



*Participation in the budgeting process
by medical specialists;
cure or care?*

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MASTER THESIS

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ISALA KLINIEKEN
ZWOLLE

Due to the sensitive nature of the material contained within this report, all names are made anonymous.

TITLE PAGE

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PREFACE

"Everything should be made as simple as possible, but not simpler."

(Albert Einstein)

'When you go to the university, you must be smart', this cause – effect relationship is something I would like to question. Because, what determines you to be smart? In my opinion you are smart if you can explain difficult things in an easy way so everyone understands, the barber, the paperboy or a lawyer.

During my work at Isala Klinieken, I sometimes questioned myself; do the receivers of this document understand what the message is? Usually, I found convincing arguments and I would send it to recipients. My research, and especially the interviews opened my eyes about how difficult and complex some of the recipients found documents received from for example Concern Control. Then you start to question, what went wrong?

Being able to explain difficult things does not have to do with knowledge or perceptions about the topic by the messenger, but by the receiver. If you understand what the receiver needs, determines not only how you should present your message but also what items to consider for explaining the message. Even though writing your master thesis is seen as the final step, to me this is the final lesson learnt before achieving my master's degree in business administration. I will take this lesson to the future, just as Isala takes this document as a lesson for the future.

Finalizing my thesis also determines the end of my time at Isala. Therefore I would like to thank Mark Klein Koerkamp for his input and support during this research. Besides, I obviously would like to thank all participants for making time for the interviews as well as reviewing transcriptions.

Finally, I would like to thank Roy for giving me all the time needed to complete my thesis.

Suzan Valster

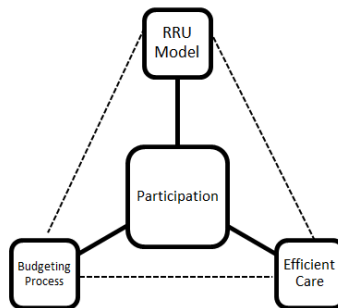
MANAGEMENT SUMMARY

(A Dutch summary can be found in Appendix I)

The aim of this research is to provide Isala Klinieken with knowledge about participation of medical specialists in the budgeting process in order to gain input for efficient care. This aim derives from upcoming changes in health care with regard to the income of medical specialists. It is expected that medical specialists can give input for efficient care, this input is important for the budgeting process as the budget has the same time span as the results of negotiations with insurance companies. Therefore the next main research question is formulated:

How can medical specialists participate via the RRU model in the budgeting process in order to have input for efficient care?

In this study three items are recognised as the context of participation: budgeting process, efficient care and the RRU model (*RRU: results responsible units*).



In order to answer the main research question, three sections with sub questions are designed. The first section contains collection of theoretical information, for which a literature research is done. The second section contains data collection through interviews and the third section contains a comparison and discussion. Outcomes from three sections resulted in an advice.

Budgeting systems are an element of financial results control and a budget is a short term financial plan. Participation is a process in which a group or individual are involved with, and have influence on, in this case the determination of their budget and targets. There are three mechanisms that illustrate participation: cognitive, motivational and social. In the table below, positive effects, negative effects and solutions of these mechanisms are summarized.

	Cognitive	Motivational	Social
Positive	Increased information sharing and communication. Reducing uncertainties. Increased organizational control.	Increased productivity.	Commitment to plans.
Negative	Information asymmetry. Lack of knowledge.	Lack of goal setting. Programmable budgets.	Dependence upon authoritarians.
Solution	Know risk preferences (reduce uncertainty/ give guarantees). Provide pre - decision information.	Target setting by higher authoritarians. Conscious goal setting.	Competence based trust/ discuss about the content.

Four units are recognized as the core of the organization: top management, RRU Chairman, RRU managers and supportive management. These four units are used for data collection. From all of these units perceptions and opinions about four items: participation, budgeting process, efficient care and the RRU model were asked.

Compared to theory, many of the cognitive items are mentioned by participants. Hardly any of the positive effects of the motivational and social mechanisms are mentioned. The negative effect of motivation was mentioned as well as the solution for the social mechanisms. Besides, specific attention was paid to 'opposing or conflicting interests'. This was mentioned quite often in interviews, but not specifically in theory about participation. A solution to overcome this negative effect is to organize common goods or implement accounting measurements (e.g. ROI).

The budgeting process is adapted based upon results from interviews. In total eight adaptations were done, in essence, an earlier attending from medical specialists is put in place as well as more responsibility of RRU chairman for splitting up targets.

Collaboration is seen as a way to create efficient care, a distinction is made for four opportunities for collaboration. The first is collaboration with general practitioners, the second collaboration with other hospitals, thirdly, collaboration between RRU's and finally collaboration with the patient (e.g. e – health).

The last item discussed was the RRU model. A lot of items were mentioned that illustrated boundary conditions for the RRU model (e.g. competences, roles, etc.). The role of the DT with regard to the RRU gained specific attention. Development of boundary conditions and maintaining boundary conditions is seen as a key role for them.

The three sections combined, resulted in an answer to the main research question through an advice for each of the following four items:

Participation: more directive attention towards positive effects of participation and overcoming negative effects of participation and a determination of pre – decision information.

Budgeting Process: an earlier attending in the budgeting process by medical specialists and clear determination of roles in the budgeting process.

Efficient Care: further developing and determination of collaboration opportunities, use input from medical specialists for collaboration plans.

RRU Model: the organization puts effort in developing and maintaining sharper formulated boundary conditions with specific attention for the role of the DT towards the organization.

As presented in the figure on the previous page, these four items hold a relationship. Therefore, success is only established if all four advices are considered.

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1 INTRODUCTION

This thesis comprehends a research conducted at Isala Klinieken in Zwolle. This chapter contains an introduction to Isala, the aim of the research and the topics covered in this thesis.

1.1 INTRODUCTION TO ISALA

Isala is the largest top clinical hospital in the Netherlands. Top clinical hospitals provide basic care and besides, they provide care earmarked as 'academic'. This means that the hospital is in the position to educate and do research in certain fields of expertise. From 33 specialisms within Isala, 18 are earmarked as academic. Isala is a hospital that is actively looking forward. The fields of interest are innovation, research & education and collaboration with other hospitals (website Isala 2012).

Facts and figures...

In total there are about 5500 employees and 300 medical specialists working for Isala. With a turnover of 450 million per year and over 225.000 nursing days per year Isala is a key player in the region between academic hospitals in Nijmegen, Groningen and Utrecht (website Isala 2012).

New hospital

Currently Isala has two locations, one in the city centre of Zwolle and one in the periphery of Zwolle. Besides working more efficient in one location, the location in the city centre also deals with parking problems. Therefore in 2009 is started with the building of a new hospital. Newest technologies and innovative systems are implemented in order to be a top clinical hospital that can fulfil future requirements.

1.2 RESEARCH AIM

The aim of this research is to provide Isala Klinieken with knowledge about participation of medical specialists in the budgeting process in order to gain input for efficient care.

This aim derives from upcoming changes in health care with regard to the income of medical specialists, also known as honorarium. From 2015 onwards the honorarium will be negotiable between the hospital and medical specialist. As honorarium becomes a flexible, negotiable component, Isala is keen on rewarding specialist for efficient care which means the best price and quality mix possible.

Isala sees the relationship with the budgeting process since negotiations with insurance companies currently have the time horizon of one year and are usually related to outcomes of the budgeting process. The question arises if specialists are in the position to participate in the budgeting process and if so, to what extent.

The research aim results in a main research question:

How can medical specialists participate in the budgeting process via the RRU model in order to have input for efficient care?

Through a literature study and conducting in depth interviews, data is collected in order to find an answer to the main research question.

1.3 STRUCTURE FOR THIS THESIS

In the next chapter background information about the problem is given. The third chapter contains information on what is to be investigated and the fourth chapter contains the methods of conducting research. The fifth chapter contains information from theory about the topic. The sixth chapter contains results from data, which is further discussed in chapter seven. The eight and last chapter contains the advice.

2 BACKGROUND INFORMATION ABOUT THE PROBLEM

In this chapter background information about the problem is given. First, information about changes in health care are described, thereafter background information about Isala Klinieken is given followed by background information about the budgeting process within Isala.

2.1 TRANSFORMING HEALTH CARE

Roughly twenty years ago Commissie Biesheuvel presented a report¹ that stated hospitals should be more efficient organisations with good cost control. It took up to 2005 before first changes were implemented nationwide. From then onwards health care in the Netherlands has been changed (and is still changing) from a 'fee for service' system towards a market oriented and performance related health care system. The decision for a market oriented health care system emerged from an analysis of Dutch demography up to 2040. Ageing of population, increase of chronically ill people and decline in labour force alter demand for care. The impact of these demographic changes, influence quality and affordability of care². The Dutch government came with a plan³ for efficient care. According to this plan, it is expected that market force will make care more efficient. The essence of this plan is to have incentives that stimulate efficient care and cost control. As a consequence, income of the hospital and medical specialists had to change through adapting the financing system.

On page 15 a table is presented (Figure A: Income Changes 2005 - 2015) with changes in income over time. Before 2005 income of hospitals consisted of a budget which was build up from three components. Hospitals had an availability function for the region, so the fixed component was based upon number of e.g. inhabitants. The semi - fixed component, was determined upon some specific type of care that was provided. The variable component was determined upon parameters e.g. nursing days or first visits multiplied by a tariff. The income for medical specialists in employment was part of the budget. The honorarium for medical specialists were based upon a lump sum system which was different per specialism.

In 2005 a start was made towards a more market oriented health care system with the implementation of a new declaration system. Therefore a new method of registration was required. By registering Diagnose-Behandel-Cominaties, in English, Diagnose - Treatment - Combinations (for the remainder DTC), costs of execution are expected to be better traceable and awareness of costs should increase. Market force was initiated by making tariffs for a part of DTC's negotiable (B - segment) between the hospital and insurance companies. No major changes occurred for the honorarium for medical specialists not in employment.

In 2008 the lump sum system for medical specialists not in employment was abandoned and replaced by a tariff per hour, multiplied by a standard time per DTC. The tariff had a bandwidth of € 6,00 (price level 2008). Within this bandwidth it was possible to reward for specific achievements. From 2005 until 2011 market force is augmented by increasing the share of B - segment DTC's up to 40% in 2011.

In 2012 two major changes occurred. First the DTC system was replaced by DOT (short for: DTC's on their way to transparency) and the honorarium was maximized by a honorarium

1 Commissie modernisering curatieve zorg (Commissie-Biesheuvel), Gedeelde zorg: betere zorg, januari 1994

2 Source website: <http://www.rijksoverheid.nl/onderwerpen/prestaties-belonen-in-ziekenhuizen/prestatiebekostiging>

3 Tweede Kamer, vergaderjaar 2003-2004, 23 619, nr. 21

ceiling. The implementation of DOT, or health care products, was initiated because there had to be more transparency and simplicity in the declaration system. There are three segments; the free segment with negotiable prices, this can be compared to the former B - segment, a regulated segment; negotiable prices but with a maximum tariff and a fixed segment with fixed prices. The share of freely negotiable prices is increased towards roughly 70% of all health care products.

The income of medical specialists not in employment is changed to a macro budget, or honorarium ceiling. This change comprehends the determination of a nationwide budget (€ 2.030 million for 2012) that is split based upon historically achieved turn over. This results in honorarium per institute (hospital). Per institute a tariff per fte is determined and above a variable component is introduced. The variable component consists of critical performance indicators. Those whom perform good or excellent will earn more than those with lower performances. Per institute a collective is implemented, this collective is a representation of medical specialists whom coordinate the distribution of honorarium.

In 2015 integral tariffs will be introduced. This means that there is one tariff per health care product. With this tariff, cost for the hospital and honorarium should be covered. The essence of this system is that the hospital negotiates with its medical specialists about cost and quality of care in relation to their income; honorarium.

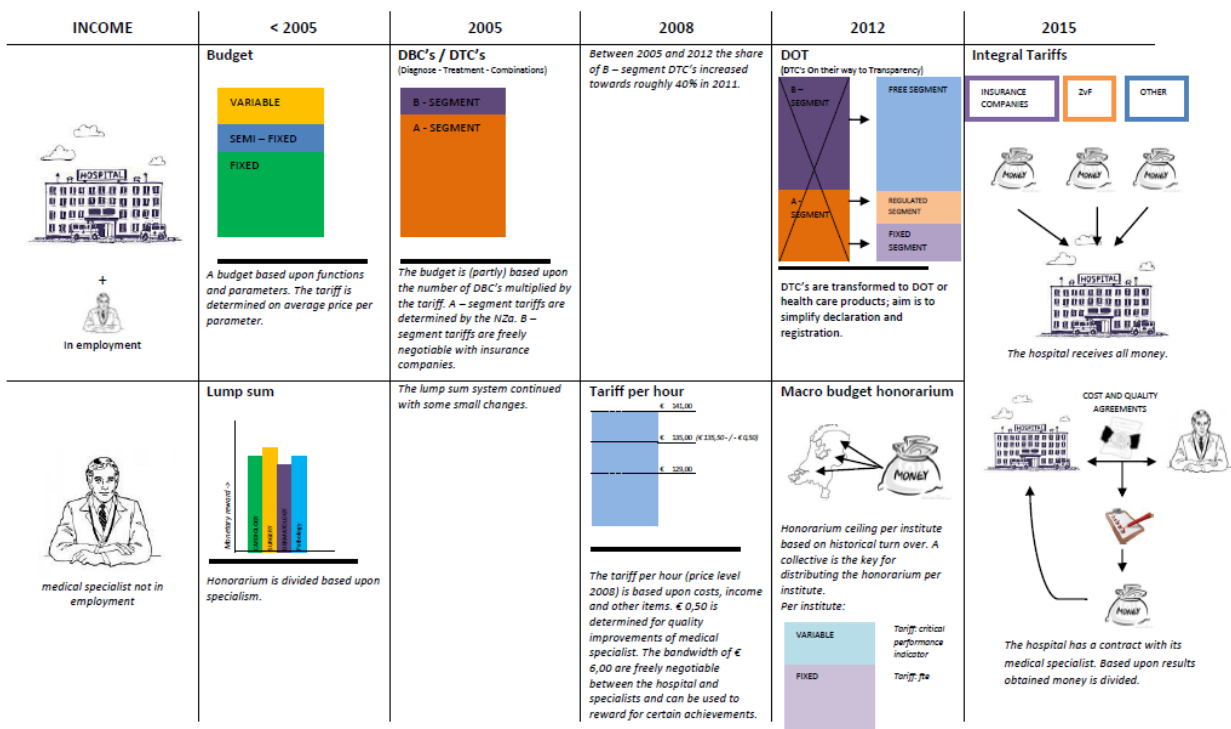


Figure A: Income Changes 2005 - 2015

2.2 ISALA KLINIEKEN

In this chapter background information is given about Isala Klinieken. First, the change program to adapt to the changing environment is described. Second, budgeting process is described. Hereafter, the evaluation of the change program and future developments are described.

2.2.1 CHANGE PROGRAM

Due to the implementation of DTC's the which emerged to adapt the organization to the changing financing system. The idea was to give medical specialist more responsibility for cost of care and organizing efficient care. Therefore Isala is gone through major organizational changes. The organizational change program implemented is called: '*Dokter aan het roer*' in English 'Doctor in charge' (Isala Klinieken 2009).

2.2.1.1 Implementation of the change program

In order to develop a management system that is better related to health care changes, results responsible units (RRU) were implemented. Each RRU represents a specialism. Decisions about revenue, quality, organization of care and responses to market developments is for responsibility of the RRU.

Dual management is chosen as an organizational form. Dual management consists of one person for medical input and one person for managerial input. This is implemented by making one medical specialist chairman of the RRU (medical input) and a RRU manager is appointed for managerial input. Both have the co - responsibility for results obtained by the RRU. To enhance this divisionalized management system, a profit and loss account per RRU is established and share of profits is implemented. This share is currently not to be used as honorarium, but for (innovative) investments.

2.2.1.2 Redesign top structure

The implementation of the change program was analysed and it became apparent that a better tuning between the RRU, top structure and management had to be established (Herinrichting top structuur Isala 2011). A threefold aim was presented; first, the position from the RRU manager had to be strengthened, second, support in terms of the RRU manager had to be established so the RRU chairman is able to act upon his responsibilities. And finally, the force to control the organization had to be strengthened.

On the next page the organization chart is presented (Figure B: Organization Chart Isala Klinieken). As can be seen, the Direction Team (DT) consists of members of the board of directors (two) and three directors of operations (DO).

Supportive management is centralized and, as mentioned, each RRU represents a specialism. Each RRU has a RRU chairman and a RRU manager. The manager can have more than one specialism, dependent upon the size of the specialism.

