

SEEKING PERFORMANCE-BASED ACCOUNTABILITY IN ITALIAN PUBLIC HEALTHCARE ORGANIZATIONS

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Abstract

Using content and cluster analysis and considering a time span of five years, this study examines the adoption and compliance level of Performance-Based Accountability (PBA) in the Italian Local Healthcare Authorities (LHAs) under the Legislative Decree no. 150/2009. The results showed a barely sufficient level of PBA compliance. Higher levels of citizen involvement in PBA processes, the commitment of Regions, and integration with other accountability systems are three conditions for improving the effectiveness and usefulness for stakeholders of this NPM reform for LHAs.

Keywords: performance-based accountability, transparency, New Public Management reforms, Italian public healthcare organizations.

1. Introduction

Reforms inspired by the New Public Management (NPM) principles have reshaped public sectors and, in particular, the healthcare sector (Andrews, Beynon and McDermott, 2019). The direct impact of the latter on the well-being of citizens together with vast public resources invested in it increased the attention of public healthcare organizations (PHOs) to performance management and accountability systems (Mattei *et al.*, 2013; Anessi-Pessina and Cantù, 2016), framed in the public management literature (Pollit, 2018).

In public organizations, those systems aim at supporting not only the internal managerial dimension, based on performance measurement, but also the external reporting processes (Fryer, Antony and Ogden, 2009). The close connection between the latter and public accountability is afflicted with the multifaceted meanings of transparency and accountability (Bovens, 2007), in particular in healthcare with its multiple stakeholders (Brinkerhoff, 2004; Ferlie, Montgomery and Pedersen, 2016). The traditional compliance-based accountability approaches, rooted in the formal compliance with regulations and the appropriateness of using public resources, evolved gradually towards PBA. 'Managing for results' requires manifesting effectiveness, efficiency and transparency in achieving results, which expresses the managerial autonomy attributed to public organizations (Borgonovi, Anessi-Pessina and Bianchi, 2018). In this framework, the PBA processes assume an effective operation of the underlying performance management systems, the adoption of which is the legacy of NPM reforms implemented in the public sector (Arnaboldi, Lapsley and Steccolini, 2015).

In the Italian public sector, particularly relevant was the enactment of the Legislative Decree (L.D.) no. 150/2009 (hereafter, Decree), which, for the first time, enforced the introduction of the 'Performance Management Cycle' (PMC) and related PBA documents. This regulation affects all public organizations, including PHOs. Its transparency and PBA purposes are debated in the context of the effects of the NPM reforms and conditions necessary for NPM to 'work' in the public sector (Dan and Pollitt, 2015).

From this perspective, studies on public healthcare conducted international comparative analyses on the intentional and unintended impacts of the reforms (Simonet, 2011), verifying the effects of combining multiple reforms in increasing efficiency, effectiveness and equity of healthcare services provision (Mattei *et al.*, 2013) or examined specific impacts of new regulations in individual countries (Longo, Salvatore and Tasselli, 2011). Respecting the latter, research focused on the impulses of national legislation in the adoption of performance management systems and related PBA models in PHOs provided conflicting results (Jacobs, Marcon and Witt, 2004; Andrews, Beynon and McDermott, 2019). The moot point was the effectiveness of legislation-driven approaches in promoting those systems and in increasing transparency and PBA in healthcare organizations (Chang, 2006; Lehtonen, 2007).

Studies that evaluated the impacts of the reforms on PHOs' results and outcomes generally agreed on the improvement in quality, efficiency and equity in the public

healthcare services provision (Love, Revere and Black, 2008). In particular, higher openness and active participation of citizens in PBA increased patients' awareness of medical services available (Canaway *et al.*, 2018), as well as triggered improvements in the PHOs' performance following the benchmarking logics (Bevan and Hood, 2006; Nuti, Vainieri and Bonini, 2010). Furthermore, increased transparency on PHOs' performance helped to prevent corruption, promoted broader organizational legitimacy (Curtin and Meijer, 2006; European Commission, 2013), and increased attention of national healthcare plans in rewarding quality and efficiency of these organizations (Ferlie, Montgomery and Pedersen, 2016). However, the same studies pointed out that greater openness to patients' assessments and data sharing resulted in PHOs providing ambiguous information or generating 'information noise' when complying with the transparency obligations (Bevan and Hood, 2006). This reluctance to develop a culture of transparency was also highlighted by Italian studies on the performance management and accountability systems adopted by PHOs, both of those implemented voluntarily or complying with sectoral regulations, with few studies (Mauro and Talarico, 2015; Bonollo and Zuccardi Merli, 2016) specifically investigating the PMC adoption pursuant to the Decree, and the contents of related PBA models.

To fill the literature gap on PBA, our research of exploratory-descriptive nature aims to evaluate the adoption of the PMC in Italian LHAs, by exploring PBA contents produced during 2013-2018. Using content and cluster analyses, we verify the compliance level of the information presented in the PPs and the PRs with the accountability contents required by the Decree.

To achieve this goal, in section 2 we review the literature on transparency, and PBA approaches in public organizations, in particular in LHAs. Sections 3 and 3.1 analyze the evolution of transparency measures in the Italian context. Section 4 presents the sample and the research method, while section 5 shows our results. The main conclusions are discussed in section 6.

2. Transparency and PBA: an overview

PBA purposes in public organizations are manifold since the concept of public accountability expresses the responsibility of these organizations for explaining and justifying their conduct towards stakeholders (Bovens, 2007). OECD (2001, p. 87) underlines that public organizations 'have an obligation to account for the use they make of citizens' inputs received, be it through feedback, public consultation or active participation'. To achieve their accountability purpose, these organizations 'need to ensure open and transparent decision-making processes amenable to external scrutiny and review'.

These forms of openness are vital for public control, promoting greater accountability and answerability of public organizations (Borgonovi, Anessi-Pessina and Bianchi, 2018; Pollit, 2018). In particular, the principles of transparency constitute a prerequisite for PBA models and an impulse for organizations to focus on the role

and effective functioning of the underlying performance management system (Hood and Heald, 2006; Fryer, Antony and Ogden, 2009). Moreover, technological advancement increases the timeliness of information and provides innovative ways to interface with public institutions, including the recent models of Open government and E-government (Holzer, Manoharan and Melitski, 2019). Higher levels of openness and interdependence of transparency with PBA processes can foster good governance practices (Osborne, 2010), stimulating organizations to efficiently use public resources and continuously improve their performance (Hood and Heald, 2006), also with incentives and sanctions (Brinkerhoff, 2004). A higher 'surveillance' on good governance practices promotes organizational legitimacy and prevents corruption (Curtin and Meijer, 2006). However, the literature does not agree on the impacts deriving from greater transparency compared to the purposes of the PBA (Hood and Heald, 2006). This is due to the complexity of performance measurement in public organizations, which makes concluding difficult (Hatry, 2002; Borgonovi, Anessi-Pessina and Bianchi, 2018), up to the risk of distorting organizational priorities and inhibiting innovation (Arnaboldi, Lapsley and Steccolini, 2015).

In PHOs these problems escalate due to the absence of a market, personalization of services and related quality levels, clinical risk management, variety of outputs and unclear cause-effect relationships (Lega and Vendramini, 2008; Fryer, Antony and Ogden, 2009). Furthermore, the nature and purposes of accountability in PHOs is a challenge itself. The sector-specific literature interpreted this concept in several ways, primarily referring to the ability of organizations to 'give account' to patients, clinicians, health personnel, but also to satisfy public, political, and commercial health demands of communities (Brinkerhoff, 2004; Canaway *et al.*, 2018). The wide range of audiences makes PHOs to focus more on easy-to-find and easy-to-understand information targeting the general public which mainly addresses the accountability type that Bovens (2007) defines as 'horizontal', whose nature complicates the links with performance measurements in these organizations. The complexity of the measurements mentioned above affects the effectiveness of PBA processes, comprehensibility of information by the public, and the stakeholders' trust (Love, Revere and Black, 2008; Halachmi and Holzer, 2010). Consequently, public organizations often used 'complexity' as an excuse for goal displacement and gaming, providing ambiguous information when complying with transparency obligations (Hatry, 2002; Ferlie, Montgomery and Pedersen, 2016). They hid relevant data in 'information noise' or 'information overload' or pursued the logic of 'blame-avoidance' on the results (Bevan and Hood, 2006).

