

Individual Culture Orientation and Public Physicians Performance Accountability

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ABSTRACT

The purpose of this current study is to empirically investigate whether the public physicians' professional autonomy affects their performance accountability. It also aims at examining the moderating role of individual culture orientation, i.e. power distance orientation, on the relationship between professional autonomy and performance accountability of public physicians. Data were collected through self-administered questionnaires distributed to 86 practicing physicians in 7 local public hospitals in the Bali Province of Indonesia. Data analysis was conducted by performing a structural equation modelling (SEM) with a partial least square (PLS) technique. The results provide evidence that institutional pressure positively affects the performance accountability of public physicians. It is also found the moderation effect of power distance orientation on the relationship between professional autonomy and performance accountability of public physicians. This study has a practical implication for strategies formulation of performance accountability improvement in public organizations dominated by professionals.

Keywords: *Performance accountability, Power distance orientation, Professional autonomy, Public physicians*

1. INTRODUCTION

Over the last few years, to hold healthcare providers to be more accountable has become one of the major challenges in the healthcare sector [1],[2] and [3]. Despite its importance in improving public satisfaction as well as promoting a more efficient and equitable health system [4], the extant literature shows that physicians as professional healthcare practitioners give a little, if any, concern about performance accountability. Reference [5] found that physicians feel to have the freedom to make their clinical decision autonomously without the need to report their work to an outside organization. Moreover, the research by [6] observed that physicians perceive accountability as an unimportant mechanism since it makes the focus of the organization no longer on providing the best treatments for patients.

The purpose of this current study is to empirically investigate whether the public physicians' professional autonomy affects how they maintain their performance accountability. The "professional autonomy–performance accountability" relationship is considered to be worth testing in the public sector context to better describe the extent to which autonomy does have an

impact on accountability. When compared to those in the private sector, physicians of public health providers were found to have lower performance accountability [7]. Besides, since medical professionals nowadays face the threat of de-professionalization through the mandatory implementation of standardized clinical practice guidelines (CPGs) [8] and [9], the physicians of public health organizations perhaps become the most susceptible groups to the impact of this health initiative. Given the greatly institutionalized circumstance in which these organizations perform, public health organizations were more likely to comply with government mandate [10], as well as expected on its medical professionals' behaviour [11].

This study is primarily motivated to extend research by [12]. Reference [12] found that public physicians who work under institutional pressure are preferred complying with government regulations to implement CPGs while ignoring their professional autonomy. The result successfully confirmed the Institutional Theory's notion that organizations will passively respond to external pressure through conformity and compliance [13]. The research, however, leaves unanswered the question about what factor(s) can explain the

fundamental shift in professional behaviour of public physicians, i.e. from autonomy to accountability.

This current study addresses the issue by examining the moderating role of individual culture orientation, i.e. power distance orientation, on the relationship between professional autonomy and performance accountability of public physicians. Power distance orientation refers to one's acceptance level of the unequally distributed power in an organization [14]. Individuals, who have higher rather than lower level of power distance orientation, will accept the inequalities of power without need further justification and will have to worry about being punished if they express disagreement with those who have higher authority. This cultural dimension manages individuals' beliefs about status, authority, and power [15]. Considering the highly hierarchically structured of public health care organizations characteristic, therefore, we expect that power distance orientation does have a significant role in facilitating the accountability behaviour change of public physicians.

2. LITERATURE REVIEW

2.1. Professional Autonomy and Public Physicians' Performance Accountability

Reference [16] emphasized that professionals are differentiated from other occupations by the lawful domination they hold over their work. Professionals are an extraordinary case of employees who, by their comparatively vast education and training, must be given the discretion to administer their work mainly beyond the administrative oversight of their organizations [17]. From the professional autonomy perspective, it is argued that a broad discretion must be given to the professionals in managing their work without any interference of organizational, administrative control and oversight to ensure the effectiveness of the services. Due to the status of autonomy granted to them, the professionals then have sufficient privileges to control vital organizational resources without having to be accountable for the use of these resources [17]. Thus, since accountability is viewed as opposed to autonomy [18], the feelings of suspicion, sceptic, and even resistance are commonly demonstrated by a medical professional in responding to attempts to make their practice more externally transparent [19].