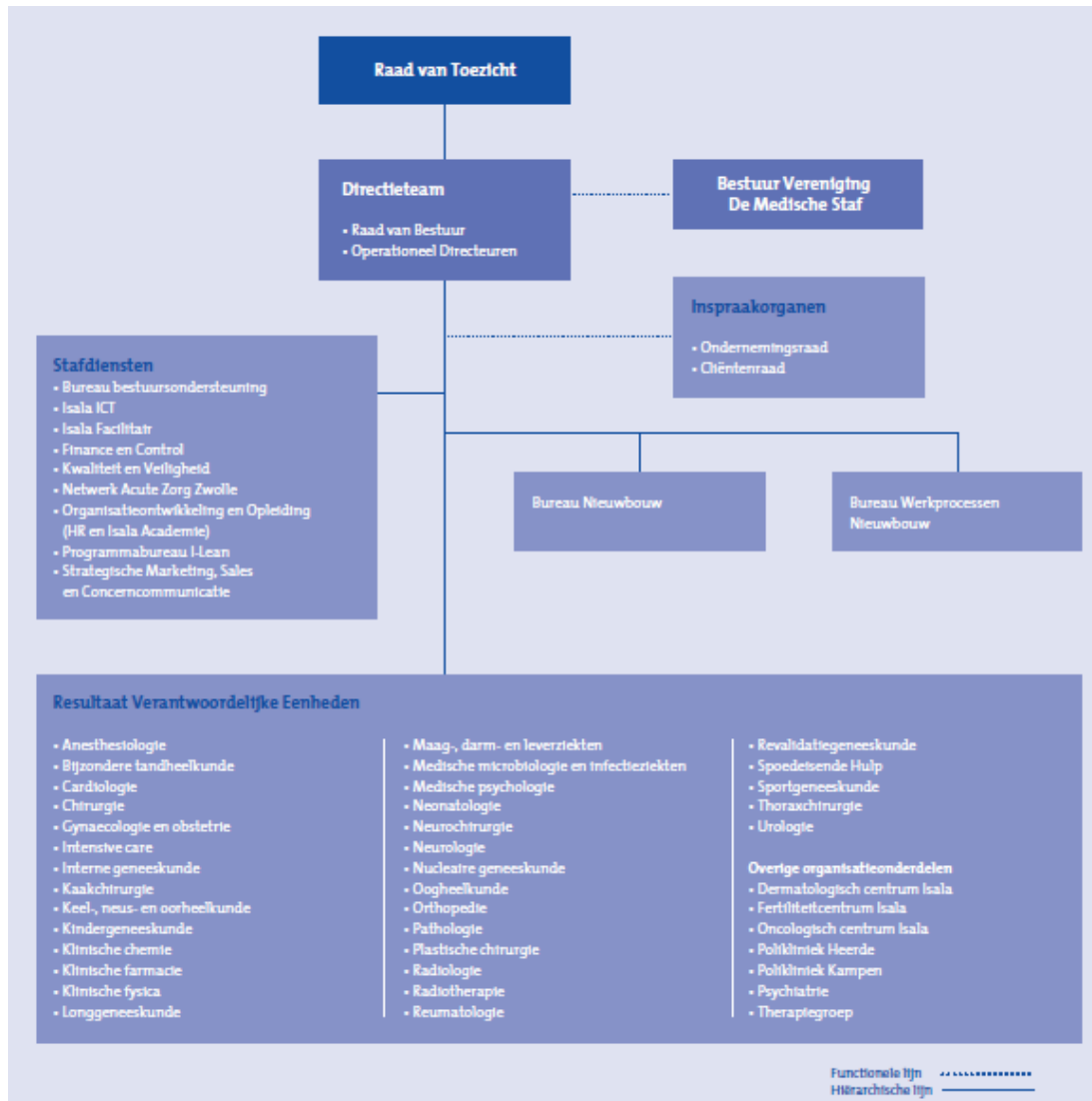


Figure B: Organizational Chart Isala Klinieken (source: Isala.nl)

2.2.1.3 Planning and control cycle

The implementation of the RRU structure required a new planning and control cycle because the responsibilities about budget items were changed. These changes (RRU structure) had to be reflected in the planning and control cycle. In appendix II the 'Planning and control & cyclus Isala 2012' is illustrated.

Monitoring takes place through interviews about results and analysing critical performance indicators. The interviews take place at different moments throughout the year and in different settings which is illustrated in appendix II: Planning and Control Cyclus Isala 2012.

The budgeting process is part of the planning and control cycle which is extensively discussed in the next paragraph.

2.2.2 BUDGETING PROCESS

The planning and control cycle is strongly related to the budgeting process. Therefore the budgeting process within Isala is further elaborated on. First the initial, bottom up budgeting process is described, second, the budgeting process 2013 is described.

2.2.2.1 Bottom up budgeting process

The table below illustrates the budgeting process within Isala. The explanation accompanied with this process is given in this paragraph.

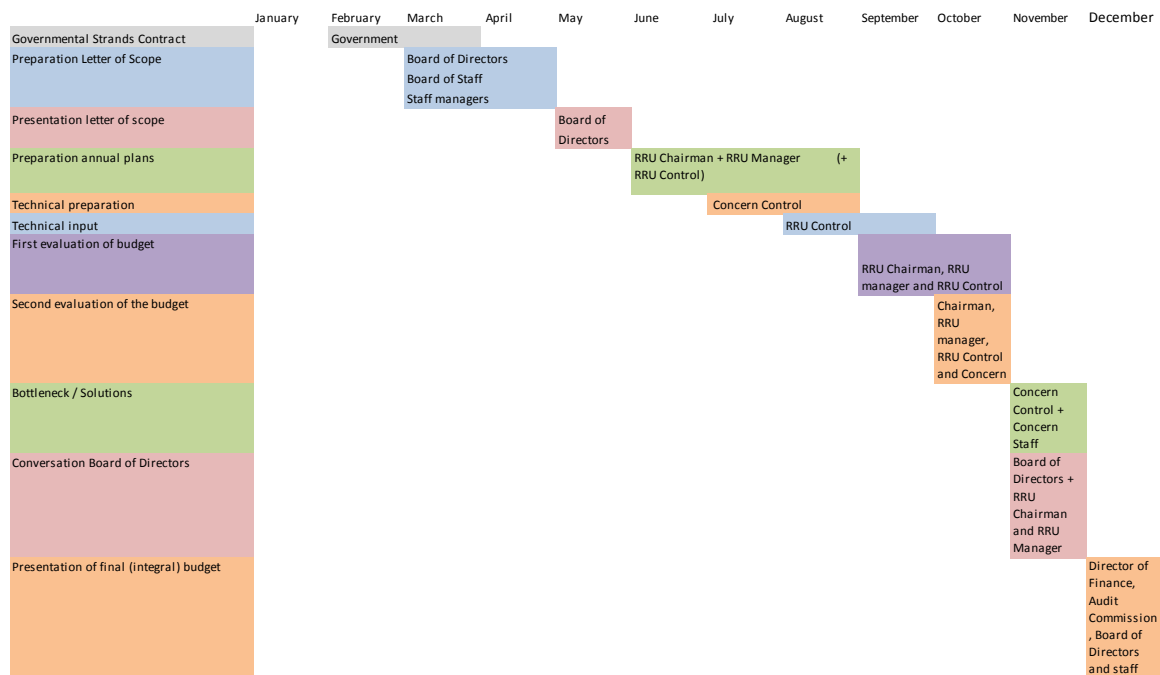


Figure C: Budgeting Process

The budgeting process has its formal starting point in May. In May the board of directors present plans for the upcoming year through a letter that determines the scope for plans for the coming year. This is the starting point for the budgeting process per RRU and this letter highlights areas of attention e.g. quality indicators or revenues.

Before these plans are presented, the board of staff (which consists of six RRU chairman to represent medical specialists) and the board of directors together with staff managers determine strategic plans within the scope of the governmental strands contract. This contract is to guide growth of care nationwide in order to fulfil the requirements of efficient care.

After the presentation of the plans for the coming year, RRU chairman together with RRU manager and, if necessary the RRU Controller, make a plan for the coming year. The plan is commonly known as the 'year plan'. If there are business plans or other organisation wide plans, they will be updated by Concern Control. In the meantime, technical preparations are done by Concern Control.

When plans are updated, the budget is technically build up by input in numbers of DTC's, personnel, materials required etc.. This bottom up budget is first analysed by Concern Control. They will analyse whether or not all plans fit within the plans of the organization presented in May.

In September, reduction plans are introduced and there will be a first evaluation of the budget. In this setting the RRU Chairman, RRU manager and RRU Controller analyse the budget and a first attempt to reduce slack in the budgets per RRU is done.

In October there is a second evaluation with the RRU Chairman, RRU manager and RRU control, but this time Concern Control is also attending. The aim of this setting is to reduce slack from the budget, 'sharpen' targets and eventually come to an integral budget.

If there is still a bottleneck situation after the two evaluation rounds, concern staff (Marketing, Sales and Finance) discusses solutions for these bottlenecks. If these solutions are approved by the board of directors, they are processed in the budgets of the RRU.

The semi – final step in the budgeting process is the conversation of the RRU Chairman and RRU Manager with the board of directors. This is a moment to formally approve the budget for the coming year.

Finally, the budgeting process is completed by informing staff, board of directors and the audit commission about the integral budgets and RRU budgets.

2.2.2.2 Budgeting process 2013

In contradiction to the process described above, the budgeting process for 2013 was different. Starting point for the budgeting process was the statement: Budget 2012 = Budget 2013.

The first step in this budgeting process was to determine where there were major defects that had to be fixed. For this step, re-adjust the budget, the RRU Chairman, RRU Manager together with RRU Control could hand in a list with items they want to adjust.

After this step, changes in production could be handed in. This means that the budget 2012 is adapted towards new expectations about production. Different than the first step is the fact that the actual budget is correct, but that there is a change in the number of patients or type of care.

Hereafter, the cost reduction plans were introduced. Each of the Directors of Operations, were given the responsibility to make and implement a plan for cost reduction. These plans are roughly divided into three categories; 'surgery', 'diagnostics' and 'nursing' and splitting up the targets per RRU was mostly done by (RRU and/ or Concern) Control. Besides these three plans, a plan for the staff and a plan for purchase was developed.

An additional, unique step, was the approval of one-time only budgets with regard to costs that will be made with regard to the new hospital e.g. investments, extra personnel costs or costs for moving.

The budgeting process was formally finished at one day were, just as in the former budgeting process, the RRU Chairman and RRU manager gave their approval in presence of the Board of Directors and Director of Operations.

2.2.2.3 Participation and the budgeting process

Participation in the budgeting process is seen as a necessary requirement for getting input about efficient care as this generates a structural implementation of these plans. The current structure already has a form of participation with a RRU Chairman and a RRU Manager. From this point of view it becomes interesting to know what the opinion is about a participative approach with regard to current experiences. It is recognized that the RRU model and efficient care as well as the budgeting process have to be seen in context of participation. The figure on the next page represents participation and its context.

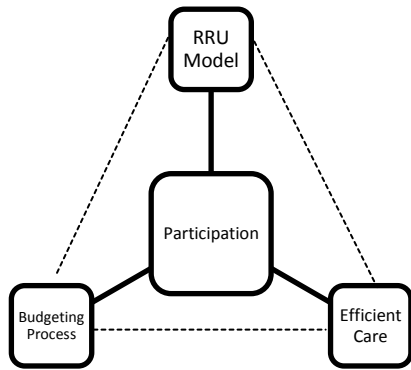


Figure D: The context of participation

2.2.3 EVALUATION OF THE CHANGE PROGRAM

The change program is evaluated internally and by an external company⁴. Implementation of the RRU model has had many positive effects, especially in financial terms. It has been proven to be a tool to put financial consequences on the agenda of medical specialist. However, there is confusion about the managerial role from the medical specialist and the future position from specialists. Besides recommendations for meetings and the role of the RRU chairman, recommendations are made for competences and managerial tasks for either the management or RRU Chairman.

From orientating interviews before the start of this research, it became apparent that the wish emerged from management to know whether or not medical specialists want to participate and if so, to what extent. This emerged from the 'feeling' that effort from medical specialists is declining on the one hand. But on the other hand the importance is seen of gathering information from efficient care through participation with medical specialists.

2.2.4 ISALA AND FUTURE DEVELOPMENTS

Isala sees the changing context of care as an opportunity to create a stronger financial connection between the hospital and medical specialists. Participation is seen as a way to create this stronger connection. Therefore participation is the central theme.

To what extent care can be efficient, should be generated from input from medical specialists as they are in charge of providing care. The relation with the budgeting process is sought since there must be agreements to test the actual performance of medical specialists and there must also be a connection with the contracts agreed upon with insurance companies. Input is considered as quality and quantity (financial) items with regard to their own specialism.

⁴Twynstra Gudde 'Resultaten discussie 20 april 2012'

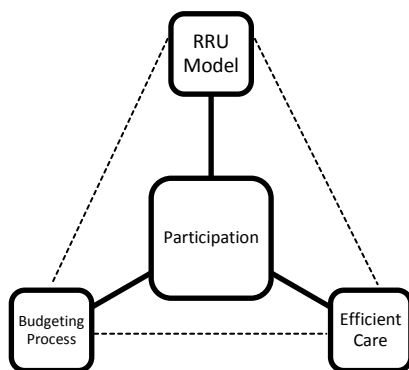
2.3 CONCLUSION

Health care is changing towards a system that increases awareness and control of costs. Changes appeared in the funding system for either the organization and the medical specialists. Until 2015 there are separate streams of funding, but from 2015 this will be one stream through integral tariffs.

Isala responded to first changes by implementing results responsible units (RRU's). Additionally the top structure (management) was changed in order to better serve the RRU's. One medical specialist per RRU is the Chairman and together with the RRU manager they are the board of the RRU. Top management consists of two members of the board of staff and three directors of operations, supportive management is organized central.

Isala wants to respond to the upcoming changes in 2015 by having medical specialists participate more intensively, especially in the budgeting process. It is expected that medical specialists can give input for efficient care, this input is important for the short term horizon as this is related to the (current) time span of negotiations with insurance companies.

In order to illustrate the connection between participation, the budgeting process, efficient care and the RRU model the figure below is designed.



It becomes important to know whether or not the current budgeting system fits the requirements of a participative approach and besides, to what extent the context of participation influences the level of participation.

3 RESEARCH

In this chapter the research objective, research question and relevance of this study are described.

3.1 RESEARCH OBJECTIVE

In the previous chapter an introduction and background information are given about the topic of this thesis: participation by medical specialists in the budgeting process. This topic emerged from the wish of Isala to know if medical specialists can participate in the budgeting process in order to give input for efficient care. Therefore the objective of this research can be stated as follows:

“The objective of this research is to advice Isala by studying a participative approach in the budgeting process in order to know if medical specialists can participate and give input for efficient care.”

This research objective is aimed at participation, however, contextual factors for participation (the RRU model, the budgeting process self and efficient care) are seen as important factors that might determine outcomes of this research as well.

3.2 RESEARCH QUESTION

In the previous paragraph the research objective is stated and therefore the main research question can be formulated:

How can medical specialists participate in the budgeting process via the RRU model in order to have input for efficient care?

With medical specialists is meant those whom are registered medical professionals. The budgeting process is considered as the budgeting process within Isala. The RRU model refers to the current structure within Isala. With input is meant quality and quantity items that both together determine ‘efficiency’. Finally, with efficiency is meant the best price and quality mix possible for the required care per patient.

3.3 SUB QUESTIONS

In order to find an answer to the main research question, sub questions are formulated. The sub questions are divided into three sections to structure the process for retrieving an answer to the main research question.

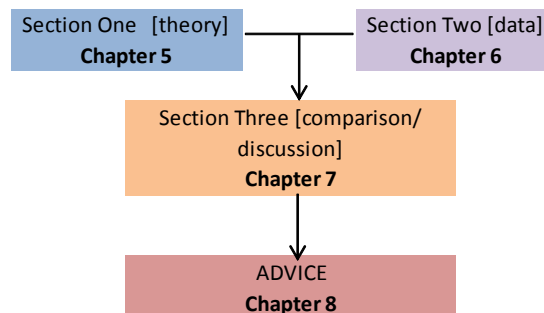


Figure E – Sections in the research process

The first section contains the collection of theoretical knowledge about the budgeting process and a participative approach. Results are presented in chapter five and sub questions related to this section are:

- 1.1 What is the budgeting process?
- 1.2 What are positive effects of participation?
- 1.3 What are negative effects of participation?
- 1.4 Are there solutions or mechanisms to overcome negative effects of participation?

The second sections contains the collection of data. From the different units⁵ data is collected and therefore first differences per unit are described.

- 2.1 How does top management see participation by medical specialists?
- 2.2 How do medical specialists see participation?
- 2.3 How does RRU management see participation by medical specialists?
- 2.4 How does supportive management see participation by medical specialists?

In the third section results from the different units are combined and a comparison with theory is made. Sub questions related to the third section are:

- 3.1 What is the relation between the RRU model and participation?
- 3.2 What is the relation between the RRU Model and efficient care?
- 3.3 What is the relation between efficient care and participation?
- 3.4 What is the relation between efficient care and the budgeting process?
- 3.5 What is the relation between participation and the budgeting process?
- 3.6 What is the relation between the budgeting process and the RRU Model?

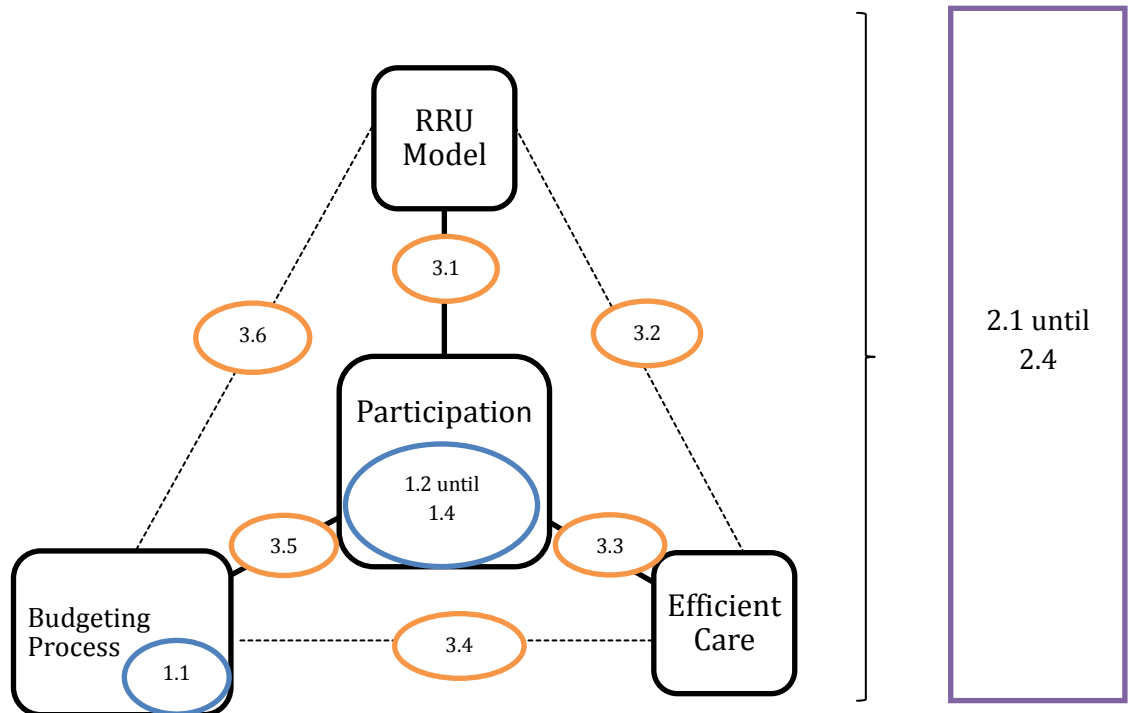


Figure F: Schematic overview research questions

⁵ The units are described in chapter 2.2.1.2 Phase I: Redesign top structure

Finally, the advice can be made. This advice can be found in chapter eight, in this chapter an answer to the main research question is formulated.