Literature also investigated the role of the legislative reforms inspired by the NPM in encouraging transparency within the framework called 'Freedom of Information Act' (FOIA). Many studies discussed conditions under which NPM legislative reforms 'could work' in the public sectors of different countries (Dan and Pollitt, 2015), including healthcare (Simonet, 2011; Mattei *et al.*, 2013; Andrews, Beynon and McDermott, 2019). The research focused on the impulses of national legislation for

building the transparency culture and on the effectiveness of legislation-driver in promoting performance management systems in public organizations delivered different results (Hood and Heald, 2006; Fryer, Antony and Ogden, 2009), also in the PHOs context (Chang, 2006; Lehtonen, 2007).

The studies highlighted the diffusion barriers to these systems, referring to the 'context', 'process' and 'content' factors, typical for the public sector (Bourne *et al.*, 2002; Behn, 2002). However, in PHOs further limitations to the use of performance management systems in supporting decision-making processes were identified (Jacobs, Marcon and Witt, 2004; Oppi *et al.*, 2019). At the same time, several studies also highlighted benefits deriving from the higher levels of transparency and PBA in the PHOs resulting from regulatory reforms. Increased quality, effectiveness, efficiency and equity of the healthcare services provided by PHOs was evidenced (Love, Revere and Black, 2008; Demartini and Trucco, 2017; Vukovic *et al.*, 2017). Moreover, patients' choices of the hospital to seek the treatment at were enhanced (Canaway *et al.*, 2018), and improvements in the PHOs performance based on benchmarking approaches were observed (Sargiacomo, 2002; Nuti, Vainieri and Bonini, 2010), also at European level, following the introduction of the Directive 2011/24/EU on the patients' rights in cross-border healthcare, to promote good governance practices and prevention of corruption measures (European Commission, 2013; Ferlie, Montgomery and Pedersen, 2016). Nonetheless, other studies showed that greater openness to patient assessments and data sharing culture presented higher gaming risks and goal displacement in the PBA of PHOs (Chang, 2006; Bevan and Hood, 2006). Furthermore, contrary to openness to the PBA models in other public organizations, many healthcare managers introduced the transparency principles only when a legal obligation was imposed and only in the presence of related sanctions (Brinkerhoff, 2004; Ferlie, Montgomery and Pedersen, 2016). This initial organizational resistance to changes resulted in formal compliance with legislative reforms or the opportunistic external communication (Hatry, 2002; Jacobs, Marcon and Witt, 2004; Lehtonen, 2007).

3. PBA perspectives in the Italian PHOs: the introduction of the PMC

Italian legislation on transparency in public organizations, including the PHOs, evolved until the last L.D.97/2016 (called the 'Italian FOIA') following the international orientations considering citizens' access to information a prerequisite for PBA. These principles of transparency and accountability, in relation to the performance of all public organizations, had already been introduced by the Decree to allow an analytical assessment and participation of citizens.

However, the peculiarities of the healthcare context had made transparency and PBA approaches a topic of interest both in legislation and in literature much earlier. Starting from the L.D.502/92 and the L.D.229/99, the reforms of the Italian healthcare system increased the legislative power devolved to Regions within the National Health Plan. Consequently, Regions organize and provide healthcare services locally

through a network of public and private providers of which LHAs are the main PHOs. Therefore, LHAs are directly accountable for their results to Regions which, in turn, are accountable to the Ministry of Health. This Ministry directs and coordinates the National Health System and publishes online data on Essential Levels of Care, control and accountability of performance involving Government, Regions, and LHAs. These inter-institutional information flows converge in the 'New National Information System' and are flanked by other sources of information including those of the 'National Agency for Regional Health Services' and its National Outcome Plan. The latter provides measures for monitoring and comparative assessments of quality, efficiency, and equity of health services offered by the LHAs in each Region.

Overall, this evolution of sector regulation inspired by the NPM has oriented the Italian context towards highly decentralized healthcare management, associated with a quasi-market and managerial logics (Rea, 1998; Longo, Salvatore and Tasselli, 2011). In this governance model, various levels of responsibility, multidimensional accountability, and healthcare performances have been progressively strengthened, by providing incentives and imposing sanctions based on the trends of effectiveness, efficiency and equity of the Essential Levels of Care of each Region.

Literature that investigated the effects of the reforms also in comparison with other countries (Simonet, 2011; Andrews, Beynon and McDermott, 2019) showed 'cultural' and 'institutional' resistance deriving from the administrative tradition of Italian public organizations (Anessi-Pessina and Cantù, 2016). Similar problems were highlighted by studies focusing on PBA models that PHOs implemented voluntarily or in compliance with other sectoral regulations (Lega and Vendramini, 2008; Vagnoni and Maran, 2013; Reginato, 2016; Spanò, Cicellin and Scuotto, 2019).

Starting from 2011, the sectoral regulatory framework also comprised the Decree that imposed the PMC adoption and its PBA model to all Italian public organizations. Recently this provision was integrated by the L.D.74/2017 even if, for now, its application concerns only Central Administrations. The PMC consists of the typical phases of the strategic planning and management control processes – whose implementation is supported by the guidelines of the 'Commission for Evaluation, Transparency and Integrity of Public Administrations' (Commissione per la Valutazione, l'Integrità e la Trasparenza delle amministrazioni pubbliche, CIVIT), later replaced by the 'National Anti-Corruption Authority' (Autorità Nazionale Anti-Corruzione, ANAC), and the preparation of a Performance Plan (PP) and the corresponding Performance Report (PR). These two documents, providing content to the PBA dimension required by the Decree, must be produced and issued annually. In detail, the PP is prepared by 01/31 of each year and contains triennial planning of strategic objectives and related annual operational objectives, in line with the economic and financial planning cycle, and a specification of targets, indicators and criteria for achieving the objectives. The PR must be prepared by 06/30 of the following year and includes the results obtained in the previous period, a comparison with the planned goals, deviations observed, and information on resources used. In addition to supporting internal deci-

sion-making processes, these documents must provide a reliable representation of the performance in exercising public control, allowing stakeholders to make informed assessments and, therefore, satisfying the PBA purposes. To ensure these objectives, the Decree introduces an ‘Independent Evaluation Body’ in each public organization.

These provisions of the Decree, while applying to all Italian public administrations, would not have immediate application to the PHOs, given the regulatory autonomy granted to the Regions in health matters. Thus, pending an adaptation of the regional regulations, the LHAs are required to apply the Decree (art. 16), as also specified by ANAC (ex-CIVIT) Resolution no. 113/2010. Due to this specific sectoral regulatory framework, only a few studies investigated the PMC adoption in the LHAs. Moreover, they analyzed compliance with the Decree in the broader context of other healthcare reforms (Mauro and Talarico, 2015). Only Bonollo and Zuccardi Merli (2016) specifically addressed the adoption of the Decree by conducting a content analysis of PRs published by LHAs during the first three-year period of application. The results showed that only 50% of LHAs published at least PRs, with low compliance levels with the regulatory framework.

4. Sample and methodology

Starting from the entire Italian group of 101 LHAs listed in 2019 on the website of the Ministry of Health, our study focuses on those that published at least a PP or a PR during the last five years (2013-2018) in the ‘Transparent Administration’ section of their websites. We considered the documents directly downloadable from the website (Decree, art. 11), selecting only the latest version published to reduce the effects rationalization in Italian LHAs during this period (the number of LHAs went down from 142, in 2013, to 101, in 2019). Furthermore, we eliminated those documents which did not correspond to the provisions of the Decree even if they were called ‘Performance Plans’ or ‘Performance Reports’.

Considering the exploratory and descriptive nature of the research, we firstly applied the content analysis (Krippendorff, 2004) to verify the compliance of PPs and PRs with the PBA contents provided by the Decree. This technique—if strict procedures of measurement and information coding are applied—effectively captures underlying meanings of texts and allow deductions on contents, reducing risks of subjectivity (Smith and Taffler, 2000). Based on the Decree provisions and those of the ANCA (ex-CIVIT) Resolutions no. 112/2010, for the PPs, and no. 5/2012, for the PRs, we elaborated two evaluation grids summarizing various types of information disclosed (quantitative, qualitative, tabular, graphical). Each grid included six information areas (IAs) for the PPs, and five IAs for the PRs, with related sub-elements of the content (ICs), within a multilevel hierarchical model (the details on the IAs and ICs within the two grids can be found in Figures 1 and 2, together with the results). The two grids were filled in using a five-point Likert scale (with scores ranging between 1, for the ‘insufficient’ level to 5 for the ‘full’ disclosure) measuring compliance

levels. The content analysis of the documents was carried out by two researchers autonomously to guarantee the reliability of results. Then, data were compared, and the final tables of content codes and results were prepared.

