006). The Turkish Ministry of Health officials stipulated a gradual transition, and therefore, required that only 100 items of JCI accreditation metrics should be implemented by the public hospitals in the first phase. Today, the number of metrics used by the Ministry of Health auditing process has increased to 400. In order to facilitate the adoption of JCI metrics, the Ministry engaged the outcome of performance audits to a grading system, which in turn, determined the level of funds to be transferred to the hospital by the Ministry. Thus, better conformance to JCI metrics increased the funds of the public hospital, which in turn, increased the amount to be paid to the hospital staff.

Turkish-style accreditation had similar issues with the French style (Pomey et al. 2004; Touati and Pomey 2008). When systematically analysed, a number of interesting attributes of the accreditation process were uncovered:

- In every 4 months, it is mandatory for healthcare organisations.
- It is performed by a dependent government agency.
- During visits, the surveyors have to report all measure results to the ministry of health.
- The survey report is a semi-public document which is sent to the regional administrative authorities.
- Regional administrative authorities can use the information in the survey report to modify hospital budgets and plan activities.
- The accreditation process confers legitimacy through its use of external evaluation.

Apart from—but related to—the above monitoring process, the government launched other initiatives, which intensified the market efficiency norms among public hospitals. The first one was the obligation to prepare strategic plans and pro-forma budgets, which was made compulsory not only for public hospitals but for all public organisations. The second one was the prohibition of freelance working status for publicly staffed medical doctors. This latter initiative considerably intensified the stress for the implementation of performance-

based monitoring since doctors had a choice to abide by the performance management system, or else to leave for a private hospital with better wages. Furthermore, a new regulation on patients' rights was accepted which gave patients stronger legal rights and contributed to the perception of patients being considered as customers. Taken together, these regulatory changes substantially disrupted the institutional norms of the public hospital field and an exigency for strategic change in order to adapt to the new initiatives became obvious.

The Study: Action Research and Methodology

As it is well-developed in literature, action research methodology has its roots in the *praxis* notion of Aristotle, whereby one acts upon the real life conditions which surrounds him/her in order to change them (O'Brien 2001). Praxis was used to juxtapose *theoria*, which refers to science-making as an end in itself, stripped off from values and subjective processes. Therefore, action research endorses researcher involvement in the research object and denies apolitical and distantiated researcher role (Winter 1987). It is in stark contrast to logical positivism and remains somewhat distant to interpretive paradigm because of the latter's "expert researcher" stance. If the social phenomenon to be studied is embedded within the daily social fabric and context-specific language, which we believe usually is the case for public hospitals, then action research will offer substantial added value for producing reliable results (Winter 1987, 1989). Therefore, when we were consulted by the quality manager of a public hospital about their need to abide by the new standards of the Ministry, we thought that this would provide a good opportunity for both parties.

We employed a 'hybrid' action research protocol, which can be defined as a combination of traditional and participative action research approaches (O'Brien 2001). Traditional action research generally recognises scholar-researcher's role in the research process as dominant, is usually more systematic and structured in its phases, requires less collaboration in joint decision making and attempts to achieve pre-defined instrumental goals. On the other hand, participative action research is genuinely democratic and collaborative in all research processes, scholar-researcher's role is equal in standing with other research participants, endorses active participation in every stage and "it aims to be an active co-research, by and for those to be helped" (Wadsworth 1998). The reason for employing a hybrid protocol was—to a large extent—situation-specific. In this case, the hospital decision-makers and problem-owners perceived an academic consultancy as a differentiated expertise, they had a poor repertoire for strategic management concepts, tools and practices and therefore they were more inclined to work with a dominant "expert" role, who would take the lead whenever the project encountered with difficulties. This does not mean, however, that we did not involve relevant constituents of the problem in the participative inquiry process. We tried to involve key decision makers in critical decision-making stages, participatively constructed and re-viewed models, measures and application frameworks with the hospital project committee and relevant process owners. Yet, our approach was not a genuinely democratic one since initial problem specification, model development and measure derivation processes were pretty much dominated by scholar-researcher teams. Therefore, the action research protocol, as it was applied in this study, incorporated characteristics of both traditional and participative approaches to action research.

The project started in September 2007 and lasted approximately for 10 months. Two principle investigators and three graduate students worked on the project on the academic part, whereas there was one project coordinator and a twelve-person-committee working

on the part of the public hospital. No formal letter of agreement was signed, however top management support, namely the approvals of the surgeon general and vice surgeon general were secured.[1] In order to sustain theoretical rigor, and the status quo position with reference to the internal power relations of the public hospital, one of the principle investors remained largely immune to the work setting, whereas the other actively involved with the project coordinator and the committee. Principle investigators and graduate students systematically got together to evaluate the progress of the research during the project time and the non-involved principle investigator acted as an outsider observer in these meetings to critically analyse and review the whole research process. The project followed a hermeneutic pattern, which involved five interdependent and recurring cycles. In the initial step, the nature of the problem was identified and data for additional diagnosis were gathered. In this step, frequent referrals to the theory were made in order to make a more rigorous judgment. Also, serious of training sessions for the hospital project staff were designed in order to overcome communication barriers and facilitate a common language. The second step was to introduce possible solution sets and collectively agree on a single solution to be implemented. This step once again involved referrals to the theory of strategy and the distinction made between resources and capabilities. A Balanced Scorecard (BSC) approach integrated into a more conventional strategic management process was configured and collectively uphold during the meetings. Once this step was achieved, and capability-focused strategic management system was formulated, implementation step commenced. This step involved a series of collective sessions within which the vision, mission, a thorough strategic audit and basic strategies of the public hospital were formulated in a collective sense. Furthermore, both the hospital staff and the graduate students were engaged in an extensive effort to determine appropriate measures of performance control for each strategy and scorecard clusters. On the other hand, the information system of the hospital was assessed in order to design a business intelligence system, which can aid in automatic retrieving, calculating and visual monitoring of performance metrics. In the last step, because of the lack of top management support, the final report was produced and submitted both to the academic and public hospital authorities to conclude the project.