In the context of healthcare service, clinicians as a medical professional, indeed, opt to work in condition unburdened by any type of prominent accountability procedures, other than the norms and values foisted by the profession itself [20]. It is also well avowed that dominant professionals, such as physicians, will actively refuse any efforts taken by management to urge red-tape arrangements and mechanisms that endanger their

autonomy [21]. The first hypothesis in this study, therefore, formally stated as follows:

H1: Professional autonomy is significantly negatively associated with public physician performance accountability

2.2. Institutional Pressure and Public Physicians' Performance Accountability

Institutional pressure is an external pressure that comes from the existence of functional, political, and social norms or practices in the operational environment of the organization [12]. Reference [22] divides institutional pressure into categories of regulative, normative, and mimetic pressure. Regulative pressure is institutional pressure in the form of rules, rewards, and sanctions that originate from political influences by interested parties who have large authority (e.g. the government). Meanwhile, normative pressure stems from the existence of collective expectations, values, and standards that apply in the context of the organizational environment. On the other hand, mimetic pressure appears as a behavioural imitation of other organizational practices to minimize perceived uncertainty.

In general, organizational practices, such as accounting and financial reporting practices, are an organizational responses to the social and institutional pressures, expectations, and values faced by the organization [23]. These responses are then manifested in the form of uniform internal structures adopted by different organizations in a similar institutional environment. The uniformity of the structure (i.e. institutional isomorphic) presented is an organizational effort to gain institutional legitimacy as well as social and economic stability from its environment [24]. Legitimacy is important for organizations in order to maintain operational existence and sustainability because it can have consequences on gaining economic and financial supports [25].

Reference [24] identified three ways by means of which institutional isomorphic change occurs. First, coercive isomorphism results from external pressures given on organizations by other organizations whereupon they are contingent (e.g., by government, regulatory, or other agencies) to implement certain structures or systems and are frequently corresponded with legal provisions, health and safety rules, or contractual obligations with other actors [26]. Second, mimetic isomorphism arises as an adaptive response to the uncertainty force. It is considered to be reasonable and necessary that under conditions of uncertainty, organizations may imitate or mimic themselves after the next organizations in their sphere that they believe to be more legitimate or successful [27]. Third, normative isomorphism, emerges substantially from

professionalization through the socialization of professions members (such as physicians, attorneys, and university professors) that occurs as they brought together in a similar training; as well as when they interact through professional and trade associations, which further spread ideas among them [28]. The processes raise a source of institutional values and, then, create shared expectations and generally accepted worldviews to be confirmed within the organizational field [29].

References [30] and [31] found that decisions made by clinician managers of a large public hospital to change the organization's internal accountability structure and accounting system are influenced by institutional pressure, which was exerted primarily through state funding agencies. Drawing on a case study of mandated hospital networks in Australia, research by [10] found that all three networks being studied generally demonstrate adherence to institutional pressure by exhibiting structural and control attributes that reflect integration, which is expected to lead to a high degree of accountability. Considering the demand from the institutional environment to public physicians for being accountable in their performance, the second hypothesis in this study, therefore, formally stated as follows:

H2: Institutional pressure is significantly positively associated with public physician performance accountability.

2.3. Power Distance Orientation as a Moderator of Both the Institutional Pressure–Physician's Accountability and the Professional Autonomy—Physician's Accountability Relationships

Reference [24] argues that organizations respond to institutional pressure in order to maintain their legitimacy, that is, to be socially accepted by the environment. Taking this into account, we assume that in similar to public health care organizations where they work, public physicians also tend to behave in such a way in accordance with social expectations and values. In other words, in the context where high demands for accountability from the institutional environment are existing, public physicians will attempt to appear accountable for their performance.

The 'gain for legitimacy' motivation of doing accountable, then, can be facilitated by the extent to which public physicians perceive and accept the relative degree of power held by the institutional pressure sources. The more powerful the pressure sources have, the higher the legitimacy can be gained [32]. These behavioural patterns are aligned with the idea of power distance orientation culture. Power distance orientation refers to one's acceptance level of the unequally

distributed power in an organization [14]. Compared to the lower ones, individuals with a higher power distance orientation level will recognize power disparities without further explanation and will have to worry about being punished if they communicate disagreement with those with higher authority.

Reference [14] suggests that individuals with low power distance orientation are more pleased working in environments in which they feel authorized to make choices independently rather than co-dependently. In addition, power distance is also found to be negatively correlated with the level of autonomy [33]. On the other hand, individuals with high power distance orientation tend to have a high need for approval from the social environment [14]. They, therefore, will always make a decision that increases the potential for either gaining social acceptance or avoiding social rejection. Reference [34] found that corporations with a high power distance culture have a greater need in disclosing information regarding their CSR efforts and activities to reduce or avoid political consequences.