Next, based on the results of content analysis, we applied a cluster analysis to investigate the existence of internal information policies or informal standards in LHAs' approaches to the PBA model. The cluster analysis was performed in Statistica software, using Ward's agglomeration method, offering flexibility in a decision on how many clusters would ultimately be considered (Valadkhani and Ville, 2010). In the agglomeration process, all IAs included in PPs and PRs were considered to guarantee a comprehensive disclosure panorama.

5. Results

Although the PPs and PRs were directly available in the 'transparent administration' section of the LHAs websites, the results showed a low diffusion of the PMC in Italian LHAs. Of the entire group of 101 LHAs, 79 published a PP and 84 a PR over the last five years. Given the time frame analyzed, the number of documents was not high, with more considerable attention by LHAs to the publication of PPs rather than PRs. There are no significant differences in the LHAs' approaches to PBA neither concerning their sizes nor regions (with some LHAs in northern and central Regions showing slightly higher disclosure levels than in the rest of the country).

5.1. Content analysis of PPs and PRs

In Figures 1 and 2, we report the grid, including the IAs and the ICs, together with the results of the compliance level of the two documents with the Decree and the integration of the ANAC (ex-CIVIT) Resolutions. We present both average levels and the typical ranges (within +/- one sigma range) of disclosure evaluations.

In Figure 1, the PPs' content analysis shows that all six IAs in the grid present comparable informativeness levels, with average values ranging between 2.61 and 3.61. The most comprehensively disclosed IAs include PP-IA.1 and PP-IA.4, with average compliance scores around 3.60. Within PP-IA.1 the highest rate of conformity is that related to IC.1.3, 'How we work', including information about activities such as hospitalizations, etc. In the case of PP-IA.4, the most detailed information is included in IC.4.1 describing strategic direction for the next three years (with a score of 3.92). The information about 'Strategic objectives', followed by that on the 'Operational objectives' (PP-IA.5), representing a critical aspect for effective implementation of the PBA processes, show an adequate level of detail. However, information is often provided in a generic way, with a non-significant timing (flattened at the end of the administrative year), measured with oversimplified indicators (binary) and accompanied by undemanding objectives and not confronted with stakeholders' requirements, benchmarks and historical values. If we consider ICs defining the process of translating strategic goals into operational objectives, the problems escalate. We observe

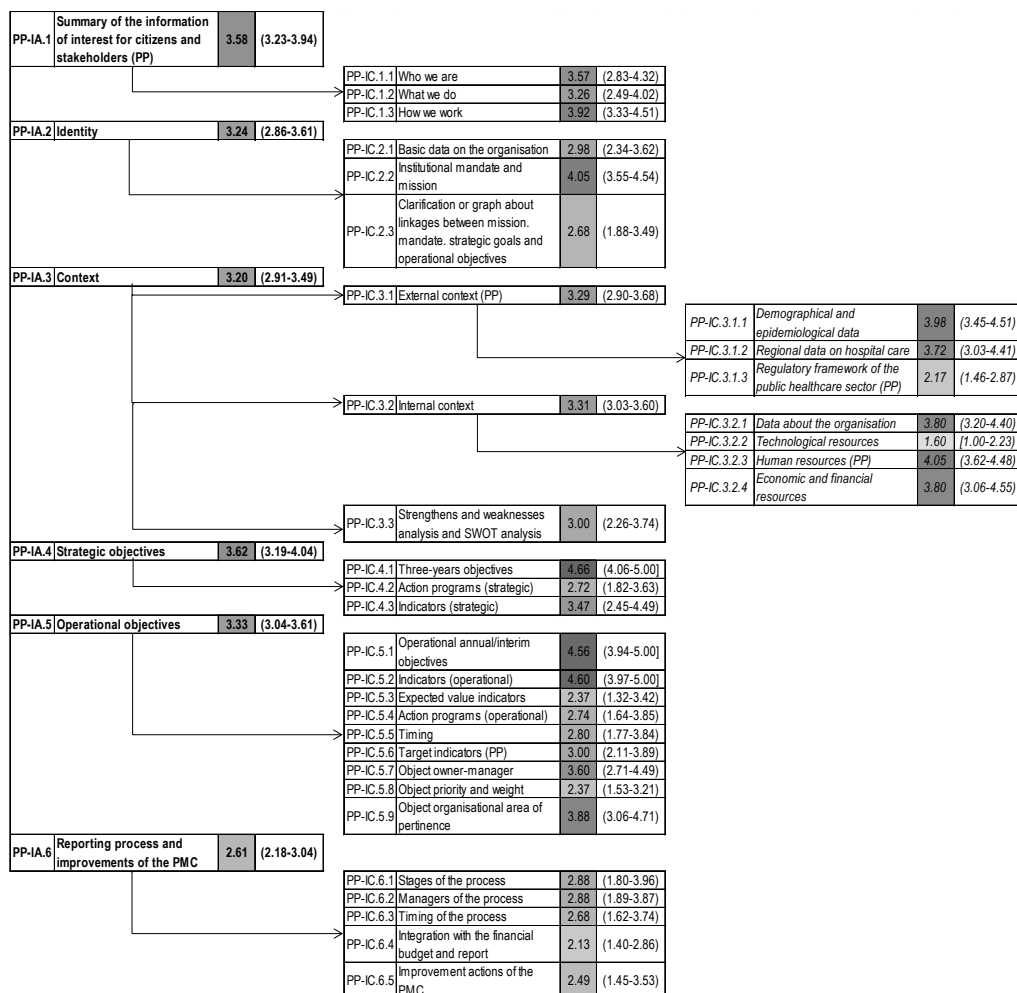


Figure 1: Results of the content analysis of PPs

Source: Authors' own elaboration

more shortcomings in adequate disclosure on expected value indicators, objectives' priority and weight (IC.5.3 and IC.5.8 both at 2.37), but also a description of the linked action programs (IC.5.4 at 2.74) and their timing (IC.5.5 at 2.80).

The information about the internal and external environment of the LHAs included in the PP-IA.3 appears to be just above the sufficiency level. Similarly, the conformity rate slightly above the sufficiency threshold (equal to 3.24) is observed in the case of PP-IA.2, where the highest compliance level is that of IC.2.2 related to 'Identification of the institutional mandate and organizational mission' (4.05). Finally, the PP-IA.6 does not match required information standards (the compliance level at 2.61), with the lowest level of detail in IC.6.4 'Integration with plans and economic and financial relations'.

The content analysis of the PRs (Figure 2) shows, contrary to those for the PPs, substantial differences and variability of compliance levels regarding information disclosed in the IAs. The highest level is that of PR-IA.3, which is related to the efficiency of LHAs (average score at 3.60). Within this area, the ICs with the most insightful description covers economic and financial information (the score at 3.92), which are, however, included in the financial statements and are already available in the accounting system. The lowest conformity rates can be observed in the IAs disclosing information about the equal opportunity (PR-IA.4) and the realization process of the PR (PR-IA.5). Interesting for PBA purposes are the contents of PR-IA.1, in which the ICs with lower levels of compliance include IC.1.1.3 related to the regulatory framework of the public healthcare sector (equal to 2.25), as well as ICs 1.4.1 and 1.4.2 (average score at 2.39). The latter should report identified threats and opportunities to the achievement of (re-)planned objectives compared to needs and requests expressed by the reference community of the LHAs. Within PR-IA.2, the ICs disclosing achievement degree of planned goals reach adequate compliance levels (4.56 for both strategic and for operational objectives), even though these results are often measured with percentages rather than multidimensional performance indicators. The information is limited to descriptions of the degree of achieving goals about quantities and types of services provided by LHAs, with little attention is paid to outcomes and efficiency. This refers not only to the organization's performance but chiefly to the individual one (PR-IC.2.4). At the same time, the feedback on variances between the objectives included in the PPs and achieved results in the PRs, and about their causes, is inadequate (compliance at 3.31 for the PR-IC.2.2.2, and at 2.88 for the PR-IC.2.3.2). The insufficient disclosure in the area mentioned above is the major limitation regarding PBA in the LHAs. It limits the knowledge of stakeholders both about LHAs' past activity and future planning.