3.4 RELEVANCE

This research has a practical implication since it guides Isala in deciding how to strengthen a participative approach through finding factors that determine the success of a budgeting process. Knowledge gained can, in certain situations, be generalized for other entities but the main purpose is to provide Isala with in-depth knowledge about items that result in a successful budgeting process.

4 METHODOLOGY

The methodology to generate answers is described according to three steps that comprehend academic research: research approach, research design and data collection. In the last paragraph the research process is described.

4.1 RESEARCH APPROACH

In general there are three different three different types of approaches to deal with research problems (Baarda en De Goede, 2006): descriptive research, explorative research and hypothesis testing. For this research a descriptive and explorative approach are suited. Descriptive research in general terms, is counting, sorting and describing data and trying to give an answer to frequency questions. Explorative research is used when questions have the character of an analysis of difference or association. The collected knowledge helps to analyse the problem from a number of viewpoints. Hypothesis testing is not suited since there is no proposition to be set. Hypothesis testing requires a predefined proposition.

4.2 RESEARCH DESIGN

The choice of research design depends on the situation, the subjects and the nature of the question. However, “the first contrast separates qualitative from quantitative design” (Dooley, 2009 p. 263 - 264). For this thesis a qualitative design is suited, since the essence is to find values, characteristics and experiences rather than quantities.

There are many articles about – types of – qualitative research design. A selection is made for the meta- analysis of Creswell (2007). In this article the focus is at the processes of selecting, contrasting, and implementing five different qualitative approaches. The table provided in the article⁶ guides towards a case study. A disadvantage of a case study is generalizability. This disadvantage outweighs the advantage of in-depth knowledge for this single case and the fact that case studies can be interpreted explorative and descriptive (Yin, 1994)⁷.

4.3 DATA COLLECTION

In the previous chapter an introduction is made to the research. This paragraph contains the detailed approach to arrive at answers to the sub questions and, finally, the main research question formulated.

To answer the main research question: *How can medical specialists participate in the budgeting process in order to have input for efficient care?* three sections with sub questions are formulated in the previous chapter. Per section a more detailed method for arriving at an answer is described.

⁶ Appendix III – Table: Types of Research Questions, Qualitative Designs an Illustrative Test Interpretation (TI) Examples.

⁷ Appendix IV – Types of Evidence

4.3.1 SECTION ONE

The first section contains four sub questions for which a literature research is conducted in the fifth chapter.

- 1.1 What is the budgeting process?
- 1.2 What are positive effects of participation?
- 1.3 What are negative effects of participation?
- 1.4 Are there solutions or mechanisms to overcome negative effects of participation?

First, academic books are used to gain further knowledge about the topic of participation. From then onwards, associative words were used for searching additional literature. These associative words are for example: participation, participative goal setting, budgetary slack and information asymmetry (for a full list see Appendix IV). Additional literature was sought in the webofknowledge – database, library of the university and Google Scholar. Finally, references from academic books were checked in order to see if other articles could be added to the selected articles.

Second, the results found are sorted by ‘times cited’ and / or ‘date’. The first selection took place based upon the title and expected relevance. Secondly, a selection is made based upon the abstract. Inclusion is done based upon relevance criteria:

- Participation was (part of) the research aim
- Negative or positive effects were studied
- Solutions were either studied or mentioned in the discussion

And, characteristics of the articles:

1. Published articles
2. Meta – analysis, review articles or (single) case study
3. Limitations

Articles selected are published, so for example no abstracts or papers were used. A meta – analysis or review article is considered to be of importance since it verifies results and consistencies of results over time. Case studies are included since they are aimed at gaining in - depth understanding of a problem. Limitations are checked in order to make sure that no articles were included that had weak results on questions relevant for including in this thesis.

4.3.2 SECTION TWO

Several steps are taken in order to collect all data required for answering the sub questions in section two:

- 2.1 How does top management see participation by medical specialists?
- 2.2 How do medical specialists see participation?
- 2.3 How does RRU management see participation by medical specialists?
- 2.4 How does supportive management see participation by medical specialists?

These steps are presented in the table on the next page, each step is further elaborated on in the next paragraphs. The results are described in chapter six.

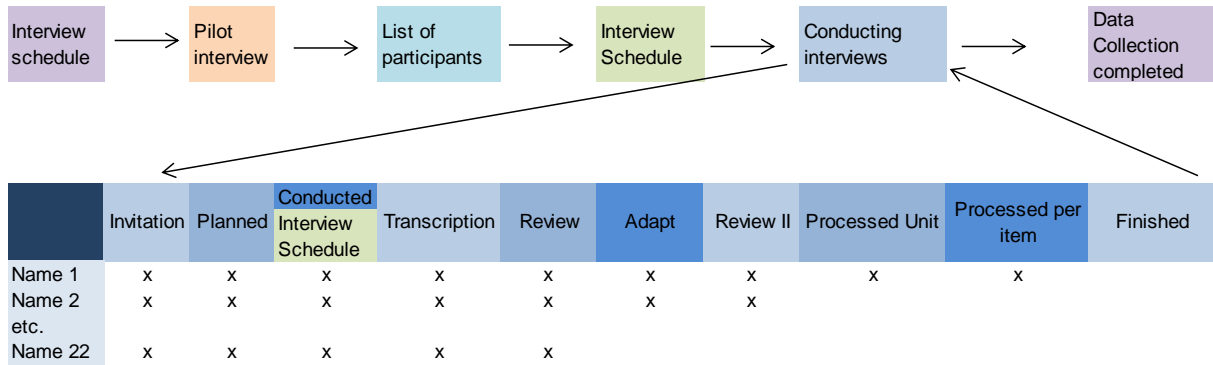


Figure G: Process data collection

4.3.2.1 Interview schedule

Before data collection was started, an interview schedule was designed. This was done prior to the interviews as this was the guide for introducing and structuring the interviews. With the knowledge of the structure, invitations are send. The interview schedule can be found in appendix IV.

4.3.2.2 Pilot interview

Before conducting the interviews for data collection, a pilot interview is conducted. For this pilot interview a professional role player is invited. He is provided with the same information that would be provided to all participants. He was instructed to play a certain role.

The pilot interview resulted in a new introduction for the interview schedule. Besides the comments on the introduction, some very useful information was given about the interview structure and conversation techniques to use.

4.3.2.3 List of participants

Four units are recognized for the core organization: top management, RRU Chairman, RRU managers and supportive management. Other units have a primarily focus at for example the building of the new hospital.

The participants are selected according to criteria. These criteria were for example size of RRU (in turn over), position in the organisation, type of RRU or a combination of these criteria.

The choice for making a specific selection for participants is made since a diverse perspective is required. A diverse perspective could not have been guaranteed if a random selection was made.

The list of participants was made together with the commissioner, this list is not presented in this thesis since all data is processed anonymous.

4.3.2.4 Invitation and planning

Before the invitation was send, approval for conducting the interviews was asked via the secretary of the board of directors. When approved, invitations are send by internal email to all participants. Interviews were planned either through making an appointment with the secretary or with the participant in person.

Initially, conducting 15 interviews was considered as the required minimum. As cancellations were expected, 21 invitations were sent. No cancellations appeared, so 21 interviews were planned. Additionally, three more interviews were planned as they were interested in the topic. Therefore, in total 24 interviews were planned.

Planning of the interviews took about two weeks and all interviews were planned within a time span of four weeks.

4.3.2.5 Conducting the interviews

From 24 planned interviews, 22 were conducted. Two interviews were cancelled by the researcher since there was not enough time to either conduct the interview or enough time to transcribe, review and process the data.

On average the interviews took one hour. The longest interview took about two hours and the shortest interview about 50 minutes. No interviews had to be interrupted because of time limitations or other appointments, time was monitored closely to avoid these situations.

During all interviews, all four topics (participation, budgeting process, efficient care and the RRU model) are covered. However, not all topics are deepened equally, this depended upon the interests of the participant as well as the position of the participant in the organization.

Notes are made during the interviews and (with the exception of two cases) the interviews are tape recorded.

4.3.2.6 Transcription

In order to be able to process the data, all interviews are transcribed within a maximum of two days after conducting the interview. Transcription is done based upon the notes and tape recordings and contain between 1500 – 2000 words.

Per item, a separate paragraph is made. This resulted in a transcription without a chronological order. The chronological order is not relevant for processing the interviews.

4.3.2.7 Review – Adapt – Review II

In order to verify data collected, the interviewee is asked to review the transcription. In total 21 interviews out of 22 were reviewed by participants. Comments on the transcriptions were further explanations on topics in order to verify that right perception or opinion is written down. There were no comments recognized as a way to reverse opinions or perceptions, therefore all comments were processed. In total nine interviews had to be adapted and are sent to the participant for a second review. In one occasion, the second review had to be adapted.

4.3.2.8 Processed per unit and per item

In order to process the interviews, a list (Appendix V) is made with all items from literature. Paragraphs from the transcribed interview were copied and pasted underneath the relevant title. If new items were recognized, they were added to the list. Per unit a separate document was made, and in a separate table (Appendix VI), scores were kept per item.

When all interviews were processed, the list with items was analysed in order to judge whether or not there are double items, or items with the same meaning. From the original list of 66 items, 55 remained since 11 items were merged with other items.

4.3.3 SECTION THREE

The last section is a discussion and a comparison about results found in order to answer the questions related to this section:

- 3.1 How is the current RRU model related to participation?
- 3.2 How is the RRU Model related to efficient care?
- 3.3 How is efficient care related to Participation?
- 3.4 How is efficient care related to the budgeting process?
- 3.5 How is Participation related to the budgeting process?
- 3.6 How is the budgeting process related to the RRU Model?

After all interviews are processed per unit, a new document is made with the items covered in the interviews. Again, all paragraphs from were copied and pasted underneath the relevant item.

Then, accompanied with the table with results from interviews (Appendix VIII: Table with results from interviews) it is analysed how many times and why items are mentioned. Besides, it is analysed if there are differences between the different units and differences compared to theory. Results of this section can be found in chapter seven.

5 SECTION ONE: THEORY

5.1 LITERATURE ON BUDGETS

Planning and budgeting systems are an essential element of financial results control. The systems produce written plans that clarify where the organization wants to go, how it wants to get there and, what results are expected. Therefore the planning processes within organizations forces managers and employees to think about the future and how to make plans that serve the organization's interest (Merchant and Van der Stede 2007).

There are three sequenced planning cycles to be distinguished in large organizations. Strategic planning involves long term planning which consists of a wide array of thinking about the organization. Capital budgeting is used for a medium time horizon and involves identification of specific plans to be implemented in the next few years (Merchant and Van der Stede 2007). From three planning cycles, (operational) budgeting is the preparation of a short term financial plan. This plan, or budget, contains as much detail as possible about revenue, costs and investments, usually for the next year (Merchant and Van der Stede 2007, Drury 2008).

There are no universal prescriptions about the budgeting process, but on average it takes four months to complete. This is a considerable amount of time and supports and influences capital and strategic planning cycles, especially since operating strategies can gain competitive advantage (Merchant and Van der Stede 2007, Langfield-Smith 1997).

Budgets are a powerful management tool to convert managements' ideas and plans into an organized set of tactics. The main characteristic of budgeting is using quantitative, usually financial data. A budget is a highly detailed plan with all revenues, costs assets and liability line-items as appropriate (Merchant and Van der Stede 2007).

An important aspect of these short term plans involve targets that affect the managers motivation to perform. A managers performance is often related to measuring how far targets are met and it informs managers how well they have performed (Merchant and Van der Stede 2007, Drury 2008).

5.2 LITERATURE ON PARTICIPATION

5.2.1 WHAT IS PARTICIPATION?

Participation is regarded as the process in which influence is shared among subordinates or groups who are otherwise hierarchical unequal, and it allows subordinates to bring in specific information about tasks (Wagner 1994, Young 1985).

Participation is described in several ways for example Haas & Kleingeld (1999) describe participation as a strategic dialogue in which '*...the collective attitude of mind is reset in accordance with changed or even new strategic priorities.*' (Haas & Kleingeld 1999 p. 233). Other authors describe the process as a group- discussion leading to a decision and a negotiation process about targets (Erez & Arad 1986, Baiman & Evans 1983). Thus, participation is a process in which a group or individual are involved with, and have influence on, in this case the determination of their budget and targets (Shields & Shields 1998, Young 1985).

5.2.2 A BENEFICIARY MANAGEMENT TOOL

Letting individuals participate in target setting and budgeting has several advantages (e.g. Merchant & Van der Stede 2007, Drury 2008). Erez & Arad (1986) distinguished three mechanisms, cognitive, motivational and social, to illustrate benefits of participation. These mechanisms are used to structure theory found.

5.2.2.1 Cognitive

From a cognitive viewpoint, participation may result in increased information sharing, knowledge, creativity and communication (Haas & Kleingeld 1994) and it will reduce uncertainty (Shields & Shields 1998). The cognitive perspective is also known as the economic reason why participation exists (Shields & Shields 1998). Letting subordinates participate in the budgeting process gives top management the opportunity to access information while at the same time it will allow the subordinate to share some of the private information and reduce information asymmetry (Dunk 1993). When sharing information in a participative – based management system the subordinate is able to reveal private information about the tasks in order to be incorporated into the budget or plans he or she is evaluated on (Shields & Shields 1998, Baiman & Evans 1983). Studies reveal that participative groups and subordinates are better informed and therefore, have accounted for the superiority of the uninformed groups and subordinates (Erez & Arad 1986).

The increase of information sharing is also associated with organizational control since targets are better aligned. Knowledge gained by superiors can therefore result in offering more efficient and goal-congruent budgets. Participation in this sense is regarded as the mechanism to create control (Shields & Shields 1998, Haas & Kleingeld 1994).

5.2.2.2 Motivational

The motivational mechanism is described as an effect of psychological ‘feelings’, for example experience of respect, feelings of equality and sense of control (Shields & Shields 1998). It is argued that whenever subordinates experience ‘more’ respect or equality, their motivation to perform and achieve targets, increases. In order to measure an increase, researchers have used ‘effort expanded’ or ‘increased effort’ to determine motivation (e.g. Searfoss & Monkczka 1973 and Fisher, Maines, Peffer & Sprinkle 2002). Increased motivation as an effect of participation is found by many researchers. It is also assumed to be related to increased productivity even if that is not a target itself (Dunbar 1971, Fisher, Maines, Peffer & Sprinkle 2002, Erez & Arad 1986, Cotton et. al. 1988).

5.2.2.3 Social

A positive attitude is regarded as the social mechanism of participation. It is therefore a powerful technique for overcoming resistance to change. Overcoming resistance has, as a consequence, a positive effect at commitment to plans (Erez & Arad 1986). It is also argued that subordinates, due to participation, understand how and why targets are set in a certain manner. This increases the feeling of a ‘fair’ budget, increases satisfaction and would therefore be felt more relevant to them (Merchant and Van der Stede 2007, Fisher, Maines, Peffer & Sprinkle 2002, Dunbar 1971).

5.2.3 ON THE CONTRARY....

Some research however, challenged participative approaches and suggest that participative styles of management will not necessarily be more effective than other styles. The three mechanisms (cognitive, motivational and social) distinguished by Erez & Arad (1986) are also used to structure theory on negative effects of participation.

5.2.3.1 Cognitive

Information asymmetry resulting in budgetary slack

The most important, and perhaps most extensively investigated, cognitive effect described by those whom challenged participative management styles is budgetary slack. Budgetary slack is also known as “*the incorporation of budget amounts that make it easier to attain*” (Dunk 1993). Biased budgets are an outcome of two possibilities, either the individual has misrepresented the information or the individual suppresses information (Dunk 1993, Baiman & Evans 1983). The misrepresentation or suppressed information is a consequence of private information a subordinate has over its superior(s) and is referred to as information asymmetry (Young 1985, Dunk 1993, Baiman & Evans 1983, Abernethy, Bauwens & Van Lent 2004, Fisher, Maines, Peffer & Spinkle 2002).

Knowledge is lacking

Budgeting is, through multiple perspectives, a complex process. Therefore another cognitive effect that may limit the positive effects of participation is the lack of knowledge by the subordinate. Research conducted focuses at several aspects of ‘knowledge’. Roughly this can be divided into two ‘types’ of knowledge: financial knowledge and knowledge to see through the boundaries of historical events.

Lack of financial knowledge appears primarily in highly specialized organizations. In this case financial knowledge by the participants is lacking as they primarily focus at the concerning technology. Financial impact of technological targets are usually underestimated in terms of costs which can result in unrealistic budgets (Baiman & Evans 1983, Merchant and Van der Stede 2007).