Engagement in the Project and the Model: Capability-Focused Strategic Management

Hospitals are defined as complex, knowledge-intensive organisations (Pettersen and Nyland 2006; Peng et al. 2007) and due to the recent changes in Turkish regulatory regime, their environment has become highly unpredictable. In our case, the public hospital initially defined its problem as establishing a performance management system, which could assure compliance to the standard JCI metrics issued by the Ministry. However, being locked in accreditation metrics was already questioned in the literature, since the latter usually measured static resources of the hospital (Duckett 1983; Keeler et al. 1992; Lemieux-Charles et al. 2000, 2003; Pettersen and Nyland 2006). Besides, replicating a foreign management practise generally fails to deliver the intended added value unless it is carefully contextualised for the setting, within which it is to be implemented.

Having these concerns, when the quality manager of the public hospital asked us to design an organisational performance system, which could serve as a tool to control and

[1] In Turkey, top management of hospitals are performed by medical doctors and administrative staff other than medical doctors have no upper level decision making authority.

measure JCI metrics, we refused to participate in such a project. We insisted that the big picture, that is, the main causes of the change necessitating such a system, should not be disregarded when attempting for an initiative. Our proposition was a participatory strategic change initiative, which included four phases, consisting of (a) a collaborative problem definition, (b) a participatory solution design, (c) implementation and (d) entrenchment phases. The quality manager of the hospital was impressed by our proposal and began negotiating the details of the project with the hospital top management team. There were some concerns among the top management team about our credibility and consequently some search for alternative service providers took place. Yet, both the quality manager and at least two vice general surgeons—as a part of the top management team—supported our initiative and the general surgeon of the hospital approved the project. General surgeon of the hospital was neither too motivated for, nor personally opposed the project, but at the time, generally took on a laissez-faire attitude towards the project. While we sensed that this could be a problem at the beginning, the quality manager and the other members of the top management team convinced us otherwise. The principal sponsor of the project became the quality manager of the hospital. We asked him to gather a team, which should be composed of diverse therapeutic areas and professions, be motivated to participate in such an initiative and be more of a manageable size—10 to 20 members.

When we—as the research team—went over 100 metrics provided by the Ministry, we found out that most, if not all, of the JCI metrics assessed the resources of a hospital, which were detached from sustaining a competitive advantage. In other words, the metrics provided by the Ministry were no more than a standard checklist to define an organisation as a functioning hospital. For example, one of the metrics was about the presence or absence of a separate entry specifically devoted to the emergency room. While this was answered as a yes/no question in the auditing checklist, in fact it became a matter of ability on the part of the related personnel to keep this gateway unblocked and accessible at all times. It meant very little to an emergency situation if the gateway had been present but not accessible because of a process based dysfunction. Therefore, the JCI metrics in real life served only to question the extent to which the fundamental elements of a hospital was there. Besides, even though these metrics would provide an immediate solution to the hospital's problem—getting an acceptable grade from the Ministry audit-, it would not be sustainable, given that the number and content of the metrics would be enlarged to build more cost-consciousness and competitiveness. In other words, the hospital should learn to abide by the new order, which required a more strategic focus and resource effectiveness. Thus, we referred to the literature of resource-based view (RBV) to lay out a new strategic management model, which could be deployed to provide a sustainable competitive advantage for the public hospital and, concomitantly, be in compliance with the JCI metrics of the Ministry.

As is well-documented in literature, RBV aims to explain under which conditions firms gain a sustained competitive advantage. (Barney 1991; Nelson 1991; Peteraf 1993; Prahald and Hamel 1990; Teece et al. 1997; Winter 2003). RBV assumes that firms can be conceptualised as bundles of resources, which are heterogeneously distributed across firms, and that resource differences persist over time. Upon these differences, firms can build competitive advantages and rent differentials (Amit and Schoemaker 1993; Barney 1997; Peteraf 1993). Recently, RBV literature has tended to differentiate "resources" and "capabilities" in that the former was defined as inert and only through required capabilities they could be put into productive use (Grant 1991). Besides, with the "hypercompetition" (D'Aveni 1994) or Schumpeterian destructive innovations (Schumpeter 1942), it has been suggested that neither resources nor capabilities could sustain competitive advantage for a long time (Armstrong and Shimizu 2007). Only by linking temporal competitive

advantages one after the other can a firm sustain its competitive position and this can be achieved by an intense focus on dynamic capabilities. Thus, the concept of "dynamic capabilities" has been developed, which refers to the ability of management's dynamic renewal and/or reconfiguration of firm resources and capabilities so as to be in congruence with the changing business environment (Teece et al. 1997). Since capabilities are defined as routines or business processes, which are generally path-dependent and idiosyncratic, we involved the project staff of the hospital in sorting out such dynamic capabilities. Moreover, the ability to renew or reconfigure resource sets requires a capability of organisational learning and development, which could only be performed collectively. Besides, the international accreditation metrics of JCI, under its comprehensive assessment criteria, included such headings as "Quality Improvement and Patient Safety", "Governance, Leadership and Direction", "Staff Qualifications and Education" and "Management of Communication and Information". The metrics grouped under these topics were generally more inclined to assess capabilities—some of which can be classified as dynamic—rather than resources. While only few of metrics from these topics were transferred to the accreditation metrics list of the Ministry, we anticipated that the list would be enlarged to accommodate all international metrics in the foreseeable future. Thus, it was inevitable to design a dynamic capability-based model rather than sticking to a short term resource-based focus.

