Vol. 13(11), pp. 353-372, 14 June, 2019
DOI: 10.5897/AJBM2019.8799
Article Number: 43A003D61228
ISSN: 1993-8233

http://www.academicjournals.org/AJBM

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African Journal of Business Management

Full Length Research Paper

Involving stakeholders in university hospital performance reporting: The state of the art in Italy

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Received 7 April, 2019; Accepted 31 May, 2019

University hospitals (UHs) need to pay attention to diverse stakeholders' interests when reporting their performance information, to meet different knowledge expectations concerning the activities they have performed and the outcomes they have achieved. In the existing literature, the level of consideration of UH performance reports reserve for a broad variety of stakeholders interested in UH outcomes, each with different information needs, has not been analyzed. To contribute to fill this gap, this study offers an empirical examination of the Italian experience by investigating whether and to what extent all the thirty-two public university hospital authorities (UHAs) involve stakeholders in their annual performance reports (APRs). First, sixteen key stakeholder groups with an interest in the performance reporting of UHAs were mapped, and the related accountability relationships were described. Subsequently, the APRs for 2017 were examined by employing the content analysis method and common descriptive statistics. Findings reveal that only one UHA involved all sixteen stakeholder groups in its performance report; sixteen UHAs involved at least ten stakeholder groups; and the remainder showed a weak, scarce or even absent involvement for stakeholders. Moreover, it emerged that three stakeholder groups were singled out for greater attention in UHA performance reports (patients, managers and regional government) over others. Involving stakeholders in performance reports needs to be encouraged, as it is an essential prerequisite for developing suitable integrated performance reporting systems.

Key words: University hospitals, stakeholder involvement, performance reporting, stakeholder relationships, integrated reporting, public healthcare, accountability, performance management.

INTRODUCTION

University hospitals (UHs) or teaching hospitals constitute a particular category of university affiliated health facilities, which perform in a complementary and interrelated way, three different types of activity. They provide care and treatment for patients (which is the typical mission of general hospitals), train current and future healthcare professionals, and advance research in medical science (which are the academic missions of university medical schools) (Smith and Whitchurch, 2002; Davies and Smith, 2004; Raus et al., 2019). For this simultaneous role of ensuring care, medical education and research, UHs enjoy a 'traditional' reputation as highly specialized care providers (Ayanian and Weissman, 2002; Kupersmith, 2005). Although the quality

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of their clinical outcomes has been questioned (Hayanga et al., 2010; Zafar et al., 2015), they play an important role in developing new surgical innovations (Yeo et al., 2018). Indeed, UHs are frequently the referral centers for complex medical and surgical patients within integrated healthcare networks (Palm et al., 2013; Nuti et al., 2016). This is especially true in the case of the treatment of rare and oncological diseases that require multiple and innovative diagnoses and advanced clinical capabilities and technologies. However, despite their clinical excellence, when compared to general hospitals, UHs suffer as a result of their *teaching status*, which can lead to lower and more costly hospital productivity, problems of coordination with the universities and greater complexity in governance (Huttin and De Pouvourville, 2001; Grosskopf et al., 2004; Kastor, 2004; Liu et al., 2012; Ali et al., 2017).

The recent literature concerning health economics has emphasized the need to manage this institutional complexity; the latter is strictly connected not only to the partnership with the university faculty of medicine but also to the presence of numerous other stakeholders within the societal environment, which affects UH governance, outcomes, the related performance measurement and reporting systems (Minvielle et al., 2008; Mauro et al., 2014; Del Gesso, 2017). Indeed, the complexity of governance is one of the structural characteristics of university hospital organizations (Schwartz and Pogge, 2000; van Rossum et al., 2016). The latter are multi-stakeholder contexts within which diverse pressures (medical, academic, financial, social, political, environmental etc.) from manifold groups of interlocutors claim interest converge. UHs, like other private and public organizations, need to consider and satisfy these interests in order to face a plurality of institutional pressures, overcome potential conflicts and empower stakeholders, factors that otherwise could threaten organizational sustainability (Zakhem, 2008; Hörisch et al., 2014).

In effect, the outcomes of UH activities have a relevant and multi-faceted impact on the territory in which they operate (for example, in terms of improving citizen health, medical training, academic research, local economy and natural environment etc.). This demonstrates a commitment from UHs to continuously improve performance outcomes in order to ensure their sustainability, as well as to increase accountability and to inform stakeholders about corporate endeavors that strive to improve sustainability performance. Moreover, it is very important for UHs to share performance results with their stakeholders, since the integration of the medical and academic missions makes such hospitals ‘knowledge intensive institutions’, meaning that their healthcare outcomes have a strong additional intangible value. Stakeholders must be able to perceive and to be aware of this additional value (Shahian et al., 2012). This gives UHs an opportunity to prepare their performance reports from a stakeholder perspective, by providing an appropriate and complete disclosure of performance results to improve accountability relationships (Ovseiko et al., 2014).

