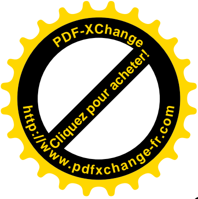
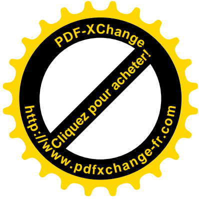
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COOPETITION AND GOVERNANCE IN HOSPITAL SERVICE AREAS

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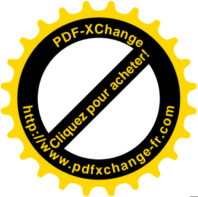
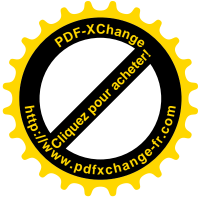
Summary

Generally, service areas, procedures, and major concepts for hybrid systems are considered as defined and controllable aspects according to the bureaucratic model of organizational structural configurations. From a viewpoint, based on a participating observation and an inductive clinical approach within medium-sized hospital centers with approximately 1,000 beds, this topic questions the assumption of a structural and controlled purpose for these procedures. We propose two additional concepts of governance: logistics and the transverse integrator, both being necessary for organizational rebalancing in services areas and procedural "co-opetitive" integration. This concept leads us to rethink and position these procedures according to areas of differentiation and integration.

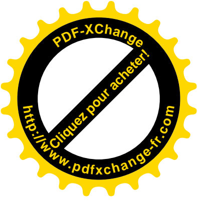
KEY WORDS. – PROCEDURES – HYBRIDIZATION – DIFFERENTIATION -- INTEGRATION.





INTRODUCTION

Primarily, the purpose of our research is concerned with the organizational transformations of hospitals in France and the profound changes that theses hospitals have confronted, such as the T2A price development for procedures, and secondly, the analysis of the organizational structures endorsed by the Hospital and limitations resulting from the perspective of hospital changes in governance that have been set in place by the Trustee Administration. The environment within which hospital organizations evolves, are characterized by an increasing complexity that involves the limitations imposed by administrative organizations (dematerialization of purchase procedures and the implementation of hospital logistical platforms), cultural changes by agreed procedures (measures of accreditation), the emergence of contact zones, areas of relevance and coherence between healthcare givers (nurses in care units) and logisticians (centralized markets, restoration, laundries, pharmacies), addressing a certain level of contractualizing between these entities and the "transverse integrator" type of organizing agent. In the field of hospitalization, one needs to know how to develop an approach to qualify the links between organization and procedures. Our proposal is based on a theoretical and methodological approach for these links on the basis of the following hypothesis: the key factors for a successful contractual policy for hospitals engaged in the development of an effective procedural management system and the need to designate an integrator framework (or integrator transverse). Carried out in the Saint John's Hospital Center (SJHC), our in-depth ethnographic type of case study highlights the role of an integrator framework, the key person managing two problematic areas, one being the organizational unbalance covering a group of four logical aspects (or spheres according to Mintzberg and Glouberman, 2001), which are, Community (administrated organizations), Control (managers), Cure (doctors), and Care (nurses and healthcare assistants), and the other being the qualification of cooperative components (contact degree and logistical involvement,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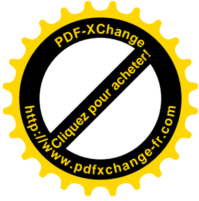
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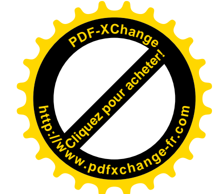
mobilized resources, exchange values and the respect of standards and protocols). For a theoretical framework that would be favorable to a critical analysis of integration and differentiation concepts, we have resorted to a procedural approach, which has largely been used in the industrial and business sectors for about ten years. Such an approach leads to a transverse view of hospital organization and involves the designation and recognition of a pilot or coordinator (an integrator or transverse integrator), where services are studied, to a large degree and for many years, by using economic and management reports (Weber, Crozier, Mintzberg, Boutinet and Crémadez). In the first part, we will try to examine the theoretical question of the structural and cultural configurations of hospital organizations, offer results and the contributions of our research, present a new hospital governance cartography, and put three central questions of scientific organization analysis into perspective, which are, the questions of organizational coherence, integration procedures, and inter-individual cooperation interaction.