5.2. Determining information policies of LHAs with cluster analysis

As noted, the cluster analysis aims to deepen the results of the content analysis to capture specific internal information policies or standards adopted within the LHAs' approaches to PBA. Even if decisions of each LHAs on forms and levels of details of their disclosure are, on the one hand, conditioned by the regulatory framework, and, on the other one, reflect internal information management culture, specific ways of communication with regulators and stakeholders may become informal standards. Moreover, as highlighted in the content analysis, LHAs could likely have replicated previously prepared contents, which may neither correspond with the regulator's intentions nor meet the stakeholders' accountability needs. The cluster analysis may also identify which IAs and ICs differ substantially in terms of compliance levels and disclosure quality between larger groups of LHAs, what would suggest that information requirements either need to be clarified better or recommended practices need to be developed and then applied by these organizations.

Taking advantage of the decisional flexibility of the Ward agglomeration method on clusters count, the authors decided to examine three groups accounting for 46, 34 and 21 objects, respectively (see Figure 3).

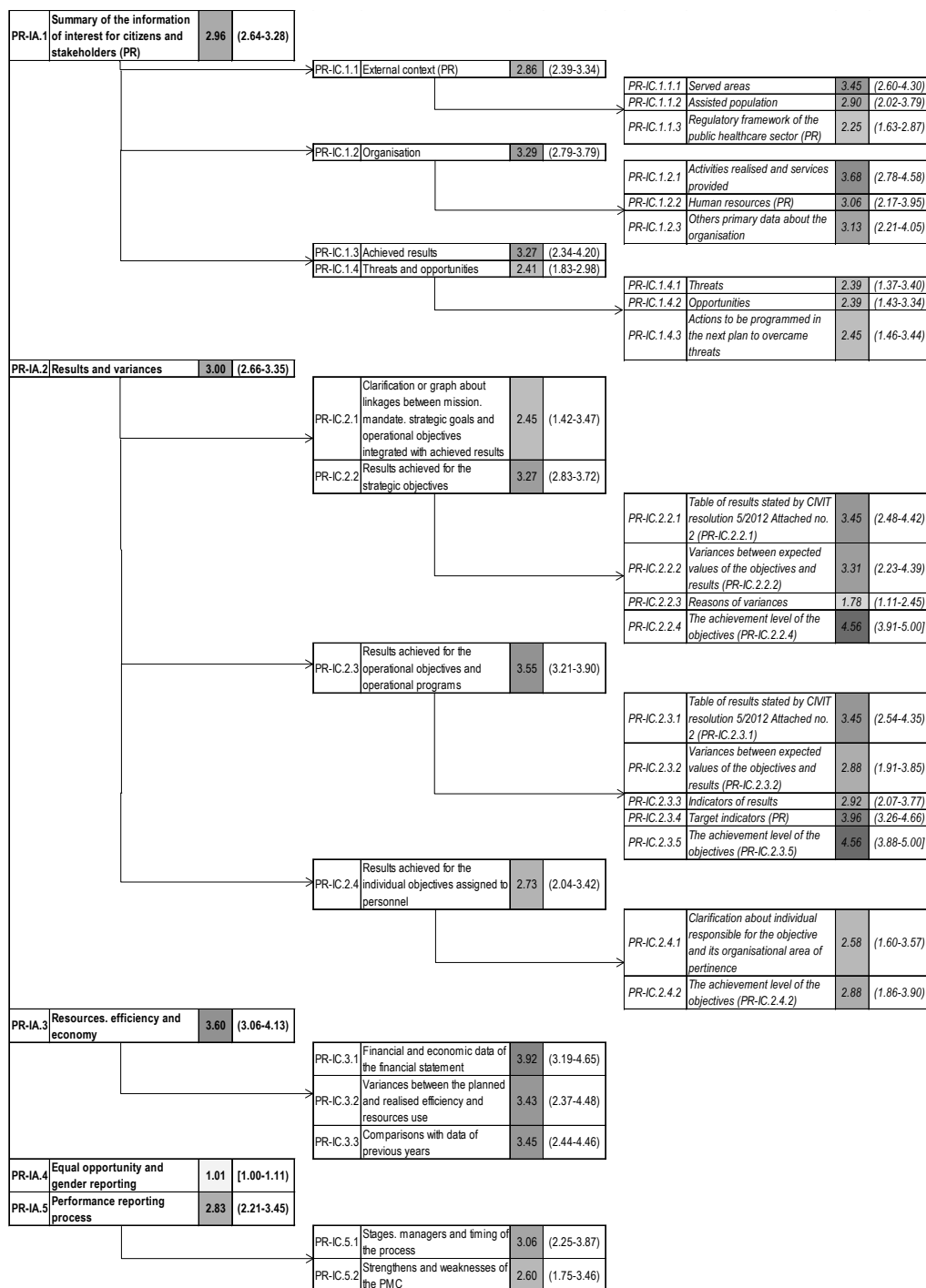


Figure 2: Results of the content analysis of PRs

Source: Authors' own elaboration

Tree Diagram
(based on Triennial Performance Plans and Annual Performance Reports)

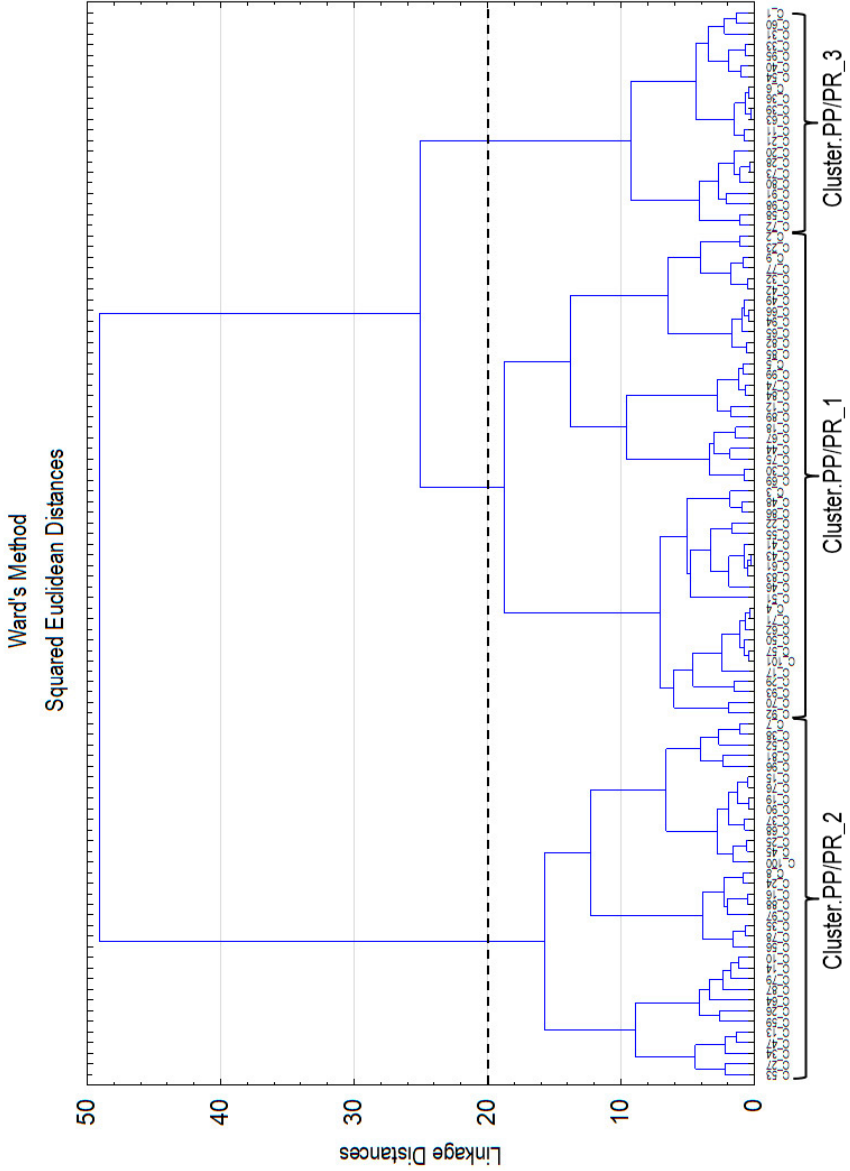


Figure 3: Clustering process based on IAs and ICs in PPs and PRs

Source: Authors' own elaboration

It may be assumed that the first cluster (later referred to as Cluster.PP/PR_1) represents the most typical information process. In contrast, the other two (Cluster.PP/PR_2 and Cluster.PP/PR_3) represent alternative approaches characterized by different quality of disclosures or information priorities being relocated to other IAs/ICs than it the ‘core scenario’ (see Figure 4).