Another limitation to the benefits of participation is knowledge of participants that is bounded to historical events. In this case, knowledge about budgeting is present, however, changes towards new technologies or dramatic changes in the business environment are not to be overseen by subordinates. As a consequence, subordinates may misinterpreted effects of these strategic changes. In this case top management is in the position to foresee and implements structural changes which could not have been implemented with a participative approach in the budgeting process (Merchant and Van der Stede 2007, Langfield-Smith 1997).

5.2.3.2 Motivational

Goal setting is lacking

A negative motivational effect of participation appears when participation is not related to goal setting. When subordinates are involved in discussing about targets, but not in setting the targets, the effect of participation on performance is little or absent (Searfoss and Monczka 1973, Dunbar 1971). Budget emphasis is therefore considered as a necessary condition since participation alone is not enough (Dunk 1993).

Programmable

Another trait towards the motivational benefits of participation are programmable budgets. Erez & Arad (1986) found no difference in goal acceptance and performance between participative and non-participative budgeting when the level of goal difficulty and the level of information were held constant. This means that, due to standardized in- and output measures, targets are programmable as they can be set based upon historical information. Negotiation or private information from the subordinate do not have consequences as they will not change much (Merchant and Van der Stede 2007, Drury 2008).

A direct link to programmable budgets is environmental uncertainty, or actually the lack of environmental uncertainty. Shields & Shields (1998) found supportive evidence that participative budgeting is beneficiary in an uncertain environment as adaption towards changes requires alignment of goals. This means that when the environment is certain, or predictable, participation will be ineffective.

5.2.3.3 Social

Personality Traits

A social limitation of participation are personality traits. When subordinates are too sensitive for responses from authoritarians it will limit the benefits of participation. These personality traits can result in unrealistic targets. This is caused since targets are likely to be set to fulfil the authorities' expectations. An early research conducted by Brownell (1981) refers to these personality traits as an effect of '*locus of control*'. Locus of control is described as the subordinate having the feeling of having control over his or her destiny. When the subordinate does not have the feeling that he or she is 'in control' or not independent towards authoritarians, targets are not likely to be very realistic. Subordinates expect the superior to adjust the targets and therefore they feel that their destinies are controlled by 'external' influences (Brownell 1981).

5.2.4 OVERCOMING NEGATIVE EFFECTS

In order to overcome negative effects of participation and reduce risks accompanied with these negative effects, literature is found on methods to reduce appearance of negative effects. Again, the three mechanisms described by Erez & Arad (1986) are used to structure theory on solutions.

5.2.4.1 Cognitive

Two negative effects of participation appeared from the cognitive mechanism both have a common characteristic: 'information'. On the one side there is intended misuse of information which leads to budgetary slack and there is unintended misuse of information which is a result of budgetary slack or lack of knowledge. With this in mind, literature is found on willingness of information sharing. The assumption is made that subordinates are willing to share information but misrepresent it if they lack knowledge (and therefore create budgetary slack) and that subordinates are not willing to share information if they purposely want to misrepresent information. This resulted in two articles.

Budgetary slack in this case is seen as the intended, misuse of information. Young (1985) described why subordinates might misuse information. In his research he described the effect of budgetary slack as an outcome of risk preferences. In other words, budgetary slack is a response

to uncertainties. A risk averse person would build in more slack to hedge the uncertainties he or she is expected to face. In order to reduce slack, risk aversion of the subordinates should be known. As subordinates are risk averse, as many uncertainties as possible should be eliminated. When subordinates are not risk averse, the appearance of budgetary slack should be low.

On the other hand there is unintended misuse of information. In this case, subordinates do not have the knowledge to represent information accurately or they cannot see through historical events. Baiman and Evans (1983) conducted a research on pre-decision information. Pre – decision information serves as a tool to help the subordinate to choose an action of choice. It is expected that a subordinate whom has difficulties with interpreting data, is willing to use (pre – decision) information in order to have a more confident position in the participation process. In order to reduce the effects of lack of knowledge, costless information should be shared prior to the budgeting process.

5.2.4.2 Motivational

The negative effect on motivation of participation can easily be overcome. Basically setting targets should overcome negative effects. However, setting goals should not be underestimated, this is extensively described in goal-setting theory.

Goals affect performance through four mechanisms; direct attention and put attention towards goal- attaining activities and away from goal irrelevant activities, energizing function, goals affect persistence and fourth, goals affect action indirectly by leading to the arousal, discovery and/ or use of task – relevant knowledge (Lock and Latham 2002).

Another important aspect in the description of goal-setting theory is that conscious goal setting is more reliable and directly tied to action than non-conscious goal setting (Lock and Latham 2002). This means that if the subordinate is more aware of goals set, action towards these goals is more likely even though the participant might not only know why he or she is taking a certain action.

5.2.4.3 Social

The negative effect described under the social mechanism is “personality traits”. Personality traits contain a wide array of effects which is described in many scientific fields. The most simple solution is that targets have to be set by higher authoritarians (Drury 2007).

For this research however, some literature is sought on social effects within top management teams since there are fields of expertise, rather than hierarchical setting. Literature is found within the field of management control and organizational behaviour. The literature assumed to be closest related to the context of this thesis is about ‘cognitive diversity’ which is seen as *“diversity in terms of differences of beliefs concerning cause – effect relationships relating to various goals of the organization”* (Olsen, Parayitam and Bao 2007). It is assumed that cognitive processes affect many decisions in businesses and that workplaces become increasingly diverse (Olsen, Parayitam and Bao 2007).

In order to have a top management team that will make the better decisions, competence based trust is a success factor. Attributes of competence based trust are dependability, competence and reliability. If a trustful situation is created, team members expect others to have enough knowledge to give good arguments. This might lead to a so called 'task conflict' but that is more beneficiary than a relational conflict. (Olson, Parayitam and Bao 2007).

5.3 CONCLUSION

In this chapter results are summarized and an answer is given to the sub questions formulated in chapter three paragraph two. These questions are written below with the accompanied answer.

What is the budgeting process?

Budgeting systems are an element of financial results control and a budget is a short term financial plan. Budgets are a powerful management tool to convert managements' ideas and plans into an organized set of tactics. The main characteristic of budgeting is using quantitative, usually financial data.

What is participation?

Participation is a process in which a group or individual are involved with, and have influence on, in this case the determination of their budget and targets.

What are positive effects of participation?

There are three mechanisms that illustrate benefits of participation. Cognitive, which determines the increased information sharing and communication, reducing uncertainties and increasing organizational control. From a motivational perspective it increases productivity since subordinates increase productivity to achieve targets. The social perspective is commitment to plans as participation overcomes resistance.

What are negative effects of participation?

Participation is not effective in all situations, again three mechanisms are used to describe effects that reduce efficiency of participation. From a cognitive perspective, information asymmetry, or budgetary slack, which is the incorporation budget amounts that make it easier to attain. Another limitation for participation is the lack of knowledge from subordinates. The motivational mechanisms is related to programmable budgets and lack of goal setting. Programmable budgets are not suited for participation since there are not much items to discuss about, this decreases motivation. Lack of goal setting is a trait for participation as well, since motivation decreases if subordinates are only able to talk about but not to determine the targets. Finally the social mechanisms associated is 'personality traits of subordinates' which can decrease the effectiveness of participations since they feel dependent upon authoritarians.

Are there solutions or mechanisms to overcome negative effects?

It is possible to overcome these negative effects, again via three mechanisms this is described. For the cognitive perspective, it is necessary to know risk preferences of the subordinates or give guarantees in uncertain situations since budgetary slack is a way to hedge for uncertainties. Providing pre - decision information is a way to overcome lack of knowledge, since subordinates are helped with choosing an action of choice. The use of target setting by higher authoritarians is a way to overcome the negative motivational mechanisms, however, conscious goal setting is a solution as well since the primary benefit of target setting is direct attention and motivation towards the goals set. Competence based trust is a way to overcome personality traits. Basically, a trust in each other competences makes it possible to discuss about the content and come to best suited outcomes.

6 SECTION TWO: DATA

In this chapter results are described from the second section, data collection, described in chapter four. There are four sub questions determined for the second section, these are answered in the final paragraph: conclusion. In order to answer the questions, data collection and the results from data collection are described in the next paragraphs.

6.1 DATA COLLECTION

Data is collected from four units: top management, RRU Chairman, RRU managers and supportive management through conducting in-depth interviews. In this study, participation is connected to the budgeting process, efficient care and the RRU model. Therefore, four items (participation, budgeting process, efficient care and RRU model) were distinguished and processed separately from the interviews. Results from these interviews can be found in Appendix IX until XIV.

6.2 RESULTS PER UNIT

In this section results per unit are described. Results are structured according to the four topics emerged participation and its context (Figure D: Context of Participation). The last paragraph per unit contains a discussion about the results found.

6.2.1 TOP MANAGEMENT

Results from interviews with top management can be found in Appendix IX. In the next paragraphs, participation, budgeting process, efficient care and RRU model are described respectively. The last paragraph contains a discussion about the results from these four items.

6.2.1.1 Participation

From a cognitive point of view, top management mention the positive effect of information sharing and communication. It is mentioned that there should be attention for the structure of the budget and important items as honorarium and production and the relation between production and costs of production. These items should be clear in order to avoid discussions during the year.

The negative effect mentioned is lack of (financial) knowledge, this is because they are not for this. Therefore providing pre-decision information is seen as a necessary tool to support the RRU Chairman but also the RRU manager. Pre - decision information is not only seen as a tool to support but also as a way of creating boundary conditions. Supportive organs have the knowledge and skills to create these boundary conditions (e.g. hire right people or buy the right equipment), this role should not be put back to the RRU manager.

Another negative effect mentioned is, opposing or conflicting interests. This is mentioned in the context of collaboration between RRU, in which a decline in income might be the consequence of collaboration. This decline in income, might result in not getting the full support even though it is more efficient. Giving (financial) guarantees or reducing uncertainties is seen as a solution for overcoming these negative effects.

6.2.1.2 Budgeting process

The budgeting process is seen as a result of quality and financial targets agreed upon in the year plan. The current process is probably the best the organization can do, as budgeting in health care is complex. However, budget 2012 = budget 2013 is seen as non-motivating, since no discussion about the content is held. It is mentioned that before summer, there should be attention for (strategic) decisions about expectations for patients and production. On the long term, strategic decisions are the spot on the horizon, (year) plans should fit within these strategic decisions.

6.2.1.3 Efficient Care

Future plans and future strategy in relation with the RRU are also discussed. Collaboration is seen as a way to create efficient care. It is expected that collaboration between RRU is difficult to establish as this has a close relation to the income of medical specialists. The contract sum is a good solution to give guarantees, however, new forms of connecting specialists to the hospital are mentioned as well. Taking specialists in employment for example is seen as a solution however, it is recognized that this not necessarily means that it becomes easier to 'manage' them since they are probably taken out of their comfort zone.

6.2.1.4 RRU model

Besides the effects and solutions of participation, the boundary conditions for the RRU model were discussed. First, the casting within the RRU model is discussed. The RRU chairman is seen as the expert for the content, for the budgeting process this means that he or she gives input about number of patients, type of production, etc.. The RRU manager, whom has the role of communicator, is the person whom elaborates the budget in the budgeting process. A competence of the RRU manager is to be a good discussion partner, this is not a competence recognised by all RRU managers.

Required competences of the RRU Chairman are the capabilities of creating a vision for his or her field of expertise. Besides, the RRU Chairman is aware of consequences of this vision in financial terms. This is not a common competence for all chairman, but there a slow change is recognized over time. It is recognized that this competence also has to do with involvement of the RRU Chairman function. Unfortunately, not all chairman are equally interested in the function. A solution mentioned for this situation are non - monetary rewards e.g. a status which allows them to do exclusive courses or have a stage to present their performances via internal media.

From an organizational perspective the importance of staff (in terms of giving input about specific content items) with regard to the RRU is mentioned. Besides, it is mentioned that from the DT more attention should be paid to the development of competences for RRU chairman, currently there is no clear description and therefore it is not clear how to judge a RRU chairman. Another point of attention is to understand the thoughts and interests of the RRU Chairman. Primarily, giving guarantees is seen as the solution, if guarantees are related to income, the collective should be in charge to give these guarantees.

6.2.1.5 Discussion

Compared with theory, top management only mentions the cognitive aspects of participation. The positive effect seen, is: increased information sharing and communication. And the negative mechanisms and solution are lack of (financial) knowledge and providing pre-decision. Pre – decision information is not only seen as a tool to support but also as a way of creating boundary conditions.

It is uncertain why motivational mechanisms are not mentioned. The social mechanisms are probably not mentioned because it is not recognized – or not associated with – subordinates being dependent upon them.

Opposing and conflicting interests are mentioned to appear in context of participation, since the organization and medical specialists have interests (e.g. production) at right angles to the organization (e.g. reduction in costs). Valid arguments are given in order to overcome this situation, but as they are primarily mentioned in the context of future developments, it might be useful to pay attention to the effects and solutions in the current situation as well.

During the interviews not much was said specifically about the budgeting process, primarily reason is that it is not known how to do it better. It is mentioned that before summer, there should be attention for (strategic) decisions about expectations for patients and production. The budgeting process is seen as a result of quality and financial targets agreed upon in the year plan, which is preferably executed bottom up.

Future plans and future strategy in relation with the RRU are also discussed. Collaboration is seen as a way to create efficient care. It is expected that collaboration between RRU is difficult to establish as this has a close relation to the income of medical specialists. Giving guarantees is seen as a solution to enforce these changes. Even though collaboration is mentioned, not much is said about how and when to further design these alliances.

Some boundary conditions for the RRU model were mentioned as well. For example, the RRU manager should be a good discussion partner and communicator and the RRU chairman should be interested and be able to create a vision for his or her specialism. These competences and characteristics are not common to all RRU chairman and RRU managers. Solutions are mentioned, however, it starts with designing good competences. So before any of the solutions are implemented, designing of competences should be done.

6.2.2 MEDICAL SPECIALISTS

Results from interviews with medical specialists can be found in Appendix X. In the next paragraphs, participation, budgeting process, efficient care and RRU model are described respectively. The last paragraph contains a discussion about the results from these four items.

6.2.2.1 Participation

From a cognitive perspective, RRU chairman primarily recognize organizational control as a benefit of participation. Organizational control in this sense is described as an effect of participation because participation resulted in an increased awareness and responsibility of costs. In several occasions they mention: *'before the RRU model we ordered what we need, now we discuss and compare information about what we need'* (anonymous).

The cognitive negative mechanisms mentioned – sometimes together – are budgetary slack and lack of knowledge. Because targets usually come at the end of the budgeting process, it might happen that slack is built in the original budget in order to be able to attain the budget. On the other hand, it is mentioned that slack might happen as an unintended effect because lack of knowledge. Lack of knowledge is also mentioned separately as an effect of not being educated for (financial) management.

In several occasions it was mentioned that the RRU Chairman is held responsible for items they cannot influence or determine. This is a motivational negative effect. It is said that since they lack the knowledge about the item held responsible for, it is felt as *'out of their influence'*.

Competence based trust is mentioned as a solution for creating a stronger organization. The organization should put more attention into organizing its opposition. There should be a balance between the organization and the opposition, it is mentioned that you grow stronger if you are constantly provoked and challenged. Currently, it is felt that there is an imbalance between the RRU's and the organization.

Practical issues for executing plans are seen as a negative effect as well. When plans are made, they are usually build in the budget from the moment it starts, this is seen as impossible since it usually takes some time to start, implement and see the type of patients required for the plan. The difficulty is that some plans are hard to quantify, and therefore assumptions are made. It is said that these assumptions are taken as a strict norm.

Another topic is conflicting or opposing interests, this started the discussion about what the interests of the hospital are and what interests of the medical specialists are. It is expected that medical specialists have more interest in continuity than (top) management purely based upon the time span of their career within one hospital. Therefore involving medical specialists in strategic plans is seen as necessary. Patients interests are mentioned as well, especially in light of the current reward system. As long as production is rewarded, and there are hardly any other incentives, the patient might receive more care than required. It is specifically mentioned that this is not harmful for the patient, since it usually means an extra visit or extra check-up.

6.2.2.2 Budgeting process

In the process for budgeting there is a strong focus at costs, this if felt as dishonest. Especially as they are also held responsible for production and production related income. Besides, they mention that there should be more attention for the year plan. The year plan should be the basis for the budget, and therefore earlier involvement is required as this gives the opportunity to put more attention towards strategic plans.

Splitting up targets should be done up front with RRU chairman, there should be no surprises at the end of the budgeting process. Ideas about the resources to use can be given in order to help them find a solution for splitting up targets. Currently, this phase is experienced as vague, non-transparent and out of their influence.

6.2.2.3 Efficient Care

Medical specialists have a strong, coherent perception about the future. They recognise that cost efficiency will be the focus as (currently) the inflow of patients is not as much as expected. Efficient care can be achieved by collaboration between specialisms and with providing care outside the hospital. It is specifically mentioned by several participants that efficient care is not to be achieved by controlling feeders and bleeders.

With outside the hospital is meant e-health or a format in which collaboration with the general practitioner is sought. Collaboration between hospitals is seen as a solution as well, a quite down – to – earth opinion is: do what you're good at, and improve these skills, for other types of care, seek a relationship with (academic) hospitals. Another form of collaboration is collaboration between RRU's. This can be either done for certain types of care but also for shared investments (e.g. robotic surgery). A pre – condition for collaboration is the distribution of honorarium, production is expected to be a limitative condition and therefore there should be another incentive for distribution of honorarium.