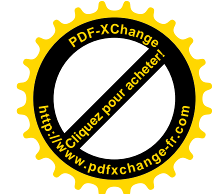
1- HOSPITAL SERVICE AREAS IN THEIR SEARCH FOR INTEGRATION

1.1 New hospital governance and its characteristics

The decentralization of logistical activities, which has been prevalent for about 15 years, some examples being found in the CHU of Tours and Montpellier, coincides with a renewal of "Hospital" plans. This renewal development results from the conjunction of four great tendencies: the acceleration of the horizontal and vertical fragmentation of hospital logistics, the multiplication and crumbling of logistical players having the effect of a nebulous sense of organization, the scrambling of the cartography and service areas inherent in the procedural strengthening of the "metropolization" and "internationalization" of the public hospital sector, and the complex system of care procedures, as well as medical and administrative treatment, leading to treatment given to the individual. Given the profound transformation of the traditional models in public health, the question is raised about knowing what shape this



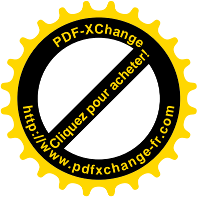
relocation of logistical activities takes and the place and role that the different players hold in this system. In this context of new governance, the logistical platforms have become the pivotal tool of local logistical strategies, such as in the area of obtaining medicine for care service areas. While their political legitimacy is rather recent (Hospital Plan 2007), the uncertainty of their expertise, the "rivalry" existing in the service areas, and the relative weakness in their human, technical and financial means, do not constitute, as it may seem, the obstacles in their development and a consensus seems to open to the acceptance of logistical platforms as a key role in the emergence of what is suitable in identifying new hospital governance. The definition of a logistical policy could be identified as a process of organizational mediation, due to the fact that the purpose of every logistical policy is to govern the disarrangements that may often be present throughout the different hospital service areas. The complexity of a comprehensive responsibility in the area of logistical health needs would therefore include, on the one hand, cooperation between logistical procedures, such as restoration, laundry, pharmacies, and central marketing, and on the other hand, the designation of a coordinator, an integrator framework that encourages "contact" relationships, and the continuity of procedures perceived as an "extended logistical organization". By connecting contractual objectives and means with cooperation among the players, the integrator framework holds the key for the contractualizing of logistical organization with care organization. The consistent recomposition of hospital organization requires the mobilization of three modes of "coopetition" from players in the health system (according to the distinction, as established by Favereau, between the three modes of the coordination of an economic system) -- limitation, contract and agreement -- limitation being the mode that regulates the activities, allowing for the justification of territorial differentiations, contract being the mode that acts as a base for negotiation and the methodology integrating the four spheres, and agreement being the mode that makes the consideration and agreement of the

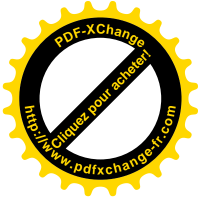


players possible -- all within the perspective of an improvement in the quality of the patient-oriented services. (Gadreau, Jaffre, Lanciau, 1999). These three components, being the origin of coordination and coopetition, could constitute the solid foundation of this new role for the integrator framework, or Pilot Owner of Procedure according to Bouchardy and Darréon, 2004, this being the real "coopetitor", responsible for the procedures. Hospital organization should be studied as a complex organization of interests and personal goals with meetings consisting of individuals and groups that have their own identities, even though they must cooperate. The existence of this organization involves the discovery of a relationship mode itself, which is an arrangement, either accepted or imposed, that assures its identity and coherence. That leads us then to other considerable questions. What is the nature of the relationships that bring hospital organization members together? What are the nature and the position of individuals and groups who put it together? How do we identify the structural and cultural borders of hospital organization? How do we distinguish relationships and the internal agents within hospital organization and those who are on the outside?

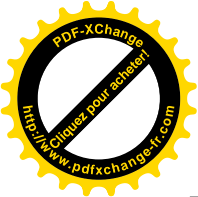
1.2 The Hospital: an organization between complexity and hybridization