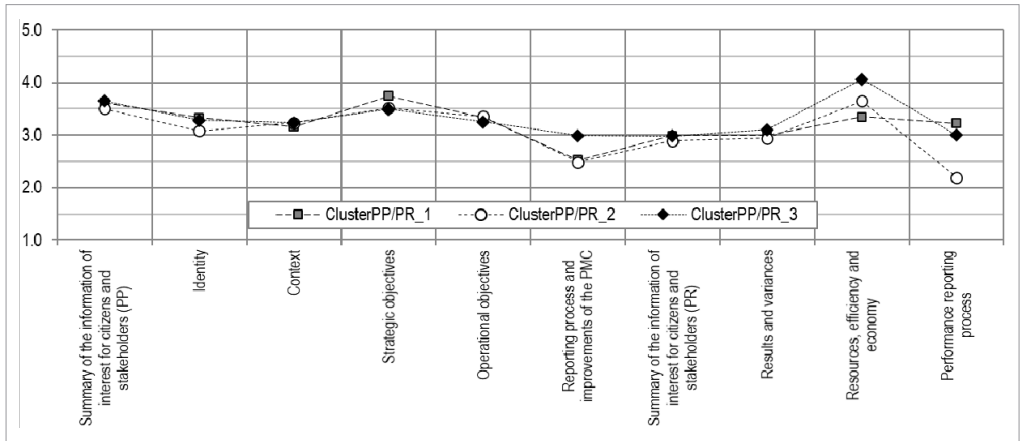


Figure 4: Results of clustering based on IAs in PPs and PRs

Source: Authors’ own elaboration

The main differences in the accents in the LHAs information policy included the following three IAs: PP-IA.6: ‘Reporting process and improvements of the PMC’, PR-IA.3: ‘Resources, efficiency and economy’ and PR-IA.5: ‘Performance reporting process’. In the first two instances, Cluster.PP/PR_3 is characterized by notably greater attention paid to disclosure quality. As for the PR-IA.5, LHAs belonging to Cluster.PP/PR_2 deviate negatively from the rest. The clustering procedure was deepened with a statistical analysis of the significance of differences between the values of all IAs and ICs using rank ANOVA.

Table 1 shows the existence of 15 main areas of difference in compliance levels between the three LHAs clusters. The first two (PP-IA.2 and PP-IC.2.3), referring to the general characteristics of the organization, instead of being standardized due to a similarity of individual LHAs’ operations, turned out not to be uniformly reported. Another two areas of discrepancies are those related to strategic objectives and indicators. A comprehensive presentation of these strategic dimensions connotes a mature organizational culture in information management and a better understanding of the PBA by stakeholders. In this sense, Cluster.PP/PR_1 indicate the direction in which LHAs should develop their disclosure practices. Similar observations can also be extended to the other two areas of operational indicators and object owner-managers. In both cases, objects qualified to Cluster.PP/PRs_3 underperform respecting compliance levels.

Table 1: Significant differences between clusters

Information Area	Symbol	$H_{2,101}$	p	Clusters based on PPs/PRs		
				CL_1	CL_2	CL_3
Identity	PP-IA.2	6.56	0.038	3.33	3.08	3.29
Clarification or graph about linkages between mission, mandate, strategic goals and operational objectives	PP-IC.2.3	9.91	0.007	2.93	2.35	2.67
Strategic objectives	PP-IA.4	7.40	0.025	3.75	3.52	3.49
Indicators (strategic)	PP-IC.4.3	8.28	0.016	3.80	3.18	3.19
Indicators (operational)	PP-IC.5.2	10.63	0.005	4.70	4.71	4.24
Object owner-manager	PP-IC.5.7	6.01	0.050	3.59	3.85	3.24
Reporting process and improvements of the PMC	PP-IA.6	19.56	0.000	2.53	2.49	2.99
Timing of the process	PP-IC.6.3	15.03	0.001	2.33	2.71	3.43
Assisted population	PR-IC.1.1.2	6.06	0.048	2.91	2.71	3.19
Resources, efficiency and economy	PR-IA.3	27.54	0.000	3.35	3.65	4.06
Financial and economic data of the financial statement	PR-IC.3.1	10.78	0.005	3.65	4.12	4.19
Comparisons with data of previous years	PR-IC.3.3	17.57	0.000	3.07	3.53	4.14
Performance reporting process	PR-IA.5	62.64	0.000	3.23	2.19	3.00
Stages, managers and timing of the process	PR-IC.5.1	19.73	0.000	3.39	2.56	3.14
Strengthens and weaknesses of the PMC	PR-IC.5.2	46.38	0.000	3.07	1.82	2.86

Source: Authors' own elaboration

Interestingly, LHAs of Cluster.PP/PR_2, which disclose their strategic goals to a lower extent than the others, explain best their operational goals, highlighting a short-term orientation of PBA in those LHAs. The areas of significant differences between disclosure policies of LHAs also include the reporting process itself, with its timing and improvement potential. Despite the generally unsatisfactory level of compliance, information policy of the Cluster.PP/PRs_3 can be considered as sufficient. Thus, some LHAs understand reporting goals well and adequately disclose their reporting practices, even if they fail to provide high-quality PBA in compliance with the Decree.

The other seven areas of differences between disclosure policies adopted by LHAs regard PRs. Interestingly, they include also the assisted population. As for the other six, two basic information models can be distinguished between. In Cluster.PP/PR_3 a lot of attention is paid to disclosures on resources and economics of operations, and in Cluster.PP/PR_1 the reporting process itself is in focus. The two models indicate a difference between the managerial approach (efficiency-oriented) and formalized reporting (legislation-driven).

Overall, cluster analysis highlighted the existence of informal reporting practices, some of which worked to the detriment of the general PBA compliance levels, whereas few (with at least 'good' disclosure levels), including PP-IC.5.2—Indicators (operational) in Clusters.PP/PR_1 and _2, as well as PR-IA.3—Resources, efficiency and economy, PR-IC.3.1—Financial and economic data of the financial statement and PR-IC.3.3—Comparisons with data of previous years in Cluster.PP/PR_3 can be treated as sectoral benchmarks. Furthermore, differences in disclosure approaches to strategic and operational issues showed higher pressure in some LHA on short-term operations rather than on long-term planning.

6. Discussion and conclusions

In the final section of the paper, we intend to highlight the main findings resulting from our analyses, which will enable drawing more generalized conclusions on barriers to introduce Performance-Based Accountability in Italian LHAs. Moreover, we will suggest recommendations, in reference to our own observations and those of other researchers, on how to increase the efficiency of the PBA reporting without compromising the effectiveness of the reforms. Finally, we explain how this study contributes to the existing body of knowledge, but also the limitations we encountered, and how they can be addressed by future research.

6.1. The main findings

The examination of how Italian LHAs complied with the Decree in the adoption of the PMC process enabled to formulate the four main conclusions:

- the diffusion of the PMC in Italian LHAs is modest;
- there exist only a few differences in approaches to PBA across Italian LHAs;

- objectives of LHAs are reported in very homogenous ways;
- stakeholders have limited opportunities to evaluate the results achieved by LHAs.

Referring to point 1, our analysis highlighted modest dissemination of the PMC practices set out by the Decree, in the 101 LHAs during the five years analyzed. The total number of PPs and PRs was moderate at best, with LHAs paying less attention to the reporting phase of PMC. Considering the timespan, we expected a higher number of PBA documents than the one recorded.