While the concept of dynamic capabilities suited to the general situation of the public hospital, there were two important problems about developing a system on such capabilities. The first problem is their definition and measurement. The second is to design a process based model to ensure that they are sustained over time so that they can maintain their "dynamic" character. In order to measure dynamic capabilities and combining them with the standard JCI metrics, we tried to employ an adjusted version of the "Balanced Scorecard" framework. Originally based on the idea to trace and maximise the value transfer throughout the value chain of the firm, BSC framework incorporates a limited number of metrics, which can be either financial or non-financial (Kaplan and Norton 1992). These metrics are both directly tied to the strategic objectives of the firm and also grouped under four clusters, originally named as "financial", "customer", "internal business processes" and "learning and growth" (Kaplan and Norton 1992, 1993). The four-cluster framework was offered in order to force managers to develop their strategic initiatives and related measures to a more balanced view of the firm rather than a short-sighted insight of output-based performance measurement (Kaplan and Norton 1993, 1996a, b). Also, the clusters are designed to emphasize organisational learning and intellectual capital, which, in turn, can contribute to the development of dynamic capabilities. Their later work tends to take the "learning and growth" as the basic perspective to develop sustainable performance outcomes and link internal perspectives causally prior to the other perspectives—customer and financial—which are primarily geared to external stakeholders (Kaplan and Norton 2000). However, BSC was critically questioned as to how causal integration between each cluster of measures and their links with associated strategies would be sustained in a statistical rigor. Besides, BSC was also accused of being detached from strategy development process and of being too focused on performance measurement.

In order to rectify these shortcomings, we integrated a strategic audit and collective strategy formulation phase to the beginning of the BSC framework and revised the content of the clusters to make more sense in a public hospital framework. This was necessary because our initial talks with the hospital demonstrated that the processes for strategic decision-making were either non-existent or poorly defined. Thus, we incorporated a

conventional strategic audit phase, which contained a thorough external and internal analysis of the public hospital. In the strategic audit of external elements, we provided a comprehensive list of topics for global/international level, national level and industry level factors, which might impinge on the competitive situation of the public hospital. We encouraged the utilisation of PEST methodology (Political/regulatory, Economic, Social/cultural, Technological) for the evaluation of global/international and national level factors. For the industry level, we encouraged the use of Porter's Five Forces Model (Porter 1980). Each factor should be rated collectively about its probability of occurrence and its relative impact on the hospital's performance. Likewise, we proposed the use of Porter's value chain analysis for key processes, especially for the processes that were identified within the BSC framework. Each main and sub-process contained under the four clusters of BSC framework were to be examined according to the relative competitive position in terms of scarcity and alternative availability for resources and ease of imitation and the level of sustainability for capabilities. Again, we urged the determination of the level of importance for each factor and a performance rating for each factor based on the relative competitive position. We then urged them to combine the results of the strategic audit on a traditional SWOT table in order to clarify the problem definition in a more systematic way. From this, alternative solution sets for direction and competitive position could be derived, which should also be in line with the vision of the hospital. Additionally, we changed the label of "customer" cluster to "patient care" and the label of "internal business processes" cluster to "clinical processes" in order to be more aligned with the hospital terminology and make more sense for all stakeholders. As expected, the model includes lots of feedback loops between phases, since the analytical cross checking requires rethinking about the earlier problem definition and alternative search phases. The original depiction of the theoretical model which was developed at the beginning of the project is presented in Fig. 1.

The Implementation: Getting Real with the Setting and the Model

During the development of the theoretical model and while sharing it among both the academic staff and the project coordinator of the public hospital, a communication barrier was observed. Even though, the project coordinator was more or less familiar with the strategic management terminology because of his quality management background, there were some basic misconceptions about the key terms of strategy processes and especially about the BSC framework. Thus, a multi-session strategic management training was designed for the hospital team.

Yet, there were problems among the committee members about the level of acceptance and diffusion as to how this project was perceived and what potential consequences would it lead to. One of the major sources of these problems was the heterogeneity of the committee members, including medical doctors, nurses and administrative staff of the hospital. The committee members perceived the strategic change according to their current status and selectively contributed to the process whenever they observed an individual benefit. Furthermore, because of the laissez-faire attitude of the surgeon general, they perceived that the project received relatively little attention from the top level management of the hospital even though it was endorsed by middle level management and professional hospital staff. Top level management was embedded more in political processes and was little concerned about a real change rather than political acceptance and legitimacy. Although, the top management, especially the surgeon general, made no negative