Hospitals, in particular, are generally considered as extraordinarily complicated organizations. However, when one separately studies organizational factors, their complexity seems to become blurred. Beyond the difficult degrees of implementation, an intelligent person can easily understand even the most tactful medical intervention. So, why does everything become so complicated when these factors are considered in an organizational context and when each of these organizations are examined in a social context? The Health World has, for a long time, been identified according to four spheres, four types of activities, four methods of organization, and four incompatible states of mind, and according to Mintzberg et Glouberman, "Our opinion is that as long as they remain disconnected, nothing fundamental will change" (page 57, 2001). We have attempted to identify these four spheres, debating the





characteristics of each, especially their differences, and considering some of their dynamic relationships. The well-known care institution, known as the hospital, has been the primary focus of our study. Management, in this case, is not identified only by a homogeneous process, but by many procedures that are usually distinct from one another. We can identify and distinguish them according to the location of their practice by using different forms of research and adapting the configurations articulated by Mintzberg. Certain players operate management procedures from the most basic concepts (down), directly arriving at the level of the operational center focused on care provided to patients. Management, as understood by others, is operated from the top (up). This is the usual viewpoint of those who control and establish institutions, such as State agencies and insurance companies. However, management can be operated, focusing from the inside (in), and then being directed to the units and staff under the control of the institution, while others hold to the idea that management can be operated, focusing from the outside (out), and directed toward those who encircle the institution, but who are technically independent of formal entities of authority. Let's look at these four types of management collectively in order to reach a conclusion concerning the four divisions of hospital activity in reference to the four previously mentioned spheres.



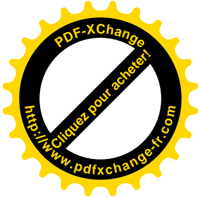
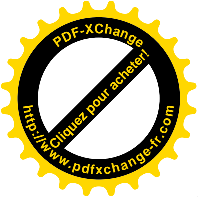
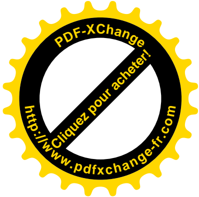


Figure 1: The four different spheres of hospital organization





1.3 The different typologies of management identified

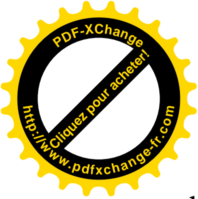
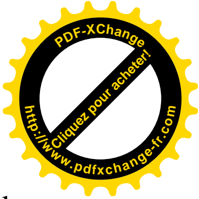
The Down-Out Management: on the left side at the bottom, we have identified the sphere for doctors (Cure). Their type of management falls into the Down category for operations concerning the operational center and also an Out category since this sphere doesn't involve making a report to the hospital hierarchy.

The In-Down Management: located on the bottom right, and playing the role of a support process, we find the care sphere (Care), essentially represented by nurses who operate according to their own hierarchical authority and through other specialists who provide basic care (ASH). Their type of management falls into the In category since this sphere is directly connected to hospital management and also a Down category since the principal goal is to satisfy the needs of patients.

The Up-In Management: the Control sphere, at the upper right side, involves a conventional management, instead of the Up type of management, since the managers are completely responsible from the viewpoint of the institution. However, this management system also falls into the In category since these managers are also directly involved at the operational level.

The Up-Out Management: finally, at the top, is the Community sphere, which is formally represented by hospital authorities, and informally by all institutions and other organizations that provide their assistance and services in hospitals. These are neither directly connected to the hospital, nor are they personally integrated operations in the hierarchy, but fall into both Up and Out categories.

Cure, Care, Control and Community deviate according to their position and managerial orientation: the doctors "clinically" directed downwards (Down), but "administratively" directed toward the outside (Out); the nurses are viewed as a (Down) management activity, but are located inside (In); the managers remain inside (In), but are required to behave in the upward direction (Up); and the authorities are outside (Out) and move upwards (Up). The

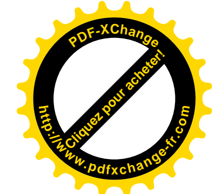



hospital, consequently, is not only an organization, but four with each part being structured independently. The system itself tends to be extended according to two lines. A horizontal line separates those that operate "clinically", "at the bottom" of the system, from those that don't operate, but which instead, work above this line, thus creating the "large chasm" in the health system. Below, are those that respond to professional requirements and technological imperatives, whereas those above respond to the needs of management review and finances. A vertical line separates those that are intimately connected to the institution, such as nurses and managers, who are implied but not formally hired or compromised, such as doctors and state-controlled authorities. In our point of view, it is the association of different divisions in terms of organization, attitude, and frame of mind, which makes it difficult to manage the system. We have described, in the information below, this disparate organization (hybrid?) of the four spheres, which are especially and significantly evident inside the hospital activities and procedures.