Considering the second conclusion, we confirmed the observations emerging in previous studies (Bonollo and Zuccardi Merli, 2016) that formal approaches to PBA showed few significant differences between the Italian LHAs, except for the number of documents and slightly higher average disclosure values in some organizations of the Northern and Central Regions. The content analysis showed a sufficient level of compliance with the Decree's provisions on average, with the content of the PPs being more homogeneous and with higher levels of disclosures compared to that of PRs. PPs demonstrated the most comprehensive reporting regarding 'Summary of information of interest to citizens and stakeholders' and the description of strategic and operational objectives.

Concerning the third conclusion, we stated that despite the overall sound levels of compliance within IAs included in PPs, there appeared specific characteristics which reduced PPs' transparency and usefulness for PBA purposes. In particular, information on objectives was relatively similar across LHAs, despite specific differences among groups of organizations highlighted by the cluster analysis. The similar orientation results directly from the contents of PRs and the cluster analysis. The highest levels of detail shown by the PR-IA.3, referring to the use of public resources and other economic performance information, suggest that LHAs often re-used accounting data prepared to fulfil the information obligations, rather than defined them appropriately for the PBA purposes. This is evidenced by the lower values of the ICs related to the 'Action programs' and 'Timing' of achieving strategic and operational objectives. This happened supposedly due to weak incentives to improve performance.

The abovementioned observations of 'self-reference' in the communicative behaviors of the LHAs, that could hide the creation of 'budgetary slacks' (Yilmaz, Özer and Günlük, 2014), lead to our fourth conclusion on low usefulness of the LHAs' reporting to their stakeholders. Particularly for healthcare organizations, the observed prevalent disclosure of the accounting data will not address more specific accountability purposes if not integrated with other multidimensional performance information (Borgonovi, Anessi-Pessina and Bianchi, 2018). If stakeholders have no specific criteria to effectively evaluate the results achieved by the LHAs, this substantially reduces opportunities for active and informed involvement of citizens in the functioning of the PMC, as envisaged by one of the main changes to the Decree introduced by L.D.74/2017, and suggested by the research on participatory accountability (Halachmi and Holzer, 2010; Bracci, 2014; Canaway *et al.*, 2018).

6.2. Barriers to introducing PBA in Italian LHAs

The main findings resulting from our research indicate the existence of general barriers to implement PBA in Italian LHAs in a way envisaged by the legislators and, at the same time, with results satisfactory to stakeholders. The main barriers include:

- the emphasis on formal compliance with reporting obligations;
- little incentives to go beyond (over)simplified reporting practices;
- insufficient level of guidance on how to implement PMC in Italian LHAs.

The first observed barrier regarding chiefly ‘formal’ compliance with the contents of the Decree is reinforced by the low levels of disclosure in both documents on the PMC implementation phases, more pronounced in the LHAs included in the Cluster. PP/PR_2 and _3. Both the PP-IA.6 on the improvement and the integration of the PMC with other management information systems in the LHAs and the PR-IA.5 focused on deepening the performance reporting process, showed the lowest levels of disclosure.

The attention to the disclosure of IAs on the PMC implementation is one of the essential dimensions to showcase a substantial adoption of these systems in supporting internal decision-making of PHOs and in particular their PBA models (Spanò, Cicellin and Scuotto, 2019). In this perspective, we can also interpret the disclosure levels of PR-IA.1, on the ‘Summary of information of interest to citizens and stakeholders’. LHAs privileged information on the areas served, on the volumes and the types of services provided (output), whereas information on threats and opportunities in pursuing the PPs objectives (PR-IC.1.4 at 2.41) and, above all, on the related actions programmed to face them (PR-IC.1.4.3 at 2.45) were neglected.

The second identified barrier, regarding oversimplified reporting measures used, has a profound influence on the general assessment of how Italian LHAs complied with the provision of the Decree. For example, in the disclosure area related to Results and variances in the PRs, the high disclosure scores regarding the achievement of strategic and operational objectives (PR-IC.2.2.4 and PR-IC.2.3.5 both at 4.56) are reached often by using simple measurements (‘reached/not reached’) rather than by multidimensional indicators informing on the outcome, quality, appropriateness and equity of the health services provided. Moreover, the reasons for deviations between planned results and those achieved (PR-IC.2.2.3) have the lowest levels of disclosure, which impairs analysis of the efficiency in the allocation choices of the LHAs, as suggested by the recent studies on performance budgeting in the public sector (Nutti, Vainieri and Bonini, 2010; Mauro, Cinquini and Grossi, 2017). Furthermore, the limited use of multidimensional indicators does not enhance the IAs, which would have been more useful for the PBA purposes provided by the Decree—especially if we consider that this information is already provided for other mandatory accountability processes, relating to the data on the Essential Levels of Care and to other flows envisaged by the New National Information System, highlighting the vital role of the related sanctioning systems (Brinkerhoff, 2004; Reginato, 2016).

Finally, we observed the third barrier to the effective implementation of PMC in Italian LHAs. We postulate the existence of certain factors which intensified the resistance against the reforms, including the uncertainties about the direct applicability to the LHAs of the Decree, the low levels of commitment of top management together with regional and national policymakers, as well as the low effectiveness of sanctions enforcing PBA (reinforced by L.D.74/2017 though). In fact, except for a few Northern and Central Regions, most Regions did not yet prepare guidelines nor provided specific directions for implementation of the Decree, leaving the LHAs any discretion in the adoption of PMC. The preparation of regional guidelines matched with the involvement of citizens constitutes two fundamental conditions of the effective implementation of the NPM reform in the context of the PHOs (Dan and Pollitt, 2015; Andrews, Beynon and McDermott, 2019).

6.3. Recommended improvements in the PBA process

In response to the three general barriers to the effective implementation of the discussed reforms in Italian LHAs, we postulate the following action lines—each corresponding to one obstacle identified in the previous subsection:

- to overcome the orientation of LHAs on formal compliance with the Decree by differentiating the message included in their PPs and PRs;
- to enhance stakeholders’ involvement in the PBA process;
- to harmonise LHAs’ reporting.

In our first recommendation we state that to encourage the involvement of Italian LHAs in the PBA processes, it is necessary to overcome their general orientation on formal compliance with the Decree, by differentiating individual information policies, as the cluster analysis highlighted it. First of all, informal reporting practices were identified, including four IAs in the two types of documents (PP-IC.5.2, PR-IA.3, PR-IC.3.1, PR-IC.3.3), acting as potential sectoral benchmarks. Furthermore, differences in prioritizing strategic or operational issues were noted in PBA approaches. Finally, certain groups of LHAs tended to pay more attention to operational efficiency, whereas others tried to optimize their reporting process, but still for formal compliance with the Decree. Nonetheless, the adoption of the PBA models was perceived by LHAs mainly as another obligation to fulfil, revealing the ‘traditional’ resistance to reforms in public organizations (Longo, Salvatore and Tasselli, 2011; Anessi-Pessina and Cantù, 2016).

In our second recommendation, we advance the necessity of involving stakeholders in the PBA processes. Such involvement would offer performance information addressing the specific needs of different stakeholders, as proposed by Pollitt (2018), and provide better information for the general public. The higher ‘contextualization’ of the contents disclosed in the PBA of the LHAs towards the communities (Canaway *et al.*, 2018) would allow overcoming other shortcomings that emerged from the results.

Firstly, greater participation and sharing of information on objectives and results would enable to differentiate the IAs vital to citizens and stakeholders in the territory in which the LHAs operate, thus reducing the generic and isomorphic definition of

objectives. This could improve the PBA processes in the LHAs, mainly in the South of the country, where lower levels of compliance with the Decree were registered. Secondly, the citizen involvement would encourage greater public control over governance practices in these organizations, counteracting the lack of interest of the public administrations in reporting results in favor of plans (Behn, 2002), and eliminating risks of bad management and corruption (European Commission, 2013). Finally, greater openness could improve the 'horizontal accountability' (Bovens, 2007) of the LHAs and increase their organizational legitimacy (Curtin and Meijer, 2006). In this way, citizens and patients could choose whether to be treated by the LHA of their territory or move to other national or European hospitals (Hood and Heald, 2006; Canaway *et al.*, 2018).