The following hypotheses, therefore, will be tested:

H3a: The interaction between individual levels of power distance orientation and professional autonomy significantly negatively affects physician performance accountability

H3b: The interaction between individual levels of power distance orientation and institutional pressure significantly positively affects physician performance accountability.

3. METHOD

3.1. Research Designs and Samples

The study makes use of a sample of practicing physicians in 7 local public hospitals (LPHs) in the Bali Province of Indonesia. Since 2009, all the LPHs had been assigned under the gubernatorial regulation as the health care provider on a local health insurance program in Bali. The sample focuses on physicians with specific criteria working both in the emergency department (ED) and outpatient departments (OPD) of the LPHs and actively participating in the program for more than one year. It, therefore, will enable the study to obtain the most relevant information from the physician who genuinely understands and comprehends their role as a service provider. Of the 140 questionnaires distributed, 130 were returned, providing a satisfactory response rate of 94%. Examination of responses, however, revealed that 44 responses were not usable, yielding a total of 86 (61%) usable responses. Demographically, the sample physicians had been involved in the local health insurance program, on average, for 3.2 years and been in current positions on average for 6.9 years. Most

respondents are general practitioners (77.9%), male (59.3%), and less than 40 years of age (65.1%).

3.2. Instruments

All variables in this study were measured by instruments that had been formerly constructed and utilized by prior researchers with some minor modifications in terms of wording to improve the clarity and appropriateness. Institutional pressure is measured by asking respondents to express their level of agreement to the extent to which specific reason (pressure) was used (felt) as (to be) a justification for being accountable in conducting their job, using a 5-point Likert-type scale, ranging from ‘strongly disagree’ to ‘strongly agree’. The items were taken from the instrument developed by [35] which included the possible reasoning that: (1) it has been established in a legal regulation issued by the Governor that the program implementation should be held accountable and transparent; (2) the local community has a high enthusiasm for obtaining health care through the program; (3) the NGOs and other independent oversight bodies were giving considerable attention to both success and failure of the health insurance program.

In measuring professional autonomy, this study used the instrument from [31]. Respondents were requested to indicate their influence degree on critical priorities as well as the degree of control over the use of vital strategic resources, ranging from 1 (to a little extent) to 5 (to a great extent). Power distance refers to the extent to which one accepts that power in institutions and organizations is distributed unequally [36] and [37]. This study assessed the variable with a four-item individual-level measure taken from Ref [38]. The items are about: (1) negative consequences for challenging the manager’s authority; (2) obligation to not questioning top-level executive decisions; (3) restriction for expressing disagreements with their managers; (4) undesired implications for letting employees participate. Respondents indicate their level of agreement to the above items using a five-point Likert type scale, anchored 1 (strongly disagree), and 5 (strongly agree).

Finally, this study uses an instrument and concept of accountability from [39] as the degree to which a job incumbent feels responsible and is asked to answer for his or her work decisions and behaviour. The instrument comprises of four items, asking the respondent to rate on a 5-point Likert type scale (‘1’ represents strongly disagree and ‘5’ represents strongly agree) the extent to which (1) their supervisor hold them personally accountable for the work decision they make; (2) respondents believe that the performance standards upon which their work is fairly evaluated; (3) respondents felt a very high degree of personal responsibility for the work they do; (4) respondents felt that it’s hard for them to care very much about whether

or not the works gets done right (reverse scale). Table 1 presents a summary of descriptive statistics for all variables.

4. RESULTS AND DISCUSSIONS

A structural equation modelling (SEM) with a partial least square (PLS) technique was used to test the hypotheses. PLS is a variance-based approach that simultaneously examines the structural models (i.e., relationships among construct) and measurement models (i.e., relationships between constructs and its indicators) [40]. PLS can estimate models with small sample sizes, handle the issue of multicollinearity among independent variables, and does not make distributional assumptions about the data used. This study used WarpPLS version 4.0 software.