6.2.2.4 RRU model

The perception about the roles within the RRU model are consistent; the RRU chairman is seen as the person for medical input, changes in health care requirements but also production. He or she is responsible to translate medical information in a way that it is understood by the RRU manager. The RRU manager is in the position (it is not always mentioned as 'responsible') to organize and make sure the RRU chairman is able to execute his function as a doctor. The RRU model is seen as positive for the department, since there is a strong focus at the functioning and results obtained by the department. However, the RRU model does not stimulate collaboration and it results in an 'island – culture' where own interests are superior to the hospital's interest.

Generalizability among RRU's is seen as a weak point in how currently RRU's are judged. Supportive specialisms mention that the perception about being a cost centre is not correct, diagnostic activities determine treatments a patient will receive and therefore further costs of care. Besides, they are dependent upon the specialisms whom apply diagnostic activities for their patients. It is said that it is underestimated that diagnostic activities determine the treatments patients receive. Generalizability is also mentioned in the context of hospital wide KPI's (critical performance indicators), some of them are not relevant or hard to monitor for a specialism. There should be more attention for specialism specific performance indicators.

RRU chairman also mention that it was not clear what was expected from them with regard to the execution of the chairman function. Besides, it is mentioned that not all chairmen are equally interested and that selection for the chairman function should be more strict. Specific competences for RRU chairman are managerial and financial knowledge and the skill to be able to translate medical items so they are understood by the RRU manager/ organization. Specific attention should be paid to the role the RRU Chairman has with regard to the venture.

The preferred role of the direction team is seen as directive and coaching, however, this is not recognized in all occasions. Besides, an integral perspective on either how to judge the KPI's and on the other hand act upon common interests of RRU's, is seen as a role for the direction team. Currently it is felt that there are too many ad hoc items and the integral perspective is not acted

upon accurately. This is supported by the opinions about the consequences of results from the RRU. It is not felt as transparent and even vague in cases of losses. *'If you are able to present your results with a good story, it is accepted and there will be no consequences'*.

It is said that that the organization underestimates the responsibilities of a medical specialist as they are responsible (in terms of lawsuits) for providing good care with justified materials. If the organization wants to organize the e.g. supply of materials, they should understand how important it is for a medical specialist to organize this so they can take these responsibilities.

6.2.2.5 Discussion

From a cognitive perspective, RRU chairman primarily recognize organizational control as a positive mechanisms and budgetary slack and lack of knowledge as negative mechanisms. Neither of the cognitive solutions were dominant nor, positive and negative effects of motivational and social mechanisms. This is probably because they are rather positive about participation, but experience more problems in terms of boundary conditions and management.

It is interesting to know why competence based trust, a solution for overcoming the feeling of dependence, is mentioned often whilst it is not mentioned that it is felt that medical specialist are dependent upon (top) management. It might be that dependence is more discussed in terms of lack of goal setting and budget items out of their influence instead of a personality characteristic that reflects their own behaviour.

Practical issues for executing plans is seen as a negative effect as well. The difficulty is that some plans are hard to quantify, and therefore assumptions are made. It is said that these assumptions are taken as a strict norm. Even though this might be seen as lack of knowledge, this situation is not to be overcome by pre – decision information. A non-participative approach probably would not have handled these strict norms.

Conflicting or opposing interests are the final, negative effect mentioned. These opposing and conflicting interests appear between management and medical specialists. For the organization it is important that these conflicting or opposing interests are mentioned, especially since they also mention that the organization underestimates the interests of medical specialists. This tells that the interests of the organization are seen, however, they perceive the interests of the organization to be superior to theirs (underestimating their interests). They would probably expect them to be equal.

For medical specialists it is important that not only costs are discussed during the budgeting process. It becomes apparent that the focus at costs is a method from the organization to create efficient care, however this message is not felt. It is even felt as dishonest since they are held responsible for production and production related income as well. This might be felt as inconsistent behaviour of the organization, and as a consequence hedging uncertainties might appear (e.g. budgetary slack)

Besides, they mention that there should be more attention for the year plan. The year plan should be the basis for the budget, and therefore earlier involvement is required. It would be good to enforce a stronger relation between the budget and strategy (of the organization) via the year plan.

Another element of the budgeting process is splitting up targets. It is mentioned that this should be done up front with RRU chairman. It is questionable whether or not this should be done up front, because it does not guarantee that the budget for the hospital would be achieved. However, a stronger involvement of RRU chairman would be beneficiary since this will reduce vagueness and increase commitment.

Efficient care can be achieved by collaboration between specialisms and with providing care outside the hospital not by controlling feeders and bleeders. With outside the hospital is meant e-health, collaboration with other hospitals or a format in which collaboration with the general practitioner is sought. This is very useful information, but as long as production is rewarded, probably none of these ideas will come to plans. Therefore the mentioned pre - condition for collaboration, other incentives for the distribution of honorarium, should be put into action.

The perception about the roles within the RRU model are consistent. This means that how dual management should be executed is clear. An important item mentioned is that the RRU model is seen as positive for the department, but that the RRU model does not stimulate collaboration. As collaboration is mentioned as most beneficiary for efficient care, other incentives have to be established. It mi

Generalizability among RRU's is seen as a weak point in how currently RRU's are judged. The organization should put in more effort to understand these differences and act upon the requirements accompanied to these differences. It might even be that comparison is not done between RRU's, but with a more outside - world - view: between privately held companies or comparative specialisms from other hospitals and the RRU from Isala.

Another point which might increase commitment and motivation is the development of competences for the RRU chairman function. As it is mentioned that they experience vagueness in terms of expectations. Specific attention should be paid to the role with regard to the venture.

Finally, another topic is the perception about the directors of operations. Whereas it is expected that they coach, direct and create an integral perspective about the performance of the RRU, this is hardly recognized. Therefore the role of the directors of operations should be more consistent and sharpened especially in light of future developments where they are seen as the key figures to connect RRU's for collaboration.

6.2.3 RRU MANAGERS

Results from interviews with RRU managers can be found in Appendix XI. In the next paragraphs, participation, budgeting process, efficient care and RRU model are described respectively. The last paragraph contains a discussion about the results from these four items.

6.2.3.1 Participation

From a cognitive perspective RRU managers see positive effects, negative effects but also solutions. Primarily, organizational control and increased information sharing and communication are mentioned and no positive effect is in favour of another. From negative effects, lack of goal setting is seen as most dominant. The feeling of lack of goal setting primarily derives from the fact that a lot of components are built in their budgets without an explanation

and out of their influence. It is felt as: *'the front door is closed, but the back door is open, how can we be responsible if everyone can change our budget?'* Besides the changing budget out of their influence, the way they are judged is felt as dishonest. When agreements are made based upon euro's, they should be judged based upon euro's and not in numbers.

Providing pre – decision information is seen as solution to overcome the negative effect of lack of knowledge. It is expected that it is underestimated how important management information is for the RRU. The consequences of not providing complete and clear information is that wrong decisions can be made.

The positive effect from the social mechanisms mentioned is commitment to plans. RRU managers mention the importance of competence based trust which is a solution seen from the social mechanisms of participation. Positive effects related are trust and a discussion about the content.

6.2.3.2 Budgeting process

In general the RRU managers say that the budgeting process should start with a preparation by them with help from RRU control. Hereafter, they go to the RRU chairman whom gives input for changes and developments with regard to the upcoming year. With the information from the RRU chairman they make, together with RRU control, a concept for the budget. This concept budget is discussed and talked about by the RRU manager and RRU chairman. Currently their major concern is that it is felt that the budgeting process is not directed by someone, this is not only aimed at RRU level, but at Concern level as well.

When targets have to be split up, the RRU chairman should be given the opportunity to come with ideas and solutions. Information to help them can come from Concern Control, but it is necessary that the RRU chairman make the decisions themselves. There should be an escape: if they do not make a decision before a certain date, the consequence should be that the Board of Directors or Direction Team together with Concern Control, decide about plans for splitting up targets. A pre – condition is that splitting up the targets, but also following them during the year should be directed by someone. Otherwise, a lot of uncertainty of attainment of the targets will make the organization 'panic'.

With regard to targets, but also to other items determined by staff, it is necessary that the right person is telling the message as well as an open culture in which is told why and how the target is set. Besides, the role of staff needs to be further specified, RRU managers feel that they have to do a lot themselves.

6.2.3.3 Efficient Care

On the long term, RRU managers see collaboration as a way for efficient care. They mention the importance of long term (strategic) plans.

6.2.3.4 RRU model

RRU managers see dual management as a good solution for overcoming difficult decisions about costs and quality of care. However, in the current situation it is not always clear who is doing what. A separation in tasks is seen as helpful, the RRU managers task is to communicate and

translate decisions from the organization, the RRU chairman should understand the rules of the game and delivers input from a medical point of view.

The RRU chairman is seen as the key person to point out what is needed and where to go. Therefore it is important that the right person is put forward, competences mentioned are persuasiveness and a positive charisma. Generally, knowledge is not a problem, in this sense, knowledge about financial items is lacking, but medical specialists are smart people whom do not have difficulties with understanding new items if they are not presented in a complex manner.

Another point of attention for the organization is that the DT should be more strict in following up targets. Not only the targets as a result of cut down in expenses but the targets agreed upon by the RRU in general (e.g. KPI's). Currently there are no negative effects if performance is really poor, and only a small incentive (share in profits) is available, and only for good financial results. It is said that it might be good to have non-monetary rewards for achieving good results.

6.2.3.5 Discussion

From a cognitive perspective RRU managers see positive effects, negative effects but also solutions. It is interesting to know why hardly any of the positive social and motivational mechanisms are mentioned, perhaps they strongly relate these aspects to the experiences they have with the RRU chairman and managerial tasks. It is said that medical specialists are not interested in managerial tasks, this might have led to a tunnel vision on motivational and social mechanisms. Providing pre - decision information is seen as an important but also underestimated tool to help the RRU. It is a valid point that there is a risk of not providing complete and clear information. Just as RRU chairman, RRU managers mention the importance of competence based trust without mentioning dependence upon (top) management. From the perspective of RRU management, this probably not related to a personality characteristic but also to lack of goal setting.

In general the budgeting process starts with input from RRU Control and the RRU manager, then information is gained from the RRU chairman. A concept budget is made (RRU control and RRU manager) and this is discussed with the RRU chairman. Because the budgeting process is a managerial and financial issue, it is good that the RRU manager and RRU Control start with the determination of the budget. However, it should not be underestimated how keen the RRU chairman is on attending early in budgeting process, not only for input about upcoming changes.

Just as the RRU chairman, the RRU managers argue that the RRU chairman should be given the opportunity to come with ideas and solutions for splitting up targets. Additionally, RRU managers mention that information should be provided to help them. This is seen as a good solution since knowledge about financial or managerial items is probably lacking by RRU Chairman. In order to control this process, a strict deadline should be maintained, after that date targets are set by higher authoritarians. This is seen as a good solution as well, since it restricts the time to discuss and actively directs towards making a decision.

For both, the budgeting process and splitting up targets it is mentioned that there should be more guidance and checking up on plans. This tells that they demand more support from supportive organs.

Not much is said about efficient care, only that long term plans should be more present and that collaboration is seen as an opportunity for efficient care. While evaluating the interviews, it became apparent that a lot of ad hoc items that determine the revenue today, were discussed. It should be questioned what cause – effect relationship lies underneath this effect. Either it has to do with the competences of the RRU managers whom operate at an operational level instead of tactical or strategic level, or the role taken by the supportive organs whom letting the RRU managers do a lot of work.

With regard to the RRU model, perceptions about the roles are clear, however execution is not always clear. This means that tasks are completed differently and that functioning of either the RRU chairman or RRU managers is not equally judged. This is seen as a task for the organization, especially the DT. This is supported by another point of attention mentioned by the RRU managers; the DT should be more strict in following up targets. Not only the targets as a result of cut down in expenses but the targets agreed upon by the RRU in general. As it is experienced as an unequal evaluation of performances, it might cause inappropriate behaviour in terms of budgetary slack.

6.2.4 SUPPORTIVE MANAGEMENT

The supportive management group consists of members from quality, concern control and RRU control. These items are processed together in this paragraph results however, are presented separately in Appendix XII until XIV.

In the next paragraphs, participation, budgeting process, efficient care and RRU model are described respectively. The last paragraph contains a discussion about the results from these four items.

6.2.4.1 Participation

All interviewees within the supportive management group, mention the positive effect from the cognitive mechanisms: organizational control. Primarily, it is seen as a necessary requirement of the RRU model because you make the RRU responsible for its results. If you make them responsible, it is necessary that they participate and discuss about how to spend money. Another positive effect, primarily mentioned by quality, is increased information sharing and communication. As mentioned by one of the interviewees from quality, this is probably because discussions about content differ. Quality has knowledge about organizing the quality system and specialists have knowledge about the content, whereas control has knowledge about organizing the financial system *and* the content.

There was no consistent view about negative effects of participation but the cognitive mechanisms, information asymmetry resulting in budgetary slack and lack of knowledge where mentioned by all organs. Interesting is the different view at the RRU manager and RRU chairman about building slack into their budgets. Two interviewees from RRU Control mention that RRU chairman will probably try to build slack into the production budget, whereas the RRU manager will probably try to build in slack in terms of personnel.

Lack of knowledge is seen from either the perspective of managerial knowledge, but also about historical boundaries. It is mentioned that this either has to do with new skills the organization demands from RRU chairman and on the other hand the lack of education for these skills. The

solution mentioned is from the cognitive perspective. Providing pre – decisions information is seen as a solution by almost all interviewees. Perceptions about pre – decisions information derive from ‘advice’ to ‘advice and directive if necessary’. The last is primarily mentioned by quality. Control, both concern control and RRU control, only mention the role of advisor. It is said that if pre – decisions information is presented relatively simple, RRU chairman usually don’t have difficulties with understanding it.

A solution mentioned by all organs about the social mechanisms of participation is competence based trust. If there is no trust, the model will not function and there will be no discussion about the content. It is said that discussing about the content is necessary to create commitment and motivate, but also to execute plans.

Another negative effects mentioned, is the fact that participation is time consuming. Initially, a RRU chairman is a doctor and not a manager. This should be considered more often. RRU Control also mentions the lack of goal setting for RRU chairman, it is important that they are held responsible for those items they can influence, not for the items out of their scope.

6.2.4.2 Budgeting process

The moment of attending medical specialists should be earlier in the process, with earlier is sometimes mentioned before the presentation of letter for scope of plans and sometimes right after the presentation of letter for scope of plans. A weak point in the budgeting process is the lack of relationship with the year plan. It is mentioned that the year plan should be leading for the budgeting process. In the current situation, a vision at the future and accompanied strategic plans are not translated to the annual plans and budgets. Overall, the year plan should meet certain requirements and the DT should put more effort in checking and judging these plans.

Splitting up targets was another point related to the budgeting process that was extensively discussed. This resulted in a diffuse perception about ‘ownership’ of the target. Opinions varied from ‘central determination’ to ‘putting it back to the Director of Operations or RRU chairman’. All organs mention the importance of freedom to choose the required resources and input from supportive management for making a detailed plan for splitting the targets.

Finally, a solution for target setting that is mentioned by quality and concern control is the usage of cost prices or benchmarks. If this is to be used it is important to determine how and what for, to use the benchmark (e.g. strict norm, guide etc.).

6.2.4.3 Efficient Care

Discussions about future plans and future strategy resulted in a view about collaboration between RRU’s. Efficient care is not expected to appear in feeders and bleeders per health care product, but efficient care is expected to be an effect of a collaboration strategy. Supportive management points out how important it is that the hospital organizes clear rules of the game. This is seen as necessary for the current strategy as well, for example, it is uncertain what ‘complex surgery’ means. If the rules of the game are understood by the supportive organs, it is said that a better discussion with the RRU manager and RRU chairman can be held.

6.2.4.4 RRU model

Almost all interviewees mentioned dual management and the separation of tasks between the RRU chairman and RRU manager. The RRU chairman is seen as the medical leader of the RRU and the RRU manager is seen as the managerial leader of the RRU. Tasks for the RRU chairman with regard to the budgeting process are input about quantities (patients, production, etc.) and quality aspects. The RRU managers responsibility is to explain consequences of targets and agreements and (together with the RRU controller) make the detailed budget.

The interest in the RRU Chairman function is seen as a risk for the RRU model. It is recognized that not all RRU chairman are equally interested. This results in less motivation and less input for e.g. the budgeting process.

Another risk mentioned are the competences of RRU manager. Even though there are big differences, explaining cause – effect relationships and being a leader of the RRU is seen as minimal required competence of the RRU manager to be a discussion partner for the RRU chairman. It is mentioned that not all RRU managers fit to these competences.

6.2.4.5 Discussion

All interviewees within the supportive management group, mention the positive effect of the cognitive mechanism; organizational control. It is interesting to know why hardly any of the motivational mechanisms are mentioned. Perhaps this has to do with experiences about time medical specialists want to spend on managerial and quality issues, because ‘time consuming’ is mentioned as a negative effect of participation. Besides, participation is seen as a consequence of the organizational model chosen this is neither a positive, nor a negative mechanism.

There was no consistent view about negative effects of participation but again the cognitive mechanisms, information asymmetry resulting in budgetary slack and lack of knowledge where mentioned by all organs. Both mechanisms have a common feature ‘information’, supportive organs are expected to be in superior position with regard to information. As a consequence, it might that lack of knowledge by other parties involved is mentioned.

Providing pre – decisions information is seen as a solution by almost all interviewees. Because perceptions about pre – decision information differ, it is important to determine what pre – decision information is. If pre – decision information has to be provided, it should be clear for the respondents what to expect, from whom to expect etc.. If this is not clear, own perceptions will determine what is required and decisions are made based upon different information sources. This can lead to unintended misrepresentation of information.