Overall, these impulses for more active participation in accountability processes would also facilitate the 'cultural' transition of citizens and LHAs operators towards PBA exploiting information technologies and open data models, as suggested by several studies (Cuccinello, Lapsley and Nasi, 2016; Holzer, Manoharan and Melitski, 2019). In Italy, this would increase public awareness of the National Outcome Plan and encourage the use of tools such as the 'Portal of transparency of health services' prepared by the Ministry. The interactive communication between LHAs and stakeholders would allow to monitor patient satisfaction with health services and to achieve homogeneous improvements in LHAs' performance across the country.

Our final recommendation concerns the critical factor that can strengthen the use of PMC and related PBA models in the LHAs (Jacobs, Marcon and Witt, 2004; Chang, 2006; Oppi *et al.*, 2019). An integrated reading of the compliance levels and the informal reporting practices emerging from the clustering results, with various obligations to which the LHAs are already subjected, suggest seeking simplification paths of the PBA content and process envisaged by the Decree. The aim is the pursuit of complementary and synergistic benefits deriving from the accounting harmonization and administrative procedures suggested by the recent literature on orientation guidelines (Anessi-Pessina and Cantù, 2016; Mauro, Cinquini and Grossi, 2017), as well as by European legislation (Directive 2011/85/EU), and introduced in Italy by the L.D.118/2011 for the public administrations at all levels, including those in the health sector (Title II).

In this sense, the contents of the two documents required by the Decree could find integration and harmonization firstly with the information flows that LHAs are already obliged to produce for the New National Information System, and above all with the multidimensional data of the Essential Levels of Care and the National Outcome Plan, while respecting the principles and purposes of each regulation. Similar integration proposals are also suggested by guidelines for the implementation of the Decree in other Italian public sectors, but also advocated by the recent L.D.74/2017, and may be applied in the case of those IAs, of the PPs and of the PRs, where the highest levels of compliance resulted from the use of data already prepared to fulfil the information requirements envisaged by other regulations.

At the same time, the existence of previous sectoral regulations on transparency, performance measurement and accountability systems may have induced the LHAs to avoid costly duplication of information in the compliance of the PBA under the Decree. Furthermore, these perspectives of integration and harmonization could direct the preparation of future guidelines by the Regions, in which the logic of coexistence with previous sector regulations can also be managed. As noted by Andrews, Beynon and McDermott (2019), these combinations in the regulations must be pursued by seeking alignment with the configurational perspectives on public governance, which suggest that effects of any given reform depend on the presence or absence of other reforms, and cannot be understood as the mere summing of independent impacts.

6.4. Contribution to the literature, limitations and future research

Our recommendations identifying the three factors which facilitate the combination of legislation-driven reforms with mechanisms that promote cultural openness to transparency and PBA models in PHOs allow our study to contribute to the literature about conditions under which NPM 'can work' in the public sector (Dan and Pollitt, 2015), and in particular in the healthcare context (Simonet, 2011; Mattei *et al.*, 2013; Andrews, Beynon and McDermott, 2019) concerning the impact of a single reform within a single country (Longo, Salvatore and Tasselli, 2011). We believe that our results allow advancement of studies more focused on the effectiveness analysis of legislation-driven approaches in improving the transparency and PBA levels of PHOs in highly decentralized healthcare management countries, offering useful implications for management and policymakers.

We are aware that our results are subject to limitations. Firstly, the regulatory basis of the grid specifically built for data collection, and the related evaluation scale increases the degree of subjectivity of the results. Furthermore, the exploratory and descriptive nature of the study does not allow a generalization of the results. Another limit of the results is its reference to the national context.

Nonetheless, we see certain possibilities to overcome the abovementioned limitations. Future research could investigate, by multi-case studies and interviews, possible factors facilitating the increase of compliance levels of PPs and PRs to the contents of the Decree or greater adequacy and consistency of this PBA model to the managerial principles proposed by national and international literature. In these perspectives, other research could focus on the effects on the PBA contents and approaches of the LHAs deriving from the first guidelines to the Decree that some Regions, especially in Northern and Central Italy, have only recently issued. Moreover, such studies could investigate the impact of the contents of both documents on the behavior of different categories of LHAs' stakeholders, such as patients, citizens, healthcare workers. Finally, future research could expand the sample to PHOs operating in other countries to carry out comparative and transnational studies on similar NPM reform aimed at introducing PBA models.

References:

1. Andrews, R., Beynon, M.J. and McDermott, A., 'Configurations of New Public Management Reforms and the Efficiency, Effectiveness and Equity of Public Healthcare Systems: A Fuzzy-Set Qualitative Comparative Analysis', 2019, *Public Management Review*, vol. 21, no. 8, pp. 1236–1260.
2. Anessi-Pessina, E. and Cantù, E., 'Multiple Logics and Accounting Mutations in the Italian National Health Service', 2016, *Accounting Forum*, vol. 40, no. 4, pp. 265–284.
3. Arnaboldi, M., Lapsley, I. and Steccolini, I., 'Performance Management in the Public Sector: The Ultimate Challenge', 2015, *Financial Accountability & Management*, vol. 31, no. 1, pp. 1–22.
4. Behn, R.D., 'The Psychological Barriers to Performance Management: Or Why Isn't Everyone Jumping on the Performance-Management Bandwagon?', 2002, *Public Performance & Management Review*, vol. 26, no. 1, pp. 5–25.
5. Bevan, G. and Hood, C., 'What's Measured Is What Matters: Targets and Gaming in the English Public Health Care System', 2006, *Public Administration*, vol. 84, no. 3, pp. 538–571.
6. Bonollo, E. and Zuccardi Merli, M., 'Le Relazioni Sulla Performance Nelle Aziende Della Sanità Pubblica: Verso Una Maggiore Trasparenza dei Risultati Raggiunti. Un'analisi Empirica', 2016, *Mecosan*, vol. 99, pp. 43–73.
7. Borgonovi, E., Anessi-Pessina, E. and Bianchi, C. (eds.), *Outcome-Based Performance Management in the Public Sector*, Springer, 2018.
8. Bourne, M., Neely, A., Platts, K. and Mills, J., 'The Success and Failure of Performance Measurement Initiatives: Perceptions of Participating Managers', 2002, *International Journal of Operations & Production Management*, vol. 22, no. 11, pp. 1288–1310.
9. Bovens, M., 'Analysing and Assessing Accountability: A Conceptual Framework', 2007, *European Law Journal*, vol. 13, no. 4, pp. 447–468.
10. Bracci, E., 'Accountability and Governance in Social Care: The Impact of Personalisation', 2014, *Qualitative Research in Accounting & Management*, vol. 11, no. 2, pp. 111–128.
11. Brinkerhoff, D.W., 'Accountability and Health Systems: Toward Conceptual Clarity and Policy Relevance', 2004, *Health Policy and Planning*, vol. 19, no. 6, pp. 89–107.
12. Canaway, R., Bismark, M., Dunt, D., Prang, K.H. and Kelaher, M., "What Is Meant by Public?": Stakeholder Views on Strengthening Impacts of Public Reporting of Hospital Performance Data', 2018, *Social Science & Medicine*, vol. 202, pp. 143–150.
13. Chang, L.C., 'Managerial Responses to Externally Imposed Performance Measurement in the NHS: An Institutional Theory Perspective', 2006, *Financial Accountability & Management*, vol. 22, no. 1, pp. 63–85.
14. Cucciniello, M., Lapsley, I. and Nasi, G., 'Managing Health Care in the Digital World: A Comparative Analysis', 2016, *Health Services Management Research*, vol. 29, no. 4, pp. 132–142.
15. Curtin, D. and Meijer, A.J., 'Does Transparency Strengthen Legitimacy?', 2006, *Information Polity*, vol. 11, no. 2, pp. 109–122.
16. Dan, S. and Pollitt, C., 'NPM Can Work: An Optimistic Review of the Impact of New Public Management Reforms in Central and Eastern Europe', 2015, *Public Management Review*, vol. 17, no. 9, pp. 1305–1332.