4.1. Measurement Model Analysis

The relative amount of convergent validity among item measures can be estimated using the size of the factor loading, the average variance extracted (AVE) and the construct reliability, with the rule of thumb for each measure, are 0.5 or higher, 0.5 or higher, and 0.7 or higher, respectively [41]. For all of the constructs being studied, as seen in Table 2 and table 3, the factor loading sizes are range between 0.547 and 0.869, the AVEs are above 0.5, and the reliability values (assessed in terms of Composite Reliability) are higher than 0.7, thus indicating adequate convergent reliability. In assessing discriminant validity, the study makes a comparison of the square roots of AVE and the correlation between constructs that the former measure should be greater than the latter [41].

The results are shown in Table 4 which describes the greater value of square roots of AVEs (presented as the elements in the diagonal) in comparison with the correlation among constructs (presented as the off-diagonal elements). It, therefore, provides supporting evidence of adequate discriminant validity.

Table 1. Descriptive Statistics (n = 86)

Constr ucts	Theoretical score		Actual score		Mean	S.D.
	Min	Max	Min	Max		
PA	1.00	5.00	1.00	3.00	1.19	0.49
PD	1.00	5.00	1.00	4.25	2.47	1.05
IP	1.00	5.00	2.33	5.00	3.74	0,80
AC	1.00	5.00	1.75	4.50	3.33	1.12

PA = Professional Autonomy; PD = Individual Level of Power Distance; IP = Institutional Pressure; AC = Performance Accountability; S.D. = Standard Deviation

Table 2. Construct Coefficients

Construct	Mean	S.D.	Loading
Professional Autonomy (CR = 0.838; AVE = 0.721)			
PA 1	1.33	0.60	0.849
PA 2	1.06	0.28	0.849
Individual Level of Power Distance (CR = 0.837; AVE = 0.587)			
PD 1	3.24	1.11	0.547
PD 2	2.26	0.92	0.832
PD 3	2.23	0.86	0.869
PD 4	2.13	0.88	0.776
Institutional Pressure (CR = 0.731; AVE = 0.523)			
IP 1	3.97	0.68	0.574
IP 2	3.91	0.63	0.847
IP 3	3.36	0.92	0.723
Performance Accountability (CR = 0.793; AVE = 0.525)			
AC 1	2.81	1.11	0.821
AC 2	2.90	1.06	0.688
AC 3	3.41	0.83	0.745
AC 4	4.21	0.87	0.632

PA = Professional Autonomy; PD = Individual Level of Power Distance; IP = Institutional Pressure; AC = Performance Accountability; CR = Composite Reliability; AVE = Average Variance Extracted

Table 3. Cross Loading

	PA	PD	EP	AC
PA 1	0.849	-0.138	-0.127	-0.078
PA 2	0.849	0.147	0.020	-0.008
PD 1	0.059	0.547	-0.268	-0.353
PD 2	-0.070	0.832	-0.151	-0.170
PD 3	0.023	0.869	-0.096	-0.227
PD 4	0.023	0.776	-0.026	-0.135
IP 1	-0.062	-0.261	0.574	0.243
IP 2	0.032	-0.120	0.847	0.353
IP 3	-0.124	-0.013	0.723	0.246
AC 1	-0.053	-0.0274	0.323	0.821
AC 2	-0.032	-0.005	0.150	0.688
AC 3	-0.51	-0.193	0.382	0.745
AC 4	-0.120	-0.258	0.254	0.632

PA = Professional Autonomy; PD = Individual Level of Power Distance; IP = Institutional Pressure; AC = Performance Accountability

Table 4. Correlations among Constructs with Square Roots of AVEs

	PA	PD	EP	AC	PA*PD	IP*PD
PA	0.849					
PD	0.005	0.766				
IP	-0.063	-0.160	0.723			
AC	-0.051	-0.271*	0.404**	0.725		
PA*PD	0.082	0.049	0.106	-0.132	0.705	
IP*PD	0.142	-0.234*	-0.157	0.033	0.246*	0.572

PA = Professional Autonomy; PD = Individual Level of Power Distance; IP = Institutional Pressure; AC = Performance Accountability; Diagonal element: square root of AVE; off-diagonal: correlation between constructs; **Significant at $p < 0.01$; *Significant at $p < 0.05$.