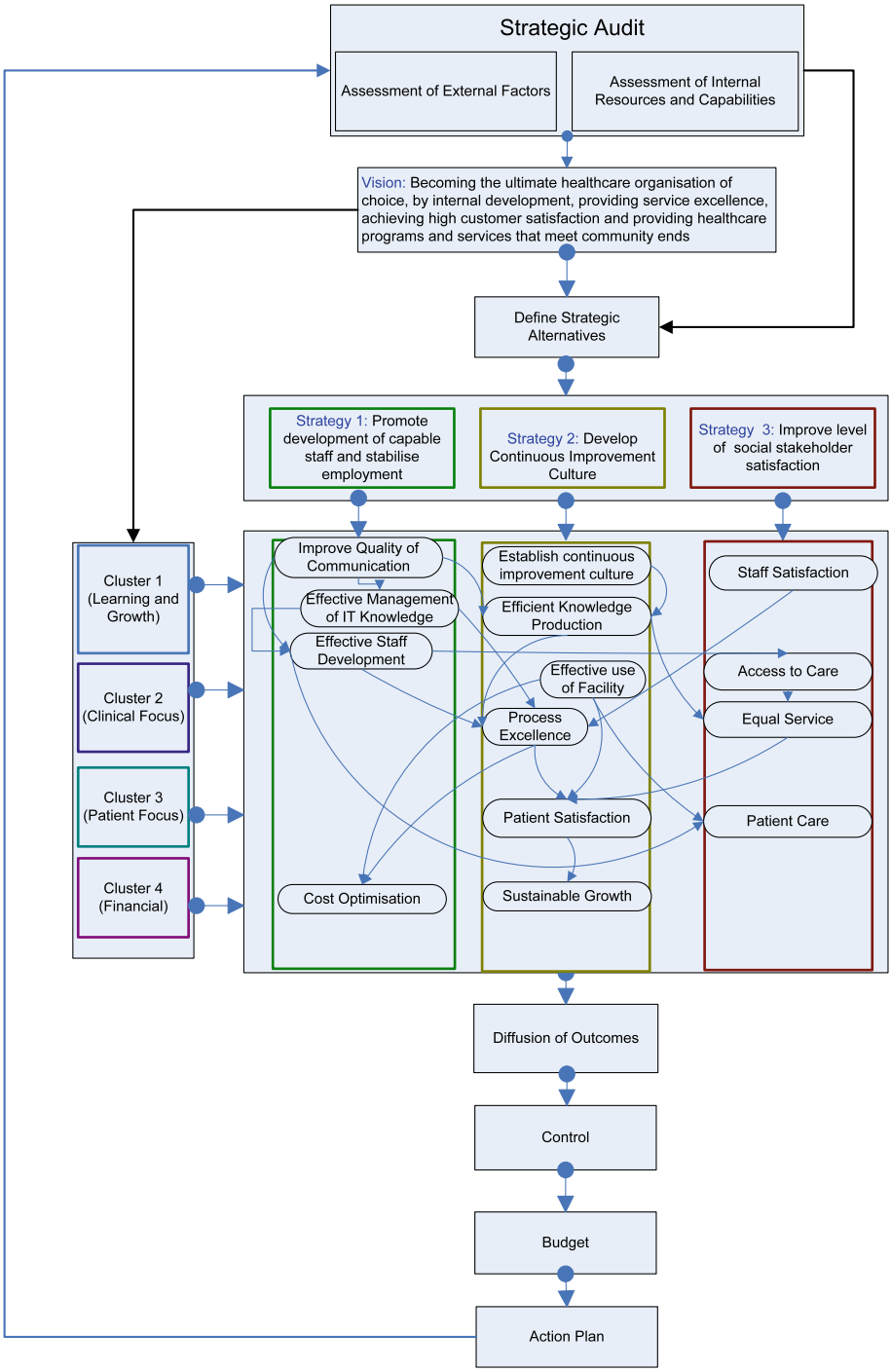

Strategic Audit
Assessment of External Factors
Assessment of Internal Resources and Capabilities
Vision: Becoming the ultimate healthcare organisation of choice, by internal development, providing service excellence, achieving high customer satisfaction and providing healthcare programs and services that meet community ends
Define Strategic Alternatives
Strategy 1: Promote development of capable staff and stabilise employment
Strategy 2: Develop Continuous Improvement Culture
Strategy 3: Improve level of social stakeholder satisfaction
Cluster 1 (Learning and Growth)
Cluster 2 (Clinical Focus)
Cluster 3 (Patient Focus)
Cluster 4 (Financial)
Improve Quality of Communication
Effective Management of IT Knowledge
Effective Staff Development
Establish continuous improvement culture
Efficient Knowledge Production
Effective use of Facility
Process Excellence
Patient Satisfaction
Cost Optimisation
Sustainable Growth
Staff Satisfaction
Access to Care
Equal Service
Patient Care
Diffusion of Outcomes
Control
Budget
Action Plan

Fig. 1 Model

comments about the project or publicly expressed disbelief in the project, his distant stance was sensed and perceived negatively by the committee members. Thus, it was relatively hard to sustain a high level of motivation for and collective contribution to the project from the beginning. It was the extensive efforts on the part of the project coordinator-the quality manager—which made it possible to move the project further and implement the model to some extent.

Under these conditions, as the initial step, a project time-plan was laid out to the project committee and critical phases were emphasized, which included specification of the strategic audit, vision-mission of the hospital, selection and determination of key strategies, deciding on objectives for each strategy and their key performance indicators (KPIs). All of these phases were operationally defined, and before each phase, trainings were given to the members of the committee to ensure productive contribution. Initially, a joint session was held, in which external and internal factors regarding the situation of the hospital were discussed, making sure that the committee understood the factors surrounding their situation in its broadest sense. However, no formal and comprehensive strategic audit was carried out at this stage. The idea was to create an initial comprehension of the situation and setting up a novel vision and mission statement. Although there were written vision and mission statements, these statements represented nothing more than discarded formulations, which just remained in dusty dossiers and did not circulate among stakeholders. Thus, the priority was given to the re-formulation of these key statements in a collective fashion. Three consecutive sessions were designed to formulate vision and mission statements, each of which contained an iterative group decision making process. At the end of these sessions, a convergence upon three alternative statements of vision and two alternative statements of mission emerged. While a session was planned, during which alternative statements of vision and mission would be collectively selected, the surgeon general of the hospital disrupted this process and individually determined both of the statements. This produced a mixed feeling amongst committee members since they both appreciated the top level manager's concern for what they did, but also they became anxious about the extent of their involvement and how potential use of the project's outcomes would be considered.