The aforementioned scenario provides the impetus for this research, which draws on the hypothesis that UHs should pay attention to manifold stakeholder interests in reporting their performance information. This is important so that stakeholder knowledge expectations can be met through the sharing of information about activities performed and outcomes achieved. Studying the involvement of stakeholders in performance reporting by UHs is interesting at a time when UHs are having to face sustainability challenges resulting from diverse contextual pressures (Ryan-Fogarty et al., 2016; Raus et al., 2019). The significance of this study also lies in the increasing emphasis on performance measurement, subsequent communication to stakeholders, and benchmarking that appear to be emerging issues in contemporary healthcare systems worldwide (Loeb, 2004; Piña et al., 2015). Prior studies have poorly addressed performance reporting systems in UHs; and a lack of attention has been paid to how much consideration their performance reports give to a broad variety of stakeholders interested in UH outcomes, who have different information needs.

In the light of this gap in knowledge, this study offers an examination of the state of stakeholders’ involvement in performance reporting in the Italian UH model, which was established by decree no. 517/1999 as a public health institution called *azienda ospedaliera universitaria*, or university hospital authority (UHA). In particular, it aims to investigate whether and to what extent all thirty-two Italian UHAs involve stakeholders in their annual performance reports (APRs). To address this aim, the study is developed in two steps: i) the key stakeholder relationships of UHAs are first defined; and ii) the APR documents of the thirty-two UHAs are then content analyzed to explore stakeholder contemplation within them. UHAs are public university hospitals and hence, represent the institutional UH model in Italy. Their mission is to integrate the activities of academic and hospital medicine, by contributing both to fulfill the care objectives of the regional health system and to realize the scientific aims of the university medical schools, for which the UHAs serve as educational sites for medical students (decree no. 517/1999, paragraph 2 (Caffi, 2013; Kiessling et al., 2017; Safarani et al., 2018).

The organizational and managerial models of UHs vary according to the heterogeneous experiences gained at the international level (Bevan and Rutten, 1987). In Italy, although many different hospitals (both public and private) collaborate with universities, the UHAs only represent the hospitals of the regional National Health Service, which are the legally designated institutions for medical education. Therefore, the Italian UHAs participate both in regional healthcare planning and university

scientific-teaching planning, by playing an important role within the health provision network of the Italian regions. The UHAs, like all public administrations in Italy, must prepare a performance report at the end of the annual performance management cycle, in order to provide performance information, to assess behavior and results, and to enable stakeholder accountability. This document, on which this study focuses, was made mandatory by the introduction of decree no. 150/2009, in order to highlight the organizational and individual results achieved at year's end. This law states clearly that a public administration must report these results to stakeholders by way of an annual performance report (APR); share these results through the publication of the APR document in the appropriate section dedicated to transparency of their institutional website; and encourage interactions and relationships with stakeholders, through the development of forms of collaboration (decree no. 150/2009, paragraphs 4, 8, 10 and 11). The APR is produced in addition to traditional financial statements and it should provide detailed performance results that should be aligned with the performance goals and the allocation of resources in the annual performance plans. Thus, the APR represents the key reporting document by which the Italian UHAs are accountable to their stakeholders for their achieved outcomes. This document is able to disclose additional information that could be very relevant and useful for stakeholders and would enable them to play an active role in observing and acknowledging UHA behavior; this could also stimulate UHAs to make better decisions leading to better performance. The findings of this study may encourage UH managers and policymakers to pay more attention to stakeholder information needs in performance reporting; this can help to build fruitful accountability relationships with stakeholders into the practice of UHs.

THEORETICAL FRAMEWORK AND APPROACH

This study was inspired and deduced from theory on stakeholders. Stakeholder theory (or stakeholder perspective, stakeholder management or stakeholder thinking) emerged in academic discourses in the late 1970s and early 1980s when Freeman, in his landmark book of 1984, originated the concept of managing and shaping the relationships with "the groups and individuals that can affect, or are affected by, the accomplishment of organizational purpose" (Freeman, 2010: 25). The management of stakeholder relationships concerning value creation and ethics helps an organization to survive and thrive in turbulent times and fields (Phillips, 2003; Parmar et al., 2010). As highlighted by Hörisch et al. (2014: 330-331), starting from Freeman's original version, the literature has developed many different types of stakeholder theory by focusing on various aspects (Donaldson and Preston, 1995). These have included the identification of relevant stakeholders, the effects of stakeholders' management on the achievement of corporate aims, and the interdependencies of the organizations within their societal and natural environment for sustainability management challenges (Hörisch et al., 2014). Indeed, the stakeholder perspective which envisages creating value with and for the stakeholders involved, by generating mutual interests, has been widely applied in various disciplines, areas and arguments including accounting, public sector and healthcare (Elms et al., 2002; Freeman et al., 2010; van Helden and Uddin, 2016). At the same time, there has been no lack of scholars who have criticized this view (Key, 1999).