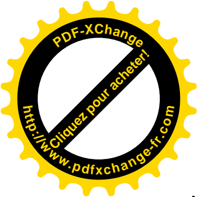
2- THE HOSPITAL BETWEEN A CULTURAL LINE AND STRUCTURAL HYBRIDIZATION

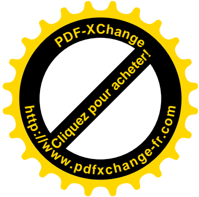
2.1 Community, Control, Cure, Care and Chain: differentiation or integration?

Hospitals, from a doctor's viewpoint, are considered as "Down-Out" structures that directly manage care services while rejecting a problem management control. For most individuals connected to the medical community, hospitals became increasingly specialized and inclined to abandon the simplest and even the most integrative forms of intervention for the benefit of the care community. It isn't a question of a lack of implication on the part of doctors, but of a certain difficulty in establishing this implication with a formal commitment. The term "Intervention", used to designate a surgical operation, seems more suitable for doctors, since their implication is inevitably intermittent as opposed to the nursing "staff". Consequently, they leave the major part of care in the hands of the nurses. These are specifically the nurses



in care units that fall into the "In-Down" category, who are greatly committed in comparison to the institution and deeply connected in comparison to the operational center. Moreover, in contrast with the interventions of doctors, nurses provide care according to a somewhat continuous process for the purpose of coordination. One of the issues for hospitals is that most of the time no one is in charge of this coordination. Nurses, it seems, are in the best position for exercising this coordination. They are often "stuck" between the doctors who claim responsibility for the patient, in spite of their absence, and the managers who claim responsibility for control, in spite of their distance from the situation. Managers exercise a formal authority over the other members of the hospital community, especially over those who are least able to claim a professional status. This also entails the ability of managers to directly control all types of "organizational patchwork" involving situations that are more or less independent, resulting in management problems for hospitals. We might note, however, that this simply is not about an ability issue. The managers are often able to cross what we called the "large chasm", where the structure is determined by professional standards and technological imperatives and not by an administrative mandate. What if the managers don't control clinical operations? Can they say that they truly manage the hospital? Maybe an objective response is in the results of all these reorganizations and other restructuring activities where hospitals were regularly used for many years. Control of hospitals, it would seem, is notoriously challenging, and in spite of a perpetual reorganization, the hospitals become entangled in their own dysfunctions. "Care", "Cure" and "Control", as we have noted, are used both as verbs and nouns, whereas the term "Community" is only used as a noun. The players who represent the institutional Community, because of their distance in relation to the spheres of care and medical patient care, usually direct their attention toward control while placing a certain amount of pressure on managers. We are therefore in the presence of a system characterized by an extraordinary and increasing differentiation as well as a lack of





integration. We propose a cartography of governance for hospital organizations (Figure 2), which was adapted by Jacot and Micaelli, 1996, Zarifian, 1996, and Glouberman and Mintzberg, 2001.

Face 2: A new cartography for hospital organizational governance

UP

COGNITION

Convergent Engineering

CONTROL

Management Controller

CHAIN (SUPPLY)

Logistician

DIFFERENCIATION

INTEGRATION

Supervision

Limitation

OUT

Organization by procedure

IN

Intervention

Coordination

CURE

Doctor

Horizontal cooperation

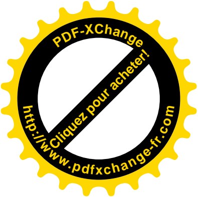
CARE

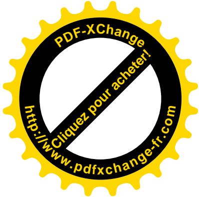
Nurse

Organization by project

ACTION

DOWN

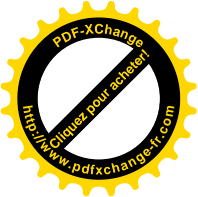
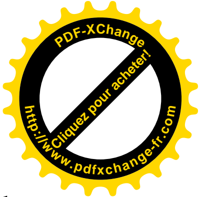




Control, Care, Cure and Chain, the four spheres that we identified, if studied in the SJHC hospital center and in the context of a mutual integrator, actually seem to consider the development of a transverse integrator as an improvement of their organization and not simply as an administrative addition to the hierarchy already in place. As stated by Glouberman and Mintzberg, "*We need to unite the two "Care" and "Cure" spheres in an efficient manner in order to coordinate services provided to individuals inside the hospital and services provided by staff inside the Community*" (Gloubeman and Mintzberg, page 69, 2001). Additionally, we need to tear down the barriers between "Care", "Cure", "Control" and "Chain" so that institutions can operate in a more collaborative manner and also to ensure that the resources of the comprehensive system are allocated more effectively.