Turkish culture was categorised as a high-power distant one (Hofstede 1980). As it is a well known concept developed by Hofstede (1991), power distance relates to the extent to which less powerful members of a society expect and accept unequal distribution of power. Thus, the acceptance of undemocratic decisions being forced from the top level authority is not uncommon in Turkey. This fact helped to curb the extent of the worries of the committee staff about such an unexpected involvement of the surgeon general. To be sure, this decision distressed us—as external project team—about the prospective added value and perceived acceptance of the project. Yet, we could not help avoiding the decision and the project coordinator again convinced us to move forward for the betterment of all project stakeholders.

Another set of ongoing participative sessions followed the specification of vision/mission, whereby a comprehensive external and internal assessment of the hospital was made. Although, there were some misspecifications about the appropriate assessment of these factors during the sessions, the overall result was acceptable thanks to the facilitation of graduate students. Once the lists of negative and positive factors in the external environment were located as opportunities and threats, and the lists of comparative assessment of internal resources and capabilities were finalised as strengths and weaknesses, an intense session on strategy formulation commenced. The challenge of strategy formulation phase was keeping the committee members' focus on the vision and making alternative strategy

paths aligned to the vision. While alternative strategic pathways were defined, these statements should also be feasible, given the immediate exigencies provoked by the Ministry audit and within the resource and capability constraints. Three major strategies were offered by the committee and these alternatives were "reworded" by the academic staff in order to be more aligned with the vision and be measurable at the same time. Besides, these strategies were carefully evaluated to be mutually exclusive so as not to instigate causal ambiguity when measuring each one's impact on overall achievement of the hospital. Once the strategy statements were formulated, academic staff and the project coordinator started to work on strategic objectives associated with each strategy. Academic staff involvement increased in this phase since both the objectives should be associated with the strategies and also they should be linked to the BSC clusters. Twenty-one strategic objectives were developed under three main strategies and four BSC clusters. The list of these strategic objectives and their associated BSC clusters are provided in Table 1.

Following the specification of strategic objectives and their respective clusters, a consecutive phase began in order to determine appropriate key performance indicators for each strategic objective. This phase required active collaboration of both academic and the hospital staff because neither of them could develop sound measures on their own. While

Table 1 Objectives and BSC clusters

Objective number	Objective	Cluster
1	Cost optimisation	Financial
2	Sustainable growth	Financial
3	Equal service	Patient focus
4	Patient care	Patient focus
5	Patient satisfaction	Patient focus
6	Environmental awareness	Clinical focus
7	Effective use of IT	Clinical focus
8	Patient safety	Clinical focus
9	Access to care	Clinical focus
10	Equipment effectiveness	Clinical focus
11	Equipment management	Clinical focus
12	Operational excellence	Clinical focus
13	Process excellence	Clinical focus
14	Effective use of facility	Clinical focus
15	Data quality	Clinical focus
16	Efficient knowledge production	Learning and growth
17	Staff satisfaction	Learning and growth
18	Effective staff development	Learning and growth
19	Improve quality of communication	Learning and growth
20	Effective management of IT knowledge	Learning and growth
21	Establish continuous improvement culture	Learning and growth

the academic staff referred to the literature on hospital-based performance criteria to sort out capability-based measures, hospital staff offered novel measures and reviewed the academic staff's offers. At this stage, some of the measures that were developed were accepted even though they represented imperfect proxies for capabilities. Time pressure and lack of motivation played a key role in not perfecting measures. However, it was possible to incorporate such key objectives as, for example, "effective management of IT knowledge" and respective questionnaire-based measures rated by a Likert scale such as "managers in the IT understand the business operation of the hospital" and "managers in hospital recognize the potential of IT as a tool to increase the service quality" (Ray et al.2004). These were radical improvements for the public hospital in that they represented clear interest in and a strong commitment to formulate dynamic capabilities and measure them to create a continuous improvement cycle. Most of the resource-based measures were directly incorporated from the compulsory JCI metrics of the Ministry at this phase. Therefore the overall result was a combination of a large number of key performance indicator metrics, which incorporated both capability focused measures and resource focused JCI metrics. All of these measures were linked to appropriate strategic objectives, BSC clusters and basic strategic pathways. At this stage, the academic staff tried to devise a weighting algorithm, while linking measures to the strategic objectives, and in turn, strategic objectives to the major strategies. Since the model was based on dynamic capabilities and these capabilities generally resided in embedded routines of the organization, we opted for a solution, which involved participation of the hospital staff including top management team. Yet, involvement of the hospital staff, especially top management, into this process could not be achieved. Thus, the weighting process was cancelled and the measures were treated as equal and a linear connection between KPIs, strategic objectives and clusters was assumed. Figure 2 depicts how KPIs, clusters, strategic objectives, strategies and vision were connected over an example pathway.