It is expected that medical specialists should attend earlier in the budgeting process. What earlier means, differs. The essence is that it is felt that information about strategic plans come too late in the process. This is supported by the statements about the year plan; there is lack of relationship between the year plan and budget. Based upon theory, the budget is a short term strategic plan, therefore, the relationship should be built to avoid mismatches between long term strategy and short term plans.

Splitting up targets was another point related to the budgeting process extensively discussed but resulted in a diffuse perception about ‘ownership’ of the target. This is probably because on the

one hand responsibility is felt to deliver input for targets, but on the other hand the supportive organs are not allowed to act upon responsibility for the targets. From this point of view, the organization should make clear who is responsible for the targets and what is expected from the supportive organs.

Collaboration is also seen by supportive organs as a way to create efficient care. Their major concern is that the organization is not clear about strategic plans. As mentioned, it is important that the hospital organizes clear rules of the game. Especially strategic decisions in medical terms are to be explained towards management and supportive organs so they do understand what is meant (e.g. 'complex' surgery).

Almost all interviewees mentioned dual management and the separation of tasks between the RRU chairman and RRU manager. There is a consistent view about tasks to be completed, however, competences are a primary concern. More specific, not all RRU Chairman are equally interested in their function, this is seen as a risk since this results in less motivation and less input for e.g. the budgeting process. It is questionable if only by creating competences motivation and interest will increase.

The competences of the RRU manager are questioned as well, it should be considered to what extent this has to do with knowledge and competences of the RRU manager or the role of supportive organs. A clear understanding of tasks and responsibilities for each party is a necessary requirement in order to judge this topic objectively.

6.3 CONCLUSIONS

In this paragraph sub questions formulated in section two are answered.

How does top management see participation by medical specialists?

Top management perceives participation as a positive mechanism, primarily from a cognitive viewpoint. Opposing and conflicting interests are seen as a threat for a participative approach, especially in future where collaboration is expected to be the opportunity for efficient care. To overcome this situation, giving guarantees (in terms of income) is seen as most beneficiary. Specific for the budgeting process is the attention for strategic plans and related decisions before summer. Furthermore, a boundary condition mentioned for the RRU model is specific attention towards developing competences for the RRU chairman function and their performances.

How do medical specialists see participation?

Medical specialists perceive participation as a positive mechanisms, especially since it creates organizational control. It is probably felt that they are dependent upon management as they require trust and discussions based upon content. The role of the organization is determining for participation as they require clear competences, a coaching and directive role from the directors of operations and a better understanding of their interests. The essence is that it is felt that the organization is against them, and that the organization takes away as much as possible. This feeling of 'taking away' rather than 'giving', results in opposite behaviour for example resistance to centralizing.

From this perspective, RRU Chairman would like to have the responsibility for splitting up targets in the budgeting process. Besides, a stronger relation between the budget and strategic plans via the year plan is demanded.

Finally, collaboration in diverse forms is seen as a way to create efficient care. Input can be delivered, however, it is seen that none of this would come to a plan as production is the incentive for honorarium.

How does RRU management see participation by medical specialists?

RRU management is somewhat sceptical about participation. They do recognise positive effects of participation but are sceptical about how the organization organizes participation. This is probably because they are at the front line of discussions of either medical issues or managerial issues. The key message from RRU managers is that the organization should put in more effort to follow and judge plans and targets and be more strict and consistent in terms of consequences for not achieving results agreed upon. Besides, practical issues are mentioned for the budgeting process, this would enforce involvement of medical specialists.

How does supportive management see participation by medical specialists?

Supportive management primarily see participation as a consequence of the chosen organizational strategy. Benefits are seen, but in general they are concerned about the competences and knowledge for both the RRU manager and RRU chairman in order to fulfil the function. With regard to the budgeting process it is mentioned that there should be a stronger relation to the year plan and according strategy, this requires earlier participation of medical specialists. An opportunity mentioned for efficient care is collaboration, but in terms of strategy, supportive organs demand an explanation about strategic choices in order to be able to be a good discussion partner for the RRU chairman and RRU manager.

7 SECTION THREE: COMPARISON & DISCUSSION

In this section an answer is given to the sub questions from section three. Before these answers are given a short review on the research process is done followed by discussing the result on each of the four topics. In the last paragraph answers are given to the research questions formulated in section three.

7.1 REVIEW OF RESEARCH PROCESS

As the demand for efficient care increases, the Dutch government introduced plans to change the health care system. Upcoming changes in 2015 determine a change in the relationship between medical specialists and the hospital. In order to control costs of care, efficient care is the focus in the future. Isala wants to know whether or not medical specialists can participate in the budgeting process. The budgeting process has a time span of one year, which is equal to current time span of agreements with insurance companies.

The essence is to know whether or not medical specialists can give input about efficient care in the budgeting process. In order to collect data, interviews were held with participants from various units within Isala. Before interviews were conducted, literature on participation is sought, to know what outcomes can be expected as well as to check the outcomes afterwards.

7.2 PARTICIPATION

In this paragraph a discussion and comparison with theory is done on participation. This is done based upon results from all participants on the topic of participation. Participation is one of four topics determined for this research.

The primarily positive and negative effects related to the cognitive mechanisms are mentioned as well as solutions to overcome these effects. Probably, because the cognitive mechanisms is seen as the economic reason of participation (Shields & Shields 1998), it was easier for the participants to recognise these effects. It is expected that participants were more aimed at 'business like' answers rather than psychological answers. This might also be the reason why hardly any of the positive effects from the motivational and social mechanism are mentioned.

From negative effects however, not only cognitive mechanisms were mentioned. From a motivational perspective, lack of goal setting is mentioned most often. It is not certain whether or not this has a relationship with the personality characteristic 'interest in chairman function', but it might be caused by lack of goal setting as well. Therefore it is important that goals are set by RRU Chairman or at least with their influence.

The primary solution for overcoming the negative cognitive effect is: provide pre – decision information. The essence of pre – decision information is recognised, however it is not certain what is meant by all participants with pre – decision information. Another cognitive solution mentioned is that the risk aversion of the subordinate is to be known. This is mentioned in the context of decisions that might have a negative impact at income. In this case, giving guarantees (and therefore reducing the risk of loss of income), can increase commitment to decisions. It is mentioned that this is not a task for the organization but for the collective. Probably the best way to organize these difficult decisions, is that the collective discusses about the distribution of honorarium, whereas the organization is primarily focused at organizing care.

The most interesting solution mentioned is competence based trust. Competence based trust is seen as a solution towards the feeling of dependence. However, this is hardly mentioned in any of the interviews. It is expected that this either has to do with personality characteristics, that people do not want to admit that they are dependent upon (top) management. But on the other hand they do not relate a discussion about the content to increased independence but as a way to clarify plans.

Items not mentioned in theory are opposing or conflicting interests, time consuming and practical issues for execution are mentioned. Because opposing or conflicting interests are mentioned so often, additional literature is sought in order to know how this situation can be overcome.

As a respond to complex environments, many firms organize a multidivisional structure. The problem of coordinating and controlling these divisionalized firms have been topic of many studies. The complexity arises when there are opposed interests and interdependencies for example when decisions affect more than one divisions profit or when the total firm interest is different than the divisions interests and authority (relative to that of superiors) is used to set targets (Groves and Loeb 1979, Christie et al. 2003, Bouwens and Van Lent 2007)).

Overcoming the situation in which interdependency occurs might be done according to the research outcomes of Groves and Loeb (1979) whom consider economical means of control. As Groves and Loeb (1979) cite: *“As common inputs affect the profits of more than one division, some coordination is necessary in order for the firm to maximize profits”* (p224). From the same perspective; Abernethy, Bouwens and Van Lent (2004) refer to summary and non – summary items; summary items can be seen as input used by more than one division (common input). The non – summary items are items only for the account of one division. The non – summary items are those items only to be affected by the division involved.

Another solution is found by Bouwens and Van Lent (2007) whom consider the importance of accounting measures (e.g. return on investment, residual income or return on capital) as a response to authority and non – financial measures as a response to interdependencies.

It is interesting to recognize that some participants mentioned *‘The hospital should organize common goods, the RRU is only held responsible for those costs and revenues related to production’*. Basically, this means organizing summary items, for example operating rooms or nursing beds. From a more economical perspective, accounting measures are interesting as well since they determine cost efficiency. Perhaps other measures rather than revenue, for example, KPI’s (critical performance indicators) can serve this purpose as well.

Finally, the use of cost prices or benchmarks for setting targets is mentioned quite often however, none of RRU control mentioned this as a solution. This can be an effective tool for

overcoming information asymmetry (budgetary slack) however, the organization should put in more effort in good cost prices and right information that is provided for the benchmark.

7.3 BUDGETING PROCESS

In this paragraph a discussion is completed on the budgeting process. This is done based upon results from all participants on this topic. The budgeting process is one of four topics determined for this research.

7.3.1 Budgeting process 2013

The budgeting process 2013 is mentioned several times. Opinions differ from, a onetime solution to not motivating at all, and in a single occasion it was said that it is better than the previous budgeting process. It can be concluded that this process (Budget 2012 = Budget 2013, with some adaptations) is not a suited approach to continue in future.

7.3.2 Budgeting process

The budgeting process is analysed and discussed extensively, this resulted in eight items to adapt the bottom up budgeting system.

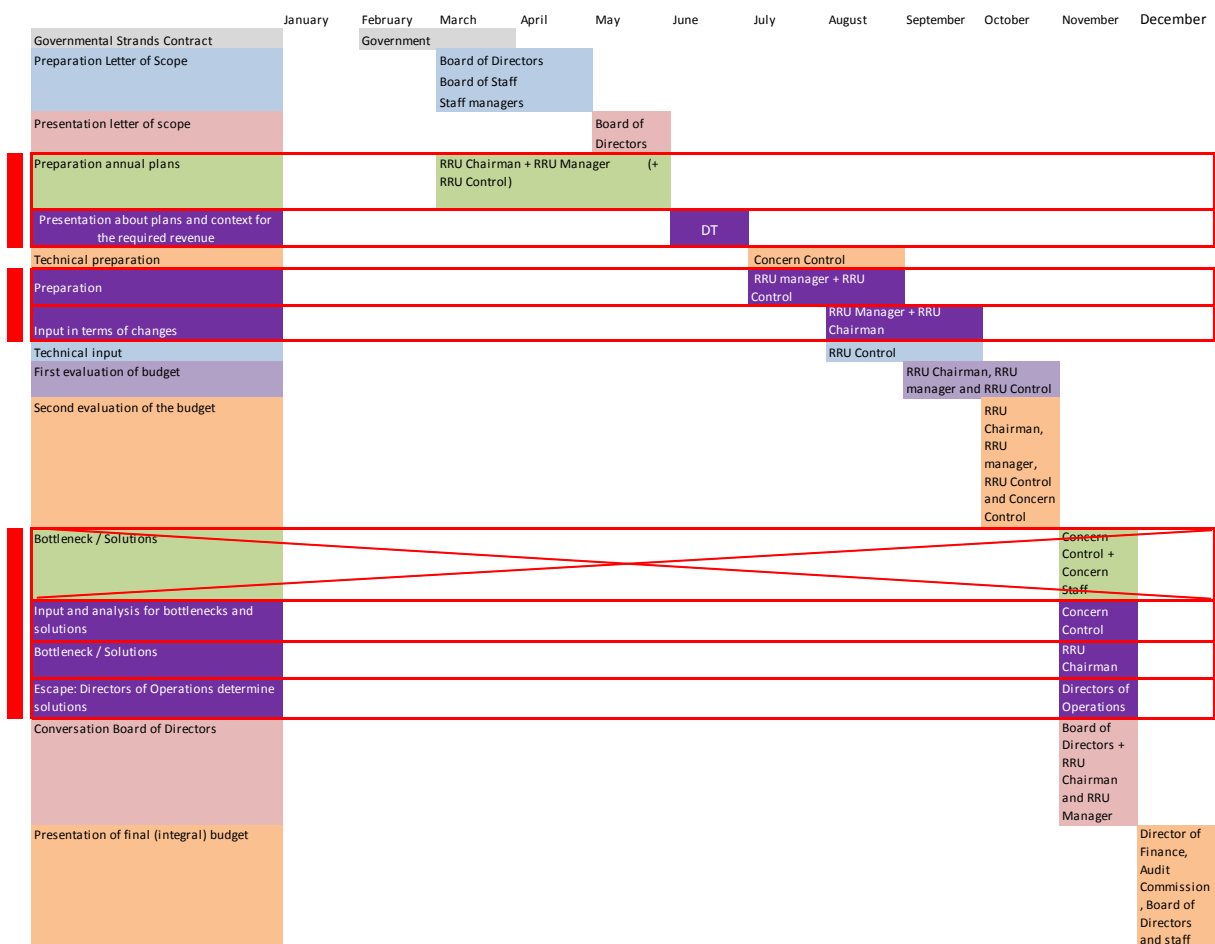


Figure H: Adapted Budgeting Process

First, it is said that the budgeting process should have a closer relationship with the year plan and strategic plans. It is mentioned that the year plans should be made before summer and preferably before the board of directors present the letter for scope of plans. If the letter is

presented, RRU's can match their year plan with these plans and from there on, make the budget.

Second, a joint meeting at the beginning of the budgeting process is seen as a way to inform about organizational plans and the required revenue for the coming year. It is desired that more explanation is given about why this revenue is required and what (financial) context the organization is in.

Then a preparation is made by the RRU controller and RRU manager in terms of deviations in the past year, realized production and upcoming changes from an organizational point of view.

Fourthly, input for the coming year, in terms of numbers of patients, production etc., should come from the RRU chairman. With this information, the RRU manager and RRU Controller make the budget. Hereafter, the RRU manager and RRU chairman discuss and evaluate outcomes, and special attention is put to the consequences of decisions and targets in the year plan.

A second evaluation with Concern Control will be done since the budgets from all RRU combined result in the budget for the hospital.

After the evaluations, it is highly likely that targets have to be set in order to achieve the required revenue. Splitting up these targets gained a lot of attention since, it was felt as a process out of their influence, vague, not transparent and not professional.

When targets have to be split up, almost everyone refers to the responsibility of the RRU chairman and that they should have the first opportunity to make a plan for splitting up targets. Concern Control should be in the lead for giving input for splitting up targets, this can be either a central or decentralized theme. The essence is that RRU chairman determine what the target is so this is felt as their responsibility. If they are not capable to come with a plan within a certain time span, the Direction Team should decide about the target. Specific attention in this phase has to be paid towards the project leader of the determined plan.

From there onwards no changes appear in the budgeting process. A formal moment is the conversation with the board of directors and the presentation of the budget by the director of finance.

7.4 EFFICIENT CARE

In this paragraph a discussion is done on efficient care. This is done based upon results from all participants on this topic. Efficient care is part of future strategy and is recognized as one of four topics determined for this research.

In general it is said that there should be more attention for strategy, not only for the strategy of the organization but also for RRU's. It is said that a clear strategy determines the existence of the hospital and this is not lacking at this point, but that a more active approach is required. It is seen that not all care provided today, can be provided in the future. Developments with regard to ZBC's (privately held treatment centre) and quality requirements (standards) forces to make choices for care to be provided.

It is seen that efficiency is the key focus in near future, methods for efficiency are seen in terms of collaboration. Collaboration is mentioned several times by several units. Basically, four ways of collaboration are mentioned for efficient care, these are illustrated in Figure I.

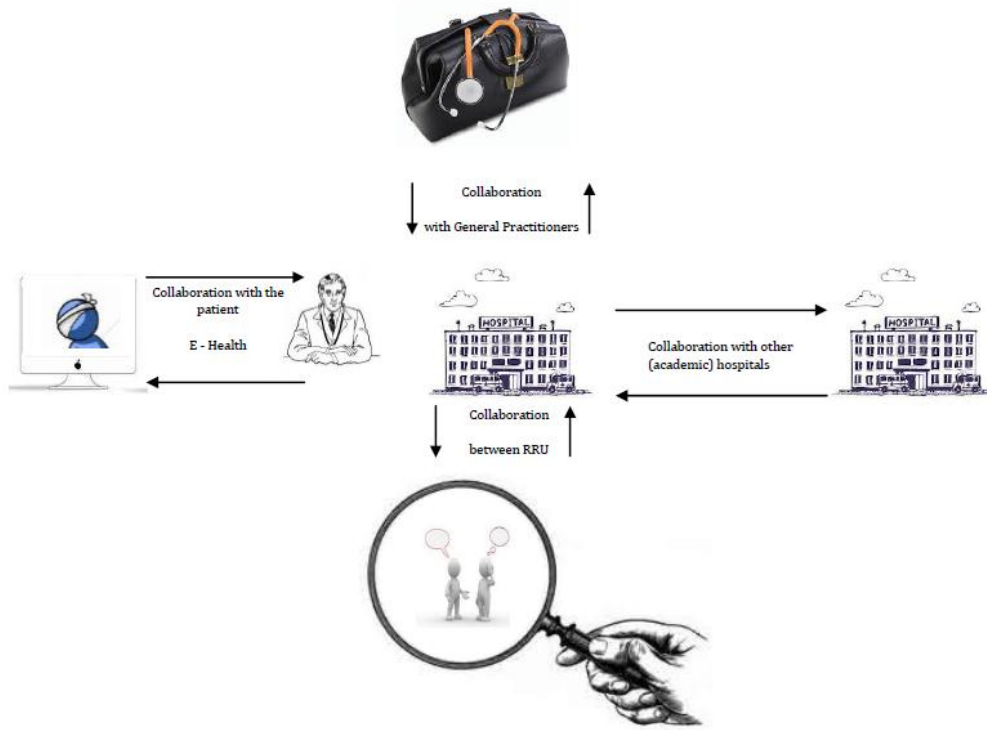


Figure I: Collaboration opportunities

From the figure above, it can be seen that collaboration with general practitioners is mentioned. There are different levels with regard to the collaboration with General Practitioners. Where some participants mention the development of service towards general practitioners to increase the stream of patients, others mention the delegation of tasks towards the general practitioners.