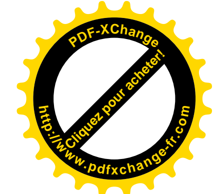
2.2 Structural hybridization and logistical integration

All five of Mintzberg's configurations can be considered as the basis for describing the hybrid structures. In terms of they economics and theory of organizations, hybrids refer to arrangements where the parties are independent, adaptable without the use of a price system, and involved in the sharing and exchange of technology, capital, products and services without a sense of common property (Ménard, 2002). A hybrid, for example, participates in two separate organizational forms of economic activities, one being the integrated firm and the other being the transaction adjusted by the price. The term "hybrid organization" is one of the numerous titles used to describe a certain type of commitment between economic agents (those connected with systems, partnerships, alliances, quasi-firms, etc.). Such a reference, however, has the advantage of being explicitly related to the organizational aspect, namely, the relationships between the players implied in a mutual commitment. Literature on the hybrid forms is significantly rich and multidisciplinary. Three such extended studies have been found in articles published in savings, management and sociology magazines. One of these studies conducted by Grandori and Soda in 1995, examined 167 contributions inspired

mostly by the management and theory of organizations. Another, conducted by Oliver and Ebers in 1998, systematically analyzed 158 articles on the systems published in four major magazines for management and sociology between 1980 and 1996. The third study was carried out by Ménard (2002), which, after recording several definitions of hybrid forms and indicating their common points, proposed interesting research avenues to consider in this field. Studies such as these, combined with the analysis of other contributions, suggest that hybrid organizations have some regularities, beyond the limitations of heterogeneity, such as the common aspect of resources -- the organization of activities through agreements of cooperation and coordination inter-establishments considers the concept of making joint investment decisions. Investments in logistical infrastructures and investments in information systems are also good references. This aspect of common resources involves a continuum in the relationship between partners and the mixture of cooperation and competition between the players, who can compete in some activities and cooperate for offering some services, or even create some products in common. Furthermore, the continuum of relationships through cooperation doesn't guarantee the development of balanced relationships between the players. In most situations relating to contact logistics, we have focused on asymmetric relationships, subject to the uncertainties of institutional, organizational and cultural environments, the contract, in terms of the questions that refer to this aspect of common resources, the need to define the sharing of profits, and the risks involved in all activities, which concerns another aspect, such as the contract between the players, which could be more or less limiting or formalized. By the usage of the term "contract", we refer to a form of "fixing the rules of the game", required for safeguarding the advantage of the cooperation between players, given the risks related to the decisions for sharing profits.[1] Since one of the common goals of our article

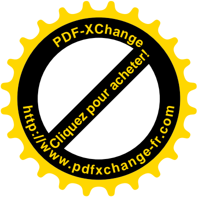
[1] This involves the neoclassic contract identified by Williamson with respect to hybrid organizational forms.

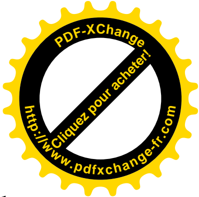


is to study the relational dynamics between logisticians and care givers in the pursuit of integrating the care chain, we chose to use this term for analyzing the common points that are harmonized in hybrid organizational forms. We are interested in a specific type of hybrid and logistics whose definition asks the question to identify the implied players, the benefit central to this type of hybrid, and finally, its significant special characteristics.

2.2 Hospital organizations as hybrid structures?

The Hospital Center’s concern is to analyze in terms of the lack of structural harmony. All organizations don't choose coherence in the design of their structure. They use, what Mintzberg called, structures that borrow their characteristics from more than one configuration. Some hybrids appear to be dysfunctional, having the characteristic of an organization that doesn’t' make decisions, or which try to combine the best elements of several configurations, and end up accumulating the inconveniences involved. However, in some cases, organizations don't have a choice since contradictory contingency factors, where they have no control, force them to adopt a dysfunctional hybrid structure. Some of these organizations, a hospital for instance, appear to require a Professional Bureaucracy structure, but are led, while rejecting their performance, to adopt some characteristics of the Mechanistic Bureaucracy under the impulse of a concentrated external control (Health Authority), and other specificities (the importance of logistical services) of an "ad-hoc" structure. Nevertheless, other hybrids appear to be perfectly logical and indicate the need to respond to a more legitimate force at the same time. This could be the case of Saint John’s Hospital Center, which is a simple professional bureaucracy that recruits doctors and nurses who are highly trained and who depend largely on their standardized qualifications in order to produce a certain quality of care, but that needs someone to pilot the procedures to assure a close coordination of operational activities. This is also the case for Adhoc entrepreneurial situations where the framework integrator, who is himself an expert, is able to maintain a sort