At the final stage of the implementation, one of the academic coordinators personally involved in the hospital's information system in order to identify the type of data storage and processing. The idea was to design and operate a business intelligence system, which could automatically retrieve the data required for the computation of KPIs, compute KPIs and compare them with the target KPIs both according to the associated strategic objectives and according to the associated BSC clusters. However, a major technical obstacle was the structure of the hospital database in that the hospital database lacked appropriate fields, which made automatic retrieval of some of the required data impossible. A new arrangement had to be made in the database fields, which necessitated cooperation with the IT vendor of the hospital. When the vendor was contacted for this project, the idea was strongly rejected because of the excessive amount of work to be done regarding the database. Indeed, the graduate students and the academic coordinator had developed most of the field work as to which fields were needed, how these fields' data would be collected and with which means the data would be incorporated into the database. However, the attitude of the vendor did not change and even, he threatened to block the whole project if it were to come to change the database system. Since the IT vendor and the top management were politically connected—which we did not know at the time-, it became impossible to forward the last phase of the project, which we thought the most value added would be harvested. It was at this stage that the surgeon general officially declared that the project would not be implemented in the hospital software. He did not call off the project, yet this statement was enough for the hospital project coordinator—the quality manager—to stop his efforts. The final report was written and submitted both to the academic and hospital authorities. Following the submission of reports, academic staff participated in two

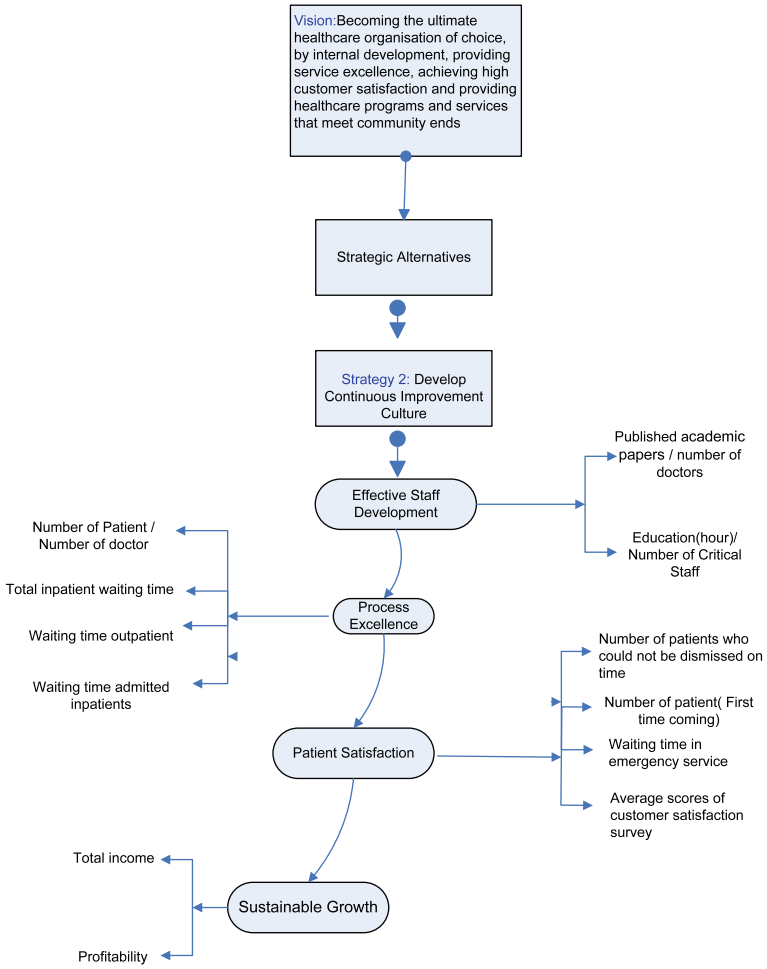


Fig. 2 KPIs, cluster, strategic objectives and vision

conferences where the case study was shared and an industrial training session was organized. Twenty participants of the industrial training session, who were from different hospitals and from divergent backgrounds, rated the project as positive and inspiring based on a post-training assessment form. On the other hand, our personal connections in the hospital stated that the strategic planning system was shut down and the committee was dislodged. Therefore, our project was thwarted at the last step and produced a capability only for the participating members of the hospital committee and was left to reside in a dossier.

Conclusion and Discussion

We believe that this study would serve at least two significant and related end results. First, the model proposed in this study would benefit hospitals of less advanced countries as well

as others, which are in need of conforming to the new demands of their changing environment. Increasing concerns for resource effectiveness and intensifying competitive dynamics urge these hospitals to employ a more strategic focus. Our model offers a viable option to develop a strategic framework, which can effectively function and be sustained under conditions of state/regulatory induced external monitoring. One of the most important features of the model is that it is based on capabilities of hospital organizations rather than resources, which other accreditation systems try to monitor. We believe that making the distinction between resource and capability-based monitoring is important, since the former is inert and does not add strategic value under conditions of increased uncertainty and competitiveness. Besides, the model is flexible in that it can incorporate various accreditation and quality improvement models, since embedding them into strategic objectives and BSC clusters is feasible. Also, KPIs provide significant added value in terms of measuring and monitoring strategic performance of the hospital. The model is open to development especially regarding its efficiency and reliability by embedding it to the information systems of the hospitals.

Second, our action research failed in bringing about the desired outcomes. However, we believe that the process outlined above shed light on at least two important factors related to the failure, one related more to the macro-systemic characteristics of Turkey and the other related to the situation specific characteristics of our hospital case. Under the former condition, which adversely affected our action research processes and outcomes, we identified national cultural characteristics and regulatory/political characteristics of the Turkish Healthcare System as the most prominent factors. For situation-specific factors, however, we distinguished three characteristics, namely the orientation of hospital top management decision making, professional norms prevalent in the hospital and the extent and magnitude of patronage relationships residing in the stakeholder relationships of the hospital. Figure 3 portrays how such characteristics influenced our action research protocol and processes, which in turn, determined the end results as failure or success.