Second, collaboration with (academic) hospitals is seen as a way to gain knowledge from other hospitals for certain fields of expertise and on the other hand, be able to provide knowledge and skills to other hospitals.

Third, collaboration within the hospital, so between RRU's is recognized. It is mentioned that efficient care can be achieved via either a more efficient usage of common goods – collaborative usage – or via collaboration between specialisms, so care can be provided via the cheapest way.

Finally, collaboration or actually shifting care towards cheaper ways of providing care is e – health. In this case, for example a digital consultation is done, basically this is a form of collaboration with the patient.

7.5 RRU MODEL

In this paragraph a discussion is done on the RRU model. This is done based upon results from all participants on this topic. The RRU model is one of four topics determined for this research.

The perception about the roles within the RRU model are rather consistent; the RRU chairman is seen as the person for medical input and the RRU manager is in the position (it is not always mentioned as 'responsible') to organize and make sure the RRU chairman is able to execute his function as a doctor.

There are some items that are often mentioned with regard to the RRU model, for example the competences of RRU chairman and RRU managers, role of DT and consequences of results. The essence however, is that there is lack of clear boundary conditions for the RRU model as well as consequences for non-confirmative acts (behaviour, results, functioning etc.).

These boundary conditions have a relationship to the different layers of the RRU model, but also to the supportive organs. As mentioned, the competences of the RRU Chairman as well as the interest in the chairman function determine a lot about how the function of chairman is executed. Besides, the role of the DT is important, they are expected to be in the role of making 'integral conclusions', not only for the RRU but also between RRU's.

Additionally, it is mentioned that there should be more attention towards the differences between RRU's. These differences appear between big and small RRU's, supportive and primary specialisms but also based upon medical content (e.g. relevant KPI's). Especially this point is valid in terms of collaboration strategies since performance compared to for example other hospitals is determining for the success of collaboration.

7.6 CONCLUSION

In this paragraph answers are given to the sub questions formulated in the third section. These questions are a combination of two out of four items in the previous paragraphs (participation, RRU Model, Budgeting Process and Efficient Care) and an answer is formulated based upon the expected effects of both.

What is the relation between the RRU model and participation?

A primarily characteristic of the RRU model is that boundary conditions are lacking. This might be reason why negative effects of participation appear, for example lack of knowledge which can be related to the competences of RRU Chairman/ Manager. Besides, a weak point in the relationship between the RRU model and participation is regarded as an unclear understanding of pre - decision information. If the boundary conditions for pre - decision information are better formulated, participants know what to make or what to expect, a stronger relationship can be built.

What is the relation between the RRU Model and efficient care?

The RRU model might be at right angles to efficient care. Collaboration is seen as an opportunity to create efficient care. If the RRU Model is put in the light of collaboration it is seen that the Direction of Operations are in charge to recognise collaboration opportunities and be a coach in terms of enforcing these collaboration opportunities.

What is the relation between efficient care and participation?

As mentioned before, collaboration is seen as an opportunity for efficient care. From a participative approach, it is mentioned that opposing and conflicting interests appear. When relating efficient care to participation, opposing and conflicting interests are seen as a threat to collaboration. However, if the organization organizes common goods and gives guarantees (in terms of income) it is expected that a beneficiary relationship can be established.

What is the relation between efficient care and the budgeting process?

It is expected that medical specialists can give input for efficient care, therefore a strong relation can be sought via the budgeting process. In order to gain this input, results from the budgeting process determine an earlier attending in the budgeting process.

What is the relation between participation and the budgeting process?

Currently, the cognitive mechanisms from participation are seen with regard to the budgeting process. However, the motivational and social mechanisms of participation should gain more attention. The cognitive mechanisms are recognized by almost all participants, but hardly any of the positive, motivational or social mechanisms are mentioned. If more attention is paid towards achieving these positive mechanisms (through overcoming negative effects), increased motivation and increased commitment are to be expected.

What is the relation between the budgeting process and the RRU Model?

In general it is seen that there is a distinction between the role of the RRU Chairman and RRU manager in terms of tasks with regard to the budgeting process. Uncertainties appear with regard to the role of supportive organs, especially RRU Control. If boundary conditions are further elaborated on, expectations are better manageable.

8 ADVICE

In this chapter an answer to the main research question *'How can medical specialists participate in the budgeting process via the RRU model in order to have input for efficient care?'* is given. This is presented as an advice for Isala. This advice is specifically aimed at top management who is in the position to start with putting these advices under attention.

Isala can receive input for efficient care by participation of medical specialists if attention is paid towards four items that determine participation and its context:

- **Participation:** more directive attention towards positive effects of participation and overcoming negative effects of participation and a determination of pre – decision information.
- **Budgeting Process:** an earlier attending in the budgeting process by medical specialists and clear determination of roles in the budgeting process.
- **Efficient Care:** further developing and determination of collaboration opportunities, use input from medical specialists for collaboration plans.
- **RRU Model:** the organization puts effort in developing and maintaining sharper formulated boundary conditions with specific attention for the role of the DT towards the organization.

These four items are further discussed in the next paragraphs.

8.1 DIRECTIVE ATTENTION FOR EFFECTS OF A PARTICIPATIVE APPROACH AND DETERMINATION OF PRE – DECISION INFORMATION

In many occasions, only few positive effects of participation are mentioned but a lot of negative effects of participation are mentioned. It is argued that the positive effects of participation are underestimated as well as the appearance of negative effects. Therefore the organization should put more attention in overcoming negative effects, e.g. lack of goal setting, and on the other hand pay more attention towards the positive effects of participation for example commitment to plans and increased motivation. Specific attention should be paid towards 'giving guarantees', as this is not only related to short term plans but also to long term plans from the organization.

It is important to recognize that a lot of negative effects are mentioned, this might reveal appearance of these effects. Therefore specific attention should be paid to the solutions to overcome these negative effects. One of these solutions mentioned is providing pre – decision information. This solution specifically gets attention since one of the requirements from RRU managers and RRU chairman was that supportive organs should better facilitate them with information.

Another important aspect is 'giving guarantees'. As mentioned this is not only seen in light of short term effects of participation, but on the long term with regard to collaboration as well. It is specifically mentioned that the collective has an active role in giving these guarantees (in terms of income). The organization should therefore not underestimate the role of the collective, as well as the time they require to develop their plans for giving the certainties in terms of income.

This advice is rather open and not action related because primarily limitative conditions are described in the advice. Besides, it has to do with a distinction that has to be made for short term plans and long term plans. The organization (DT) should decide how a participative approach would look like in the future (what do you expect from whom?). In order to come to these long term plans, gradual steps on the short and medium term are to be implemented. To illustrate this: if competences or RRU chairman (knowledge) are point of attention, it first should be determined what competences are required in the future before developing plans to improve competences. The plans are a consequence of the chosen competence, not vice versa.

8.2 EARLIER ATTENDING IN THE BUDGETING PROCESS AND DISTINCTION OF ROLES IN BUDGETING PROCESS

In chapter seven, based upon information gathered from interviews, a new budgeting process was designed (Figure H : Adapted budgeting process). Eight steps were recognised to change the budgeting process. The essence of these eight steps is an earlier attending from medical specialists in the budgeting process. This is derived from the fact that the wish emerged to have a stronger connection with the strategy via the year plan. Requirements for the year plan should be developed in order to create the link with the strategy and also the budgeting process. Besides an earlier attending in the budgeting process, it was required that roles and tasks in the budgeting process are more clear. In the explanation given in paragraph 7.3.2 this is further elaborated on.

This advice is practical and can easily be overseen however, it should not be underestimated that changing roles or tasks requires good communication. Especially since pre – decision information is found as a weak point in a participative setting. Therefore it is even more important that everyone is aware of the roles and tasks (responsibilities) associated with providing pre – decision information.

Equally important, this budgeting process should not be seen as a fixed solution for currently experienced ‘problems’. This budgeting process can rather be seen as the best fitted solution in the current organizational model and in the current contextual environment. If changes appear in this environment, for example elaboration of collaboration strategies or centralizing common goods, it might require a different budgeting process.

Besides, a specific point in this budgeting process that can lead to problems is splitting up targets by medical specialists. On the one hand it might appear that this is more difficult to them than expected, but on the other hand, their own interests might be still superior to others if revenue is rewarded. Discussions about the targets might result in indecisiveness. The last is to be controlled by the ‘escape – moment’, until a certain date RRU Chairman have the opportunity to come with a plan, if they do not have a solution, this is shifted towards higher authoritarians.

8.3 ELABORATION OF COLLABORATION OPPORTUNITIES WITH INPUT FROM MEDICAL SPECIALISTS

Efficient care in the future is seen in terms of collaboration, analysis from interviews resulted in four opportunities for collaboration. These are illustrated in the previous chapter; ‘Figure I: Collaboration opportunities’ in paragraph 7.4.

As can be seen, there are four forms of collaboration possible. For the organization it is important that a strategy with regard to the various forms of collaboration is further elaborated on. Important is that input for which way to go, should come from medical specialists. This might be seen as impossible, but as they see it, the role of the director of operations is: 'to connect hospital wide ideas'. Therefore, initially the input derives from the meetings the RRU chairman has with the director of operations. From there on, it is the role of the organization to enforce and further elaborate plans.

Whereas collaboration is associated with decline in income, this relationship does not hold for all forms of collaboration. An active, short term approach from the organization might be to pay attention e.g. more availability of required resources (marketing, sales, etc.) towards the forms of collaboration that do not have much impact at income. Still, it is the responsibility of the RRU to come with these plans.

Collaboration on the long term might result in a decline in income and therefore it is important that guarantees are given (in terms of income) so these collaborations are established. As mentioned before, the organization should therefore hold a strong and close relationship with the collective so there is enough time to adapt to changes.

The role of the collective might be sought in an earlier stage for determining other incentives than production. A trail might be put in place in order to see if other incentives serve the purpose for distribution of honorarium as well.

This advice describes the development of a strong relationship between RRU and top management. Especially since this is a description of a long term relationship, it is important that consequences for medicals specialists, and not only for income but also in terms of e.g. research opportunities, are not underestimated and openly communicated to them.

8.4 BOUNDARY CONDITIONS AND THE ROLE OF THE DT

The essence of results from interviews was that there are uncertainties of either the boundary conditions as well as the consequences of not acting upon these boundary conditions.

Even though boundary conditions might be seen as obvious and clear, the results from interviews reveal that not that much was obvious and clear. This sheds a light at on the one hand the role of the direction team whom are in the position to develop and maintain these boundary conditions, but on the other hand the people whom are experiencing negative effects due to lack of these boundary conditions. If the direction team does not receive messages that there are uncertainties with regard to competences, tasks etc., the organization cannot act upon this.

It must be said that the questionnaire evaluating the implementation of the new top structure, resulted in comparative items as well. However, if this research and the questionnaire were not held, these issues might not have received attention.

Therefore, it is the responsibility of the direction team to develop these boundary conditions, but the other organs' responsibility to deliver input for these boundary conditions.

A logical question now would be: what are the boundary conditions and where to start? From results from interviews it became apparent that there are a few items that are mentioned often, however, since they are not actively questioned during the interviews, it does not represent the scope of boundary conditions that require clarification. Therefore, additional research is necessary.

8.5 RECOMMENDATIONS FOR FURTHER RESEARCH

After this research, questions still remain.

First, from a theoretical perspective it is interesting to know why competence based trust and discussion about the content is not related to the feeling of dependence in this research. It appeared to be a solution for clarifying plans rather than the personality characteristic of 'being dependent'. Further research might explain if this is caused by not revealing dependence by participants or a wrong estimation of the researcher about competence based trust.

Besides it becomes important to know how the strategy of the hospital should fit the strategy of the RRU. Whereas it is mentioned that input for strategy should come from medical specialists, this might create difficulties in designing the organizations strategy. Perhaps a highlighted strategy e.g. 'we want to collaborate', will be sufficient, nevertheless, this has to be investigated.

Another important aspect is the incentives rewarded. Not only in the current system but also with regard to the future. Quite often it is mentioned that production should no longer be rewarded, but none could give an answer about what to use instead. Currently it is seen as the best suited method. However, this does not leave opportunities open for further research. Incentives in terms of ROI, EVA or other economic measures, as well as KPI's, might work as well.

And finally, as mentioned in the previous paragraph, a further understanding of the boundary conditions is required in order to know where to start and where to pay attention.

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APPENDICES

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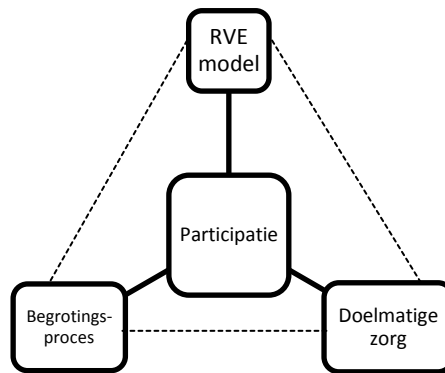
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APPENDIX I – DUTCH SUMMARY

Het doel van dit onderzoek is Isala voorzien van kennis over participatie van medisch specialisten in het begrotingsproces om input te krijgen voor doelmatige zorg. Dit doel komt naar voren door aankomende veranderingen in de gezondheidszorg met betrekking tot het inkomen van medisch specialisten. De verwachting is dat medisch specialisten input kunnen geven voor doelmatige zorg. Deze input is van belang voor het begrotingsproces omdat de begroting momenteel dezelfde tijdsduur heeft als de resultaten van de onderhandelingen met zorgverzekeraars. De volgende hoofdvraag is geformuleerd:

Hoe kunnen medisch specialisten participeren, via het RVE – model, in het begrotingsproces om input voor doelmatige zorg te leveren?

In deze studie zijn drie items erkend als de context van participatie: het begrotingsproces, doelmatige zorg en het RVE – model.



Om de hoofdvraag te kunnen beantwoorden, zijn er drie secties opgesteld met daarin sub vragen. De eerste sectie houdt in dat er theoretische informatie wordt verzameld door middel van literatuuronderzoek. De tweede sectie houdt de data verzameling in, dat wordt gedaan door middel van interviews en in de derde sectie houdt een discussie en vergelijking met de theorie in. De uitkomsten van deze drie secties resulteren in een advies.

Begrotingssystemen zijn een onderdeel van controle op financiële resultaten, de begroting heeft betrekking op het korte termijn, financiële plan. Participatie is een process waarbij een groep of een individu betrokken is bij, en invloed heeft, in dit geval de bepaling van de begroting. Er zijn drie mechanismen die participatie illustreren: cognitief, motivatie en sociaal. In de onderstaande tabel zijn de positieve effecten, negatieve effecten en oplossingen samengevat.

	Cognitief	Motivatie	Sociaal
Positief	Toename van het delen van informatie en communicatie. Reduceren van onzekerheden. Toename van (organisatorische) controle.	Toename in productiviteit.	Verbinding met plannen.
Negatief	Informatie ongelijkheid. Gebrek aan kennis.	Gebrek aan het stellen van eigen doelen. Programmeerbare doelen.	Afhankelijkheid van hogere autoriteit.
Oplossing	Ken de risico voorkeur (reducereer onzekerheden/ geef garanties) Geef informatie vooraf aan de beslissing.	Doelen stellen door hogere autoriteit. Bewust doelen stellen.	Vertrouwen gebaseerd op inhoudelijk vertrouwen (competenties).

Vier units worden herkend als de kern van de organisatie: top management, RVE voorzitters, RVE managers en Ondersteunend management. Deze vier units zijn gebruikt voor de data verzameling. Van al deze units zijn opvattingen en meningen gevraagd over vier onderdelen: participatie, begrotingsproces, doelmatige zorg en het RVE model.

In vergelijking met de theorie zijn veel cognitieve items genoemd door de deelnemers. Er zijn haast geen positieve effecten genoemd van sociale en motivatie mechanismen. Het negatieve effect van motivatie maar ook de oplossing voor het sociale mechanisme is daarentegen wel genoemd. Daarnaast was er specifiek aandacht voor tegenovergestelde en conflicterende belangen. Dit was vaak genoemd, maar wordt niet in de theorie genoemd als een effect van participatie. Een oplossing om dit negatieve effect te reduceren is het organiseren van gemeenschappelijke goederen of het implementeren van andere, economische evaluatie methoden (bijv. ROI).

Het begrotingsproces is aangepast naar aanleiding van de resultaten van de interviews. In totaal zijn er acht aanpassingen gedaan. De essentie is dat medisch specialisten eerder in het proces betrokken zijn, maar ook meer verantwoordelijkheid krijgen voor het verdelen van taakstellingen.

Samenwerking wordt gezien als een manier om doelmatige zorg te effectueren. Er wordt verschil gemaakt tussen vier verschillende mogelijkheden voor samenwerking. De eerste is samenwerking met huisartsen, de tweede is samenwerking met andere ziekenhuizen, ten derde samenwerking tussen RVE's en tot slot samenwerking met de patiënt (bijv. e-health).

Het laatste onderdeel dat besproken is, is het RVE model. Er zijn veel onderwerpen genoemd die de randvoorwaarden van het RVE model weergeven (bijv. rollen, competenties, etc.) De rol van het directie team in relatie tot de RVE kreeg specifiek aandacht. Ontwikkeling en handhaving van de randvoorwaarden wordt gezien als een belangrijke taak voor hen.

De resultaten van de drie secties gecombineerd, resulteert in een antwoord op de hoofdvraag door middel van een advies voor de onderstaande vier punten.

Participatie: meer directe aandacht voor positieve effecten, het voorkomen van negatieve effecten en een scherpe bepaling van informatie die vooraf aan beslissingen wordt gegeven.