of central control in spite of the usage of multidisciplinary project groups or partitioned communities, such as doctors, nurses and logisticians. Hybrids are all intermediaries between two, three or more configurations. This is the case for the Saint John's Hospital Center managed by an administrative public authority and controlled by its General Manager, but which also includes a proliferation of ethics and which is dependent of qualifications for its medical, nursing and logistical staff. We have, in this situation, a hybrid structure that is located between the five configurations of Mintzberg. We have discussed hybrids while only considering them as structures where each characteristic is an intermediary between the characteristics corresponding to several configurations, but another sort of hybrid that uses different configurations and different parts of the organization also exists. In this manner, there can be coherence in the structure of each part if it is not accepted by the whole organization. Inside the organizations, the forces that attract different parts for different structures always exist. Each of these parts tries to reach the attain the structure that is the most suitable for its own needs while being subject to the pressures that coincide with the most appropriate structure for the entire organization. The creative and supportive model for the activities of inter-organizational forms would be to look in the human relationships that preexist among organizations and their players. Granovetter uses the term "*embeddedness*" to designate the adhesive force that derives from all relationships. Therefore, cooperation that is continuous between the hospital players entails the development of satisfactory relationships from a human viewpoint rather than optimal relationships from an economic viewpoint.

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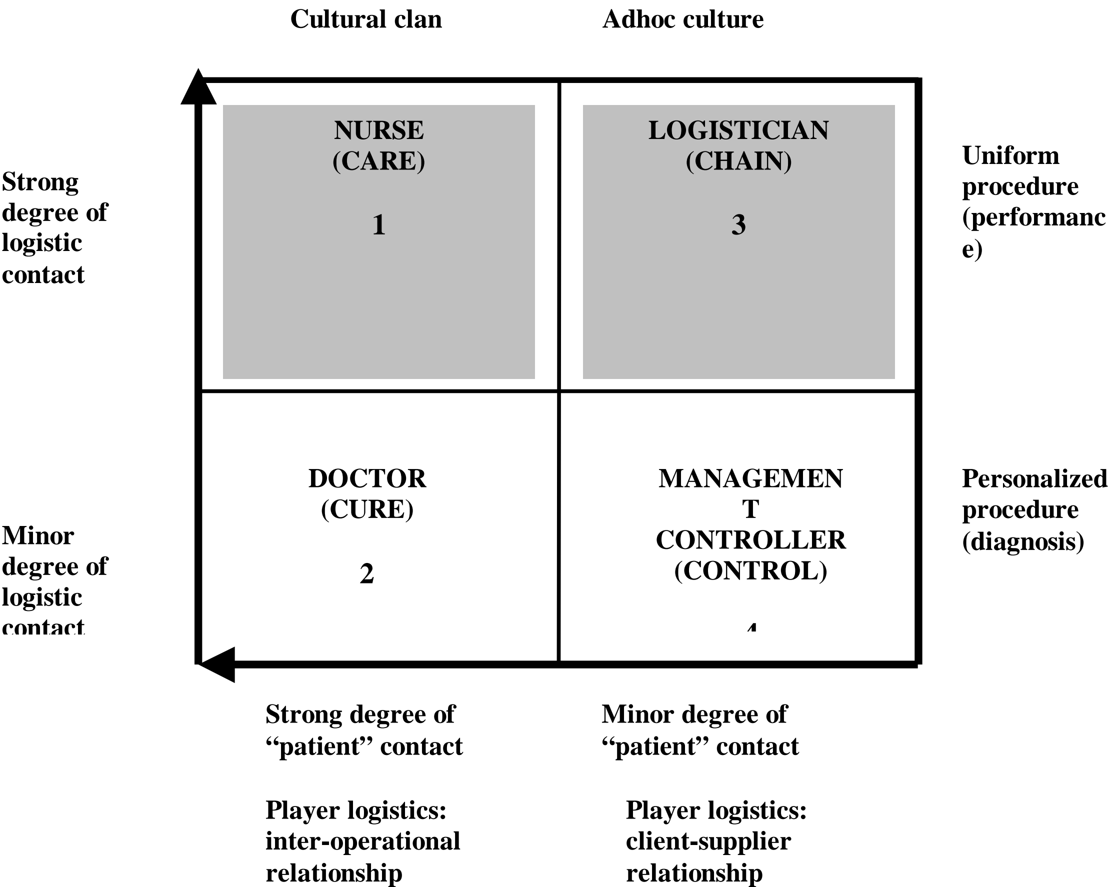
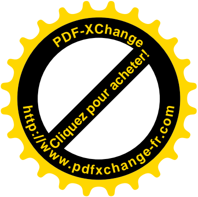
2.3 Contact positioning and hospital governance