We identified high-power distance orientation prevalent in the Turkish national culture as one of the macro-systemic characteristics, which negatively affected our action research process and outcomes. High power distance Turkish culture negatively influenced the participation component of our action research approach since it disrupted collective strategy making. Also, high power distance culture amplified the effects of some situation-specific characteristics, such as top management decision making orientation and professional norms, which also adversely affected our action research process and outcomes. On the other hand, the political and regulatory framework, onto which the Turkish healthcare systems were erected, produced major obstacles for initiating strategic change. The

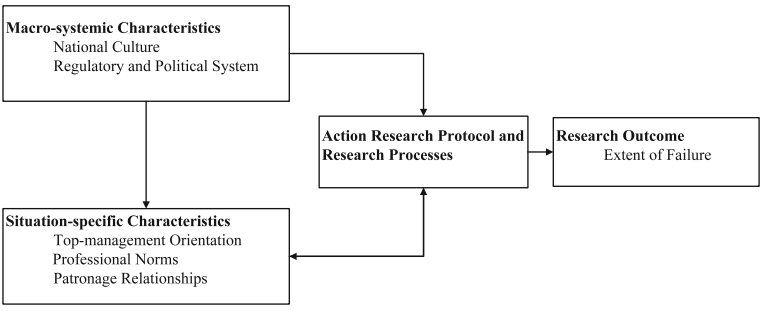


Fig. 3 Factors affecting failure in the Turkish hospital case

regulatory framework for public hospitals was highly inflexible and government's centralised control over public hospitals led to the corruption of bureaucratic logic under pressures of political rent–rent seeking. These macro-systemic characteristics also have a considerable effect on some situation-specific characteristics such as the prevalence of extensive patronage relationships and top-management's political decision making orientation.

The most significant characteristic we identified among situation-specific reasons for failure was the decision making orientation of top management. Of course, top management support has been identified as vital almost in every change process, yet the extent of the support and its disposition requires more attention. In our specific case, characteristics of the Turkish culture such as high power distance between hospital staff caused us to misjudge the level of top management support, since hospital top management generally displayed a laissez-faire attitude to almost every internal conduct. Besides, we have underestimated the politicisation level of the top management in that the top management focused all their attention to sustain and advance their career positions even at the expense of their role requirements. Therefore, we conclude that not just the lack of sincere commitment on the part of the top management but also the ability of researchers' to sense and secure such commitment is critical for engaging in a collaborative action research.

Moreover, hospital environment produced major difficulties about collective action and open communication because of strong professional norms. Medical doctors and other professional domains tended to clash during the project because of the potential dislocation of power positions. Inherently, the medical profession dominated the authority structure of hospitals in many cultures (Aksoy 2007, Fogel 1989), however high power distance amplified the dominance of medical doctors in the decision making structure of the Turkish hospitals. This created extra-tension about the formation and use of multi-disciplinary teams in strategic change. Even though we tried to balance participation and traditional expert dominant approaches in our action research methodology, we observed that unequal distribution of authority and status among professions residing in a hospital environment considerably deteriorated the benefits obtained from collaborative inquiry and decision making. We suggest that performing a T-groups/sensitivity training program for all members of the on-site research team prior to the research process may help to overcome differences between group members and curb the disruptive conflict. Also researchers, undertaking projects in situations where heterogeneity of team members has potency to negatively affect team processes and outcomes, should more effectively utilise conflict management and communication tools during the research process in order to increase the value added to be gained from collaborative action.

Consequently, Turkish public hospitals represent a political arena because of the prevalence of extensive patronage relationships, which pervade majority of Turkish state-controlled institutions. In this case, political ties hampered the implementation of the project because of an external and politically loaded patronage relationship. Therefore not only internal stakeholders and top management support can be enough to initiate and maintain a strategic change initiative but also the support and commitment of key external stakeholders shall be sought. As our case indicated, a supposedly weak tie between an IT vendor and a hospital can hamper a change effort, making it redundant. We believe that these findings significantly add value to the following efforts about designing and implementing a strategic framework in a hospital setting.

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References

Aksoy B (2007) Bir Meslek Örgütünün Kurumsal Değişimdeki Yeri: Türkiye Sağlık Alanı Örneği, PhD thesis, Institute of Social Sciences, Baskent University

Amit R, Schoemaker PJH (1993) Strategic assets and organizational rent. Strateg Manage J 14:33–46

Arias ME, Guillén MF (1998) The transfer of organizational techniques across borders: combining neo-institutional and comparative perspectives. In: Alvarez JL (ed) The diffusion and consumption of business knowledge. Macmillan, London, pp 110–137

Armstrong C, Shimizu K (2007) A review of empirical research on the resource-based view of the firm. J Manage 33:959–986

Aydın B (2008) Ministry of Health http://www.izleme.saglik.gov.tr/aa/ab1.ppt. 17 Accessed April 2009

Barney JB (1991) Firm resources and sustained competitive advantage. J Manage 17:99–120

Barney JB (1997) Gaining and sustaining competitive advantage. Addison-Wesley, Reading, MA

Cohen WM, Leventhal DA (1990) Absorptive capacity: a new perspective on learning and innovation. Adm Sci Q 35:128–152