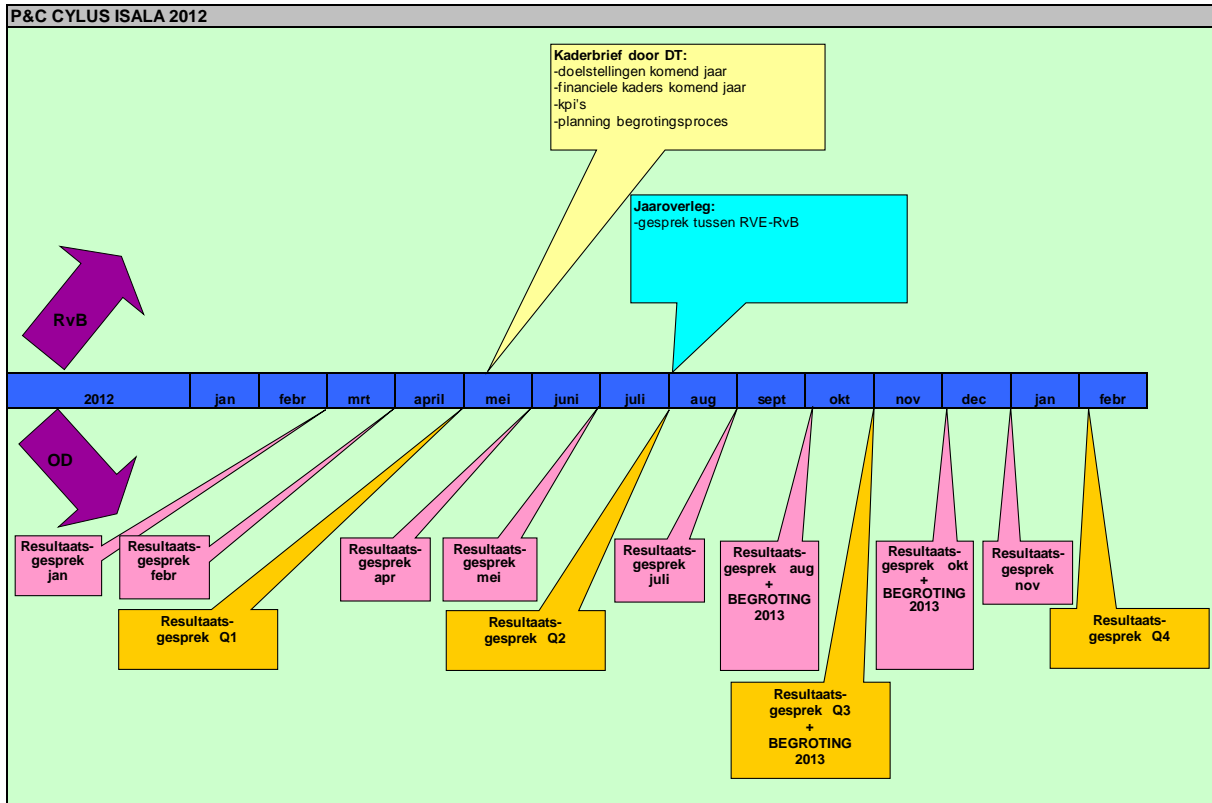
Begrotingsproces: een eerdere betrokkenheid van medisch specialisten in het begrotingsproces en een heldere formulering van rollen in het begrotingsproces.

Doelmatige zorg: verder ontwikkelen en bepalen van samenwerkingsmogelijkheden, maak daarbij gebruik van de input van medisch specialisten.

RVE model: de organisatie moet zich inspannen de randvoorwaarden verder te ontwikkelen en te behouden met daarbij specifiek aandacht voor de rol van het directieteam.

Zoals te zien is in het figuur op de vorige pagina, houden de vier bovenstaande items verband. Daarom zal succes alleen bereikt worden als aan al deze vier punten aandacht wordt gegeven.

APPENDIX II – PLANNING & CONTROL CYCLUS ISALA 2012



Adapted from (internal document): Planning & Control Cyclus Isala 2012

Each colour represents a different setting for the interview about financial developments and Critical Performance Indicators.

In the table below an overview is given about the persons attending the different interviews.

	Raad van Bestuur	Directeur Operations	RVE management	RVE Voorzitter	RVE control	Concern Control
Maandgesprek	-	X	X	X	X	-
Kwartaalgesprek	-	X	X	X	X	X
Jaargesprek	X	X	X	X	-	-

APPENDIX III – TYPES OF RESEARCH
QUESTION, QUALITATIVE DESIGNS, AND
ILLUSTRATIVE TEST INTERPRETATION (TI)
EXAMPLES

TABLE 1: Types of Research Questions, Qualitative Designs, and Illustrative Test Interpretation (TI) Examples

<i>Type of Research Question</i>	<i>Qualitative Design</i>	<i>Illustration of Questions Within TI Context</i>
Chronological/story-oriented questions: Questions about the life experiences of an individual and how they unfold over time	Narrative research	What stories does a client tell us about the TI process?
In-depth, descriptive questions: Questions about developing an in-depth understanding about how different cases provide insight into an issue or a unique case	Case study	How do four counselors share problem-focused or potentially “hard-to-hear” test results with clients?
Process questions: Questions about experiences over time or changes that have stages and phases	Grounded theory	What theory best explains the therapeutic effects of TI?
Essence questions: Questions about what is at the essence that all persons experience about a phenomenon	Phenomenology	What does <i>timing</i> mean to counselors who regularly share test results with clients?
Community action questions: Questions about how changes occur in a community	Participatory action research	How do community mental health centers better optimize their use of psychological tests in day-to-day practice?

SOURCE: Adapted from Morse and Field (1995, p. 25).

NOTE: TI = test interpretation.

Source: Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five traditions* (2nd Ed). Thousand Oaks, CA: Sage.

APPENDIX IV - TYPES OF EVIDENCE

Source of Evidence	Strengths	Weaknesses
Documentation	<ul style="list-style-type: none"> • stable - repeated review • unobtrusive - exist prior to case study • exact - names etc. • broad coverage - extended time span 	<ul style="list-style-type: none"> • retrievability - difficult • biased selectivity • reporting bias - reflects author bias • access - may be blocked
Archival Records	<ul style="list-style-type: none"> • Same as above • precise and quantitative 	<ul style="list-style-type: none"> • Same as above • privacy might inhibit access
Interviews	<ul style="list-style-type: none"> • targeted - focuses on case study topic • insightful - provides perceived causal inferences 	<ul style="list-style-type: none"> • bias due to poor questions • response bias • incomplete recollection • reflexivity - interviewee expresses what interviewer wants to hear
Direct Observation	<ul style="list-style-type: none"> • reality - covers events in real time • contextual - covers event context 	<ul style="list-style-type: none"> • time-consuming • selectivity - might miss facts • reflexivity - observer's presence might cause change • cost - observers need time
Participant Observation	<ul style="list-style-type: none"> • Same as above • insightful into interpersonal behavior 	<ul style="list-style-type: none"> • Same as above • bias due to investigator's actions
Physical Artifacts	<ul style="list-style-type: none"> • insightful into cultural features • insightful into technical operations 	<ul style="list-style-type: none"> • selectivity • availability

Source: Yin, R. (1994). Case study research: Design and methods (2nd ed.). Thousand Oaks, CA: Sage Publishing. P 80

APPENDIX V – ASSOCIATIVE WORDS

Budgetary slack

Budgeting process

Information asymmetry

Negative effects of participation

Negative effects of participation

Overcoming budgetary slack

Overcoming negative effects of participation

Participation

Participation and budgets

Participation and motivation

Participative approach

Participative goal setting

Participative management

Planning and control cycle

Positive effects of participation

Reducing budgetary slack

Reducing information asymmetry

Target setting and participation

APPENDIX VI – INTERVIEW SCHEDULE

Interviewschema

ALGEMEEN

Functie:

Datum:

Geplande tijd:

Starttijd:

Eindtijd:

Duur:

PRAKTISCH

- Geluidsopname (gewist na transcriptie)
 - Y/ N
- Data verzameling voor masterthesis
- Aangeven duur interview
- Open vragen
- Publicatie
 - Tijdens dit interview maak ik aantekeningen, deze worden zo snel mogelijk na het interview digitaal uitgewerkt.
 - Alle namen die worden genoemd, evenals de naam van de geïnterviewde wordt **anoniem** gehouden (niet in transcriptie).
- Publieke versie
 - In de publieke versie worden geen uitgeschreven interviews getoond. Dit zal wel het geval zijn in de vertrouwelijke versie.
- Validatie
 - Nadat alle interviews zijn afgenomen, zal u gevraagd worden de uitwerking te beoordelen. Op deze manier wordt een zo getrouw mogelijk beeld van het interview weergegeven.

INTRODUCTIE

Ik ben Suzan, werkzaam binnen Concern Control en daarnaast student aan de Universiteit Twente. Daar studeer ik bedrijfskunde in de richting van financieel management en ben bezig met het schrijven van mijn scriptie. Voor de dataverzameling maak ik gebruik van interviews waarvoor ik u uitgenodigd heb. Er is een selecte groep personen gekozen voor het afnemen van de interviews. De reden hiervoor is dat er op deze manier zoveel mogelijk diversiteit binnen de respons is. Zo verschillen de respondenten bijvoorbeeld in de rol die zij hebben of zijn er duidelijke verschillen in omzetomvang van het specialisme dat zij vertegenwoordigen. De reden waarvoor u bent geselecteerd is Ik zou u dan ook willen vragen zoveel mogelijk vanuit deze rol de vragen te beantwoorden.

Het onderwerp van mijn scriptie is 'deelname van medisch specialisten in het begrotingsproces'. Het RVE – model dat enkele jaren geleden is geïmplementeerd, is hiertoe een eerste aanzet. De reden voor het implementeren van het RVE model is de verandering van de zorg. De marktwerking zorgt voor een meer resultaatgerichte organisatie zowel op financiën als kwaliteit, met als doel efficiënte zorg. Met de aankomende veranderingen voor de beloningsstructuur van medisch specialisten wil Isala een sterkere verbinding aangaan met haar medisch specialisten. Dit onderzoek is erop gericht om te kijken in hoeverre medisch specialisten input kunnen leveren voor efficiënte zorg, specifiek gericht op het begrotingsproces.

De resultaten en informatie uit het onderzoek zullen dienen als input voor het begrotingsproces 2014.

DEFINITIES

- **Deelname/ participatie**
"met participatie wordt bedoeld het proces waarbij een individu betrokken is en invloed heeft op, in dit geval, de begroting en begrotingstargets.
 - **Begroting / begrotingstargets**
"Alle onderdelen van kwaliteit en financiën zoals deze in de begroting van de RVE terugkomen."
 - **Kwaliteit**
"De onderwerpen die onder kwaliteit kunnen vallen zijn bijvoorbeeld de inzet van extra onderhoud of extra personeel, kwaliteitsprogramma's en andere kwaliteitsaangelegenheden die in de begroting verwerkt (kunnen) worden."
 - **Financiën**
"De onderwerpen die binnen financiën vallen, hebben betrekking op zowel de opbrengsten- als kostenkant. Naast een omzetbegroting (productie), zijn ook de formatiebepaling en personele- en materiële kosten onderdeel van het financiële gedeelte van de begroting."
-

CHECK

Interviewer vraagt:

Heeft u een goed beeld van wat ik bedoel met participatie van medisch specialisten aan het begrotingsproces?

Antwoord:

START

- Wat vindt u ervan dat er meer dat medisch specialisten deelnemen (aan het begrotingsproces)?
-

AFSLUITING

Bedanken en aangeven wanneer wat te verwachten. Tot slot wordt hen de mogelijkheid geboden om publieke versie van mijn scriptie te ontvangen.

APPENDIX VII – LIST WITH ITEMS FROM LITERATURE

Positive effects of participation

Increase information sharing and communication
Reduce uncertainty
Reduce information asymmetry
Organizational control
Increased motivation (productivity)
Commitment to plans (attitude)

Mechanisms that create negative effects of participation

Information asymmetry (budgetary slack)
Lack of knowledge: managerial knowledge (finance & quality)
Lack of knowledge: historical boundaries
Goal setting is lacking
Programmable budgets
Personality traits (locus of control)/ feeling of independence

Solutions

Risk aversion of subordinate should be known/ reduce uncertainties/ guarantees
Provide pre-decision information
Targets should be set by higher authoritarians
Competence based trust: discuss about the content
Conscious' goal – setting

APPENDIX VIII – TABLE WITH RESULTS FROM INTERVIEWS

		Total
PARTICIPATION		
Positive effects of participation		
Increase information sharing and communication	x x x x x x x x x x x x x x x x	6
Reduce uncertainty		-
Reduce information asymmetry	x	1
Organizational control	x x x x x x x x x x x x x x x x	15
Increased motivation (productivity)		-
Commitment to plans (attitude)	x x x x x x x x x x x x x x x x	6
Mechanisms that create negative effects of participation		
Information asymmetry (budgetary slack)	x x x x x x x x x x x x x x x x	7
Lack of knowledge: managerial knowledge (finance & quality)	x x x x x x x x x x x x x x x x	9
Lack of knowledge: historical boundaries	x x x x x x x x x x x x x x x x	3
Goal setting is lacking	x x x x x x x x x x x x x x x x	5
Programmable budgets		1
Personality traits (locus of control)/ feeling of independence		1
Lack of commitment by other parties involved (no RRU Chairman or RRU manager)	x x x x x x x x x x x x x x x x	1
Opposing or conflicting interests	x x x x x x x x x x x x x x x x	8
Time consuming	x x x x x x x x x x x x x x x x	4
Practical issues for execution of plans	x x x x x x x x x x x x x x x x	5
Solutions		
Risk aversion of subordinate should be known/ reduce uncertainties/ guarantees	x x x x x x x x x x x x x x x x	5
Provide pre-decision information	x x x x x x x x x x x x x x x x	10
Targets should be set by higher authoritarians	x x x x x x x x x x x x x x x x	3
Competence based trust: discuss about the content	x x x x x x x x x x x x x x x x	7
Conscious' goal - setting	x x x x x x x x x x x x x x x x	2
Use of benchmarks or cost prices	x x x x x x x x x x x x x x x x	6
The hospital organizes common goods, the RRU is only responsible for those costs and revenues directly related to production.	x x x x x x x x x x x x x x x x	4
Make sure responsibility is taken	x x x x x x x x x x x x x x x x	1
BUDGETING PROCESS		
Budgeting process 2013	x x x x x x x x x x x x x x x x	5
Process for budgeting	x x x x x x x x x x x x x x x x	19
Splitting up targets	x x x x x x x x x x x x x x x x	12
Freedom for RRU to chose the required resources	x x x x x x x x x x x x x x x x	6
STRATEGY / EFFICIENT CARE		
Long term (strategic) plans	x x x x x x x x x x x x x x x x	13
Insurance companies	x x x x x x x x x x x x x x x x	3
(Consequences of) future strategy	x x x x x x x x x x x x x x x x	11
Specialists in employment	x x x x x x x x x x x x x x x x	4
Integral perspective (RRU and/ or staff should cooperate)	x x x x x x x x x x x x x x x x	6
RRU MODEL		
RRU - model		
Perception about 'doctor in charge'	x x x x x x x x x x x x x x x x	4
Dual management	x x x x x x x x x x x x x x x x	18
RRU Model in general	x x x x x x x x x x x x x x x x	11
Share in profits / rendementsdeling	x x x x x x x x x x x x x x x x	1
Generalizability among RRU's	x x x x x x x x x x x x x x x x	7
Personality characteristics; interest in RRU chairman function	x x x x x x x x x x x x x x x x	9
Knowledge/ competences of RRU manager	x x x x x x x x x x x x x x x x	13
Competences of RRU Chairman	x x x x x x x x x x x x x x x x	9
Role of RRU Chairman with regard to the venture	x x x x x x x x x x x x x x x x	7
Organisation		
Planning and control cycle in general	x x x x x x x x x x x x x x x x	5
Transparency (targets, between RRU's, etc.)	x x x x x x x x x x x x x x x x	6
Role of DT	x x x x x x x x x x x x x x x x	8
Role of Staff	x x x x x x x x x x x x x x x x	8
Collective	x x x x x x x x x x x x x x x x	3
Behaviour and/ or functioning chairman (consequences of)	x x x x x x x x x x x x x x x x	8
Results RRU (consequences of)	x x x x x x x x x x x x x x x x	7
Understand the interests and thoughts of medical specialists and vice versa.	x x x x x x x x x x x x x x x x	7
Effects and consequences of targets and decisions	x x x x x x x x x x x x x x x x	7
Rewards: reward for acting according to patients interest	x x x x x x x x x x x x x x x x	2
Rewards: do not (only) reward in monetary terms	x x x x x x x x x x x x x x x x	4
Rewards: reward for deviation from original target	x x x x x x x x x x x x x x x x	1
Old doctor' vs. 'New doctor'	x x x x x x x x x x x x x x x x	3

APPENDIX IX – RESULTS TOP MANAGEMENT

THIS APPENDIX IS NOT PART OF THE PUBLIC VERSION OF THIS THESIS

APPENDIX X – RESULTS RRU CHAIRMAN

THIS APPENDIX IS NOT PART OF THE PUBLIC VERSION OF THIS THESIS

APPENDIX XI – RESULTS RRU MANAGERS

THIS APPENDIX IS NOT PART OF THE PUBLIC VERSION OF THIS THESIS

APPENDIX XII – CONCERN CONTROL

THIS APPENDIX IS NOT PART OF THE PUBLIC VERSION OF THIS THESIS

APPENDIX XIII – RRU CONTROL

THIS APPENDIX IS NOT PART OF THE PUBLIC VERSION OF THIS THESIS

APPENDIX XIV – QUALITY

THIS APPENDIX IS NOT PART OF THE PUBLIC VERSION OF THIS THESIS