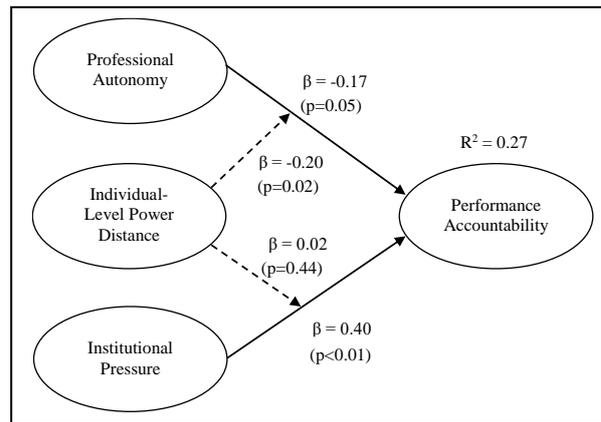


Figure 1 PLS results

4.2. Hypothesis Testing

Figure 1 exhibits the results from the examination of the model. There is a negative association between professional autonomy and public physicians’ performance accountability, yet statistically insignificant ($\beta = -0.17$; $p = 0.05$). The result suggests that the perceived sense of autonomy felt by physicians does not affect their motivation to hold accountable for performance. Perhaps, professional autonomy no longer appears to be a meaningful consideration in affecting behaviour. Physicians at public health organizations tend to prefer conforming to the mandated implementation of CPGs that promotes accountability. Moreover, it also can be related to the de-professionalization phenomenon of the medical profession [9], [42]. This finding is empirically confirmed by the result of the descriptive statistics of the variable of interest in this study, i.e., the mean score of professional autonomy which is found to be relatively low ($\mu = 1.19$). Thus, the result does not support the first hypothesis (H1).

Table 5. Results Summary

Hypo	Relation	Sign	Coef	p-value	Decisions
H₁	PA → AC	-	-0.17	0.05	Not Supported
H₂	IP → AC	+	0.40	< 0.01	Supported
H_{3a}	PA*PD → AC	-	-0.20	0.02	Supported
H_{3b}	IP*PD → AC	+	0.02	0.44	Not Supported

PA = Professional Autonomy; PD = Individual Level of Power Distance; IP = Institutional Pressure; AC = Performance Accountability

Regarding the relationship between institutional pressure and physicians’ performance accountability, the analysis gives a positive and significant path coefficient ($\beta = 0.40$; $p < 0.01$). This finding is consistent with some earlier researches that found a

positive correlation between institutional pressure and public physicians' decision to change the organization's accounting system [31] and to establish structural and control attributes that lead to a high degree of accountability [10]. Thus, the result provides support for the second hypothesis (H2) that institutional pressure would be positively associated with public physician performance accountability.

Figure 1 also presents the results of the SEM-PLS analysis to test the moderating effect of individual level of power distance orientation on the relationships between professional autonomy and performance accountability as well as on the relationship between institutional pressure and professional autonomy. The results indicate there is a statistically negative significant ($\beta = -0.20$; p -value = 0.02) two-way interaction between professional autonomy and individual level of power distance orientation influences performance accountability. Meanwhile, the two-way interaction between institutional pressure and individual level of power distance orientation in affecting performance accountability is found to be positive ($\beta = 0.02$), yet statistically insignificant (p -value = 0.44). Therefore, our hypothesis that the effect of professional autonomy—H3a (institutional pressure—H3b) on performance accountability is contingent on the individual level of power distance orientation is supported (not supported). Table 5 summarizes the hypotheses testing results of the current study.

5. CONCLUSION

This study contributes to the body of knowledge by examining the accounting behaviour of public physician based on professional and institutional theory perspectives. This study extends research by [12] that has limitation in identifying factor(s) which facilitate the fundamental shift in professional behaviour of public physicians, i.e. from autonomy to accountability. The hypothesis testing conducted provides evidence that institutional pressure positively affects the performance accountability of public physician. On the other hand, taking into account the potential role of culture dimension, it also found that individual level of power distance orientation negatively moderates the relationship between professional autonomy and performance accountability.

This study has a practical implication for strategies formulation of performance accountability improvement in public organizations dominated by professionals. Considering the result that it is the institutional pressure in the form of coercive pressure that primarily motivates public physician to be accountable, therefore, the regulator as a dominant actor have a strategic role in promoting professional accountability through statute or other means. These strategies will also be relevant to be implemented in Indonesia, where the people are

characterized by the high level of power distance orientation [43].

This study has several limitations that may affect the finding. The collecting data using self-administered questionnaires as an instrument is subject to social desirability bias. This is a need for future researchers to include other collecting data techniques, e.g. in-depth interview and/or documentation. Furthermore, the study is conducted limited to the area of Bali Province that may have a potential issue of cultural bias. Future research can construct the same topic area in different locations in order to make comparisons.

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