We will now offer a representation of a matrix type of "contact" positioning using four players in the four spheres of the hospital field. The purpose of this representation is to synthesize the theoretical and practical contributions from our research.

Figure 1: "Contact", cultural and relational positioning of hospital players providing care



We identify four spheres: Care (the nurses), Cure (the doctors), Chain (the logisticians) and Control (the management controllers). Six levels of examinations are based on our analysis: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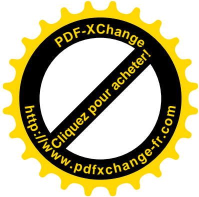
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Culture	Clan	Adhoc
Player Logistics	Inter-operational	Customer-Supplier
Degree of Logistical Contact	Strong	Weak
Degree of "patient contact"	Strong	Weak
Procedural Typology	Standardized (performance)	Personalized (diagnosis)
Profitable Factors	Methods, techniques and procedures	Interconnections, interrelations

1- CARE (nurses):

Cultural Clans. Inter-operational logic: the value was given during the interaction with the patient. Strong degree of logistic contact. Strong degree of "patient" contact. A standardized and predetermined process (accent on performance) that puts the patient at ease and fosters a convivial level of experience. Profitable factors: established and proven procedures.

2- CURE (doctors):

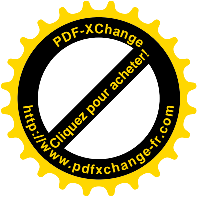
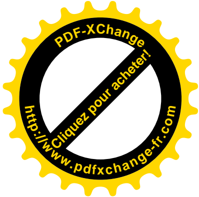
Cultural Clans. Inter-operational logic: the value was given during the interaction with the patient. Minor degree of logistic contact. Strong degree of "patient" contact. A personalized process (accent on diagnosis), diagnosis in "real time" of complex and poorly defined issues. Profitable factors: connections in consultation with other professionals.

3- CHAIN (logisticians):

Adhoc Culture. Customer-Supplier logistics: the value was given in the absence of the patient and concentrates mostly on the findings. Strong degree of logistic contact. Minor degree of "patient" contact. A standardized process (accent on performance), supervision of a team at a minor cost. Profitable factors: established methods and evolutionary techniques.

4- CONTROL (Management Controller):

Adhoc Culture. Customer-Supplier logistics: the value was given in the absence of the patient and concentrates mostly on the findings. Minor degree of logistic contact. Minor degree of "patient" contact. A personalized process (accent on diagnosis), creative management

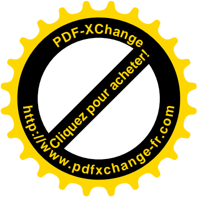



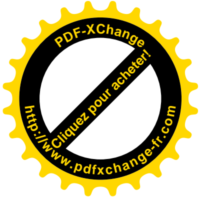
solutions, innovative methods for handling common problems. Profitable factors: connections in consultation with other professionals.

A short-term formalization of the process (standardized or personalized) already allows the players, depending on their identification in this procedure arrangement, to go beyond a largely intuitive and very partial perception of the procedures in which they participate, and to then reintegrate the relevance of the means and methods that they implement. The realization and increase in the number of care situations (nominative dispensation) confront the logistical procedures with a new piloting imperative for logistical policies. The care situations, as indicators of change in current technology and information, are the profitable framework, like a "downstream piloting" (Midler, page 103, 1996) of the logistical strategies of hospital organization.