17. Demartini, C. and Trucco, S., 'Are Performance Measurement Systems Useful? Perceptions from Health Care', 2017, *BMC Health Services Research*, vol. 17, no. 1, p. 96.
18. European Commission, *Study on Corruption in the Healthcare Sector*, Luxembourg: Publications Office of the European Union, 2013.
19. Ferlie, E., Montgomery, K. and Pedersen, A.R. (eds.), *The Oxford Handbook of Health Care Management*, Oxford: University Press, 2016.
20. Fryer, K., Antony, J. and Ogden, S., 'Performance Management in the Public Sector', 2009, *International Journal of Public Sector Management*, vol. 22, no. 6, pp. 478–498.
21. Halachmi, A. and Holzer, M., 'Citizen Participation and Performance Measurement: Operationalizing Democracy through Better Accountability', 2010, *Public Administration Quarterly*, vol. 34, no. 3, pp. 378–399.
22. Hatry, H.P., 'Performance Measurement: Fashions and Fallacies', 2002, *Public Performance & Management Review*, vol. 25, no. 4, pp. 352–358.
23. Holzer, M., Manoharan, A.P. and Melitski, J. (eds.), *E-Government and Information Technology Management: Concepts and Best Practices*, Melvin & Leigh Publishers, 2019.
24. Hood, C. and Heald, D. (eds.), *Transparency: The Key to Better Governance?*, Oxford: University Press, 2006.
25. Jacobs, K., Marcon, G. and Witt, D., 'Cost and Performance Information for Doctors: An International Comparison', 2004, *Management Accounting Research*, vol. 15, no. 3, pp. 337–354.
26. Krippendorff, K., *Content Analysis*, Beverly Hills: Sage, 2004.
27. Lega, F. and Vendramini, E., 'Budgeting and Performance Management in the Italian National Health System (INHS): Assessment and Constructive Criticism', 2008, *Journal of Health Organization and Management*, vol. 22, no. 1, pp. 11–22.
28. Lehtonen, T., 'DRG-Based Prospective Pricing and Case-Mix Accounting – Exploring the Mechanisms of Successful Implementation', 2007, *Management Accounting Research*, vol. 18, no. 3, pp. 367–395.
29. Longo, F., Salvatore, D. and Tasselli, S., 'Are Public Health Authorities Able to 'Steer' Rather than 'Row'? An Empirical Analysis in the Italian National Health Service', 2011, *The International Journal of Health Planning and Management*, vol. 26, no. 3, pp. 319–333.
30. Love, D., Revere, L. and Black, K., 'A Current Look at the Key Performance Measures Considered Critical by Healthcare Leaders', 2008, *Journal of Healthcare Finance*, vol. 34, no. 3, pp. 19–33.
31. Mattei, P., Mitra, M., Vrangbæk, K., Neby, S. and Byrkjeflot H., 'Reshaping Public Accountability: Hospital Reforms in Germany, Norway and Denmark', 2013, *International Review of Administrative Sciences*, vol. 79, no. 2, pp. 249–270.
32. Mauro, M. and Talarico, G., 'Accountability, Italian Style: How to Reply to Government Pressure?', 2015, *Risk Management and Healthcare Policy*, vol. 8, pp. 151–156.
33. Mauro, S.G., Cinquini, L. and Grossi, G., 'Insights into Performance-Based Budgeting in the Public Sector: A Literature Review and a Research Agenda', 2017, *Public Management Review*, vol. 19, no. 7, pp. 911–931.
34. Nuti, S., Vainieri, M. and Bonini, A., 'Disinvestment for Re-Allocation: A Process to Identify Priorities in Healthcare', 2010, *Health Policy*, vol. 95, no. 2-3, pp. 137–143.

35. OECD, *Citizens as Partners. OECD Handbook on Information, Consultation and Public Participation in Policy-Making*, Paris: OECD Publications Service, 2001.
36. Oppi, C., Campanale, C., Cinquini, L. and Vagnoni, E., 'Clinicians and Accounting: A Systematic Review and Research Directions', 2019, *Financial Accountability & Management*, vol. 35, no. 3, pp. 290–312.
37. Osborne, S.P. (ed.), *The New Public Governance: Emerging Perspectives on the Theory and Practice of Public Governance*, Routledge, 2010.
38. Pollitt, C., 'Performance Management 40 Years On: A Review. Some Key Decisions and Consequences', 2018, *Public Money & Management*, vol. 38, no. 3, pp. 167–174.
39. Rea, M.A., *Le aziende sanitarie pubbliche*, Giappichelli, 1998.
40. Reginato, E., *Accountability e controlli in sanità*, Maggioli, 2016.
41. Sargiacomo, M., 'Benchmarking in Italy: The First Case Study on Personnel Motivation and Satisfaction in a Health Business', 2002, *Total Quality Management*, vol. 13, no. 4, pp. 489–505.
42. Simonet, D., 'The New Public Management Theory and the Reform of European Health Care Systems: An International Comparative Perspective', 2011, *International Journal of Public Administration*, vol. 34, no. 12, pp. 815–826.
43. Smith, M. and Taffler, R.J., 'The Chairman's Statement. A Content Analysis of Discretionary Narrative Disclosures', 2000, *Accounting, Auditing & Accountability Journal*, vol. 13, no. 5, pp. 624–647.
44. Spanò, R., Cicellin, M. and Scuotto, A., 'Performance Measurement Design: A Contingency Perspective from the Italian Regional Healthcare Services', 2019, *Journal of Economic and Administrative Sciences*, vol. 35, no. 1, pp. 16–27.
45. Vagnoni, E. and Maran, L., *Il controllo di gestione nelle aziende sanitarie pubbliche*, Maggioli, 2013.
46. Valadkhani, A. and Ville, S., 'Ranking and Clustering of the Faculties of Commerce Research Performance in Australia', 2010, *Applied Economics*, vol. 42, no. 22, pp. 2881–2895.
47. Vukovic, V., Parente, P., Campanella, P., Sulejmani, A., Ricciardi, W. and Specchia, M.L., 'Does Public Reporting Influence Quality, Patient and Provider's Perspective, Market Share and Disparities? A Review', 2017, *The European Journal of Public Health*, vol. 27, no. 6, pp. 972–978.
48. Yilmaz, E., Özer, G. and Günlük, M., 'Do Organisational Politics and Organisational Commitment Affect Budgetary Slack Creation in Public Organisations?', 2014, *Procedia – Social and Behavioral Sciences*, vol. 150, pp. 241–250.

Legislation:

1. Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, published in the Official Journal of the European Union L 88/45 from 4.4.2011.
2. Council Directive 2011/85/EU of 8 November 2011 on requirements for budgetary frameworks of the Member States, published in the Official Journal of the European Union L 306/41 from 23.11.2011.
3. Legislative Decree no. 150 from 2 October 2009 (L.D.150/2009), 'Attuazione della legge 4 marzo 2009, n. 15, in materia di ottimizzazione della produttività del lavoro pubblico e di efficienza e trasparenza delle pubbliche amministrazioni'.

4. Legislative Decree no. 97 from 25 May 2016 (L.D.97/2016), 'Revisione e semplificazione delle disposizioni in materia di prevenzione della corruzione, pubblicità e trasparenza'.
5. Legislative Decree no. 502 from 2 December 1992 (L.D.502/92), 'Riordino della disciplina in materia sanitaria'.
6. Legislative Decree no. 229 from 19 June 1999 (L.D.229/99), 'Norme per la razionalizzazione del Servizio sanitario nazionale'.
7. Legislative Decree no. 74 from 25 May 2017 (L.D.74/2017), 'Modifiche al decreto legislativo 27 ottobre 2009, n. 150'.
8. Legislative Decree no. 118 from 23 June 2011 (L.D.118/2011), 'Disposizioni in materia di armonizzazione dei sistemi contabili e degli schemi di bilancio delle Regioni, degli enti locali e dei loro organismi'.
9. ANAC (ex CIVIT) Resolution no. 113 from 28 October 2010, 'In tema di applicazione del d.lgs. 150/2009 e della delibera 88/2010 agli enti del SSN'.
10. ANAC (ex-CIVIT) Resolution no. 112 from 22 October 2010, 'Struttura e modalità di redazione del Piano della performance'.
11. ANAC (ex-CIVIT) Resolution no. 5 from 7 March 2012, 'Linee guida ai sensi dell'art. 13, comma 6, lettera b), del D. Lgs. n. 150/2009, relative alla struttura e alla modalità di redazione della Relazione sulla performance di cui all'art. 10, comma 1, lettera b), dello stesso decreto'.