D'Aveni RA (1994) Hypercompetition: managing the dynamics of strategic maneuvering. Simon & Schuster, New York

Duckett SJ (1983) Changing hospitals: the role of hospital accreditation. Soc Sci Med 20:1573–1579

Erçek M (2009) DMAIC PUKO'ya Karşı: Türkiye'de Yönetim Modalarının Söylemsel Etkileşimi ve Yayılım Dinamikleri Paper presented in 17th National Conference of Management and Organization. Eskisehir: Osmangazi University. 21–23 May

Erçek M, İşeri Say A (2008) Discursive ambiguity, professional networks and peripheral contexts: the translation of total quality management in Turkey, 1991–2002. Int Stud Manage Organ 38(4):78–99

Fogel DS (1989) The uniqueness of a professionally dominated organization. Health Care Manage Rev 14(3):15–24

Grant RM (1991) The resource-based theory of competitive advantage: implications for strategy formulation. Calif Manage Rev 33(2):114–135

Hofstede G (1980) Culture's consequences: international differences in work-related values. Sage, Beverly Hills

Hofstede G (1991) Cultures and organizations. Harper Collins, London

Hood C (1995) The new public management in the 1980's: variation on a theme. Account Organ Soc 20(2/3):93–109

JCI (2006) Using performance improvement tools in health care settings, 3rd edition

Kaplan RS, Norton DP (1992) The balanced scorecard—measures that drive performance. Harvard Bus Rev 70(1):71–79

Kaplan RS, Norton DP (1993) Putting the balanced scorecard to work. Harvard Business Review, September/October

Kaplan RS, Norton DP (1996a) Linking the balanced scorecard to strategy. Calif Manage Rev 39(1):53–79

Kaplan RS, Norton DP (1996b) Translating strategy into action. HBS Press, Boston

Kaplan RS, Norton DP (2000) The strategy focussed organisation. HBS Press, Boston

Keeler EB, Rubenstein SJ, Kahn KL, Draper D, Harrison ER, McGintry ML, Rogers WH, Brook RH (1992) Hospital characteristics and quality of care. J Am Med Assoc 268:1709–1714

Lemieux-Charles L, Gault N, Champagne F, Barnsley J, Trabut I, Sicotte C, Zitner D (2000) Use of mid-level indicators in determining organizational performance. Hosp Q 3(4):48–52

Lemieux-Charles L, Guire W, Champagne F, Barnsley J, Cole D, Sicotte C (2003) The use of multilevel performance indicators in managing performance in health care organizations. Manage Decis 41(8):760–770

Nelson RR (1991) Why do firms differ, and how does it matter? Strateg Manage J 12:61–74

O'Brien R (2001) Um exame da abordagem metodológica da pesquisa ação [An Overview of the Methodological Approach of Action Research]. In Roberto Richardson (ed) Teoria Prática da Pesquisa Ação [Theory and Practice of Action Research]. João Pessoa, Brazil: Universidade Federal da Paraíba. (English version) Available: http://www.web.ca/~robrien/papers/arfinal.html Accessed 20 Jan 2002

Peng TA, Pike S, Roos G (2007) Intellectual capital and performance indicators: Taiwanese healthcare sector. J Intellect Cap 8(3):1469–1930

Peteraf MA (1993) The cornerstones of competitive advantage: a resource-based view. Strateg Manage J 14:179–191

Pettersen IJ, Nyland K (2006) Management and control of public hospitals–the use of performance measures in Norwegian hospitals. A case-study. Int J Health Plann Manage 21:133–149

Pomey MP, Contandriopoulos AP, Francois P, Bertrand D (2004) Accreditation: a tool for organizational change in hospitals. J Health Care Qual Assur 17:113–124

Porter ME (1980) Competitive strategy. Free Press, New York
Prahald CK, Hamel G (1990) The core competence of corporation. Harv Bus Rev 68(3):79–91
Ray G, Barney J, Muhanna M (2004) Capabilities, business processes, and competitive advantage: choosing the dependent variable in empirical tests of the resource-based view. Strateg Manage J 25:23–37
Rogers EM (1964) Diffusion of innovations. Free Press, Glencoe
Schumpeter JA (1942) Capitalism, socialism, and democracy. Harper, New York
Swinehart K, Zimmerer TW, Oswald S (1995) Adapting a strategic management model to hospital operating strategies. A model development and justification. J Manag Med 9(2):34–47
Teece DJ, Pisano G, Shuen A (1997) Dynamic capabilities and strategic management. Strateg Manage J 18:509–533
The Joint Commission (2009) Our History, http://www.jointcommission.org/AboutUs/ joint_commission_history.htm. Accessed 15 May 2009
Touati N, Pomey MP (2008) Accreditation at crossroads: are we on the right direction? Health Policy (in press)
Üsdiken B (1996) Importing theories of management and organization. Int Stud Manage Organ 26(3):33–47
Wadsworth Y (1998) What is participatory action research? Action Research International, Paper 2. Available on-line: http://www.scu.edu.au/schools/gcm/ar/ari/p-ywadsworth98.html
Winter R (1987) Action-research and the nature of social inquiry: professional innovation and educational work. Gower Publishing Company, Aldershot
Winter R (1989) Learning from experience: principles and practice in action-research. The Falmer Press, Philadelphia
Winter SG (2003) Understanding dynamic capabilities. Strateg Manage J 24:991–995
World Bank (2004) Report No:277 17–TU, http://www.wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2004/05/03/000090341_20040503130553/Rendered/PDF/27717.pdf Accessed 15 May 2009

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