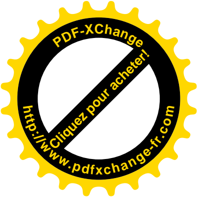
CONCLUSION

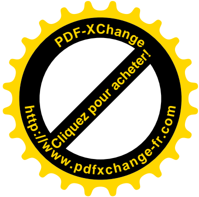
The Hospital Center’s concern is to analyze in terms of the lack of structural harmony. All organizations don't choose coherence in the design of their structure. Some hybrids appear to be dysfunctional, having the characteristic of an organization that doesn’t' make decisions, or which try to combine the best elements of several configurations, and end up accumulating the inconveniences involved. However, in some cases, organizations don't have a choice since contradictory contingency factors, where they have no control, force them to adopt a dysfunctional hybrid structure. Some of these organizations, a hospital for instance, appear to require a Professional Bureaucracy structure, but are led, while rejecting their performance, to adopt some characteristics of the Mechanistic Bureaucracy under the impulse of a concentrated external control (Health Authority), and other specificities (the importance of logistical services) of an "ad-hoc" structure. Nevertheless, other hybrids appear to be perfectly logical and indicate the need to respond to a more legitimate force at the same time. This could be the case of Saint John's Hospital Center, which is a simple professional bureaucracy





that recruits doctors and nurses who are highly trained and who depend largely on their standardized qualifications in order to produce a certain quality of care, but that needs someone to pilot the procedures to assure a close coordination of operational activities. This is also the case for Adhoc entrepreneurial situations where the framework integrator, who is himself an expert, is able to maintain a sort of central control in spite of the usage of multidisciplinary project groups or partitioned communities, such as doctors, nurses and logisticians. Hybrids are all intermediaries between two, three or more configurations. This is the case for the Saint John's Hospital Center managed by an administrative public authority and controlled by its General Manager, but which also includes a proliferation of ethics and which is dependent on qualifications for its medical, nursing and logistical staff. We have, in this situation, a hybrid structure that is located between the five configurations of Mintzberg, which are Community, Control, Cure, Care and Chain. The interaction study, regardless of the fields involved, and their purpose and approach must not then be disregarded. As a matter of fact, interactions are where socio-organizational and interpersonal relationships are continuously built, and are therefore, group entities. It is in this perspective that we propose an approach to the logistical procedures within a transactional view where logistical contacts become interactions and where each is accepted in a system of ethics and duty. Logistics can be defined as the sequential achievement of logic in logistical relationships between the success and satisfaction of care activities. Success in care activities doesn't depend therefore at this stage on what occurs or not even on the care unit in considering the realization of logistics. We must therefore introduce the concept of conditions of satisfaction in order to take into account "the post-logistics effect" of logistics. We are introducing an interactional dimension, based on dialogue, for the realization of logistical activities and care.





Bibliography

BOUCHARDY I., DARRÉON J-L. (2004), "Management by Quality and PGI: revealing contrasts of two organizational development procedures", *LERASS*.

BOUTINET J-P, (1996), *Anthropology of the Project*, PUF.

COHENDET P., JACOT J.H., LORINO P. (1996), *Consistency, relevance and assessment*, Economica.

CREMADEZ M, (1992), *Hospital strategic management*, InterEditions.

CROZIER M, FRIEDBERG E, (1977) The actor and the system, Le Seuil.

GADREAU M., JAFFRE D., LANCIAU D. (1999), "Recomposition in the hospital network systems. Between limitations, contracts and conventions ", *Finance Control Strategy*, Volume 2, n° 4, December, 53-75.

GLOUBERMAN S., MINTZBERG H. (2001), "Managing the care of health and the cure of disease", *Health care manage review*, Aspen Publishers.

GRANDORI A, & SODA G, (1995), Inter-firm Networks: Antecedents, Mechanism and Forms, Organization Studies, Vol. 16, pp. 183_214.

MENARD C, (2002), The economics of hybrid organizations, *Presidential address, International Society for New Institutional Economics*, MIT, September.

OLIVER A.L. & EBERS M, (1998), Networking network studies: an analysis of conceptual configurations in the study of inter-organizational relationships, *Organizations Studies*, Vol. 19, pp. 549-583.

WEBER M, (1971), *Economy and Society*, Plon.

ZARIFIAN P. (1996) "The emergence of organization by procedures: in search of a challenging coherence", in *Coherence, Relevance and Evaluation*, ECOSIP, coordinated by P. Cohendet, J.H. Jacot, P. Lorino, Economica, 66-86.