Furthermore, it is necessary to recall here that the stakeholders' perspective was also highlighted by the corporate governance debate concerning the mechanisms by which private and public organizations are directed and how they perform (Ryan and Ng, 2000; Letza et al., 2004; Matei and Drumasu, 2015). At first, this debate focused solely on the private sector. Subsequently it also included the public sector. This followed the emergence of the public governance concept (Bovaird, 2005; Osborne, 2010; Grossi and Steccolini, 2014), where the three basic principles of corporate governance from the 1992 Cadbury report - openness (or transparency of disclosure), integrity (or honesty and completeness of reporting), and accountability (or responsibility for actions) to stakeholders - were extended from private business to public sector entities (Ryan and Ng, 2000). By the end of the 1990s these corporate governance principles had become part of the discourses concerning (new) public governance, that underlined the need for governments to interact, involve and cooperate with internal and external stakeholders in order to improve public service policies and outcomes in the collective interest (Bovaird, 2005; Pestoff, 2011).

The relevance of the stakeholder standpoints, expectations, roles and influences also appears in the emerging notion of collaborative governance. The latter can be referred to as a collective and participating decision-making process through which interdependent stakeholders "seek a mutually satisfactory outcome" when addressing "a complex, multi-faceted problem or situation" (Robertson and Choi, 2012: 83). This notion, which has become quite renowned in public administration literature, emphasizes stakeholder participation in governance. It concerns different cross-boundary partnership forms that also include civic and stakeholder engagement in a constructive and democratic way (Bingham et al., 2005; Emerson et al., 2012; Doberstein, 2016).

More generally, through participation, stakeholders may empower their voice in governance by interacting with an

organization's decision-making processes and performance, which influence (or are influenced by) them. On the other hand, organizations can develop their stakeholder relationships and better manage them in order to create joint processes of sustainable value (Freudenreich et al., 2019). However, effective stakeholder involvement needs to be underpinned by feedback and disclosure concerning the organization's performance, outcomes and impacts. These are the main tasks of the performance reporting systems of an organization, which should provide more and more detailed and complete information (about adopted decisions and consequent impacts) relevant to stakeholders in order to enhance the organization's accountability (Mitchell et al., 2015; Freeman, 2017; Manes-Rossi et al., 2018). The need for organizations to satisfy the interests of stakeholders and their performance information needs is increasingly relevant, both in academic accounting discourses and in reporting frameworks issued by professional bodies at an international level (such as the *Sustainability reporting guidelines* of the Global Reporting Initiative – GRI, and the *International integrated reporting framework* of the International Integrated Reporting Council – IIRC). These debates have highlighted the opportunity for integrating traditional financial measurement and reporting systems with non-financial performance dimensions and communications (Dumay et al., 2016; Adams, 2015). As pointed out by Dumay et al. (2015), disclosing non-financial information to stakeholders (such as that concerning social, environmental, and governance issues) enables organizations to increase their institutional and strategic legitimacy, as well as their sustainability, through the possibility of achieving mutually advantageous outcomes for both stakeholders and the organizations themselves (Dumay et al., 2015; Freudenreich et al., 2019).

Thus, studying stakeholder involvement in performance reporting is of growing interest, because the survival and success of organizations appear ever more dependent on stakeholder relationships and partnerships. In addition, the way in which an organization creates value increasingly involves intangible and difficult aspects to be measured. This implies that the new challenge for performance reporting systems is the shift in perspective from reporting to disclosing information about impacts to stakeholders (Dumay, 2016). Indeed, in agreement with Dumay (2016: 169), organizations need to go beyond reporting mere monetary information, because they create a value that is "much more than money". Therefore, to allow stakeholders to understand how organizations create their value, they need to disclose information of "monetary, utility, social and environmental value" (Dumay, 2016: 180). In other words, performance reports represent an increasingly essential instrument through which to communicate information about activities and results back to stakeholders; at the same time, they can determine how stakeholders perceive and judge these activities and results (Hall et al., 2015). Hence, performance reporting documents can assist manager and policymakers in meeting the needs of stakeholders (Miles, 2019), by providing multidimensional information about the achieved outcomes (Romero and Carnero, 2019). Making this performance information (both financial and non-financial) publicly available increases accountability and transparency, which are essential for improving stakeholder relationships and for encouraging organizational interaction (Grossi and Steccolini, 2014; Van de Walle and Cornelissen, 2014). This is particularly important in public sector organizations where accountability (or being accountable for one's own decisions and actions) has increasingly been seen as a key issue for guarding and improving performance (Bovens et al., 2014; Schillemans, 2016). As highlighted by Van de Walle and Cornelissen (2014), performance reports are among the most important accountability mechanisms with which public organizations can present and explain their behavior and performance to service users and the various interested groups of stakeholders. In summary, it is necessary to provide complete performance information to stakeholders in order to be accountable for performance that directly interests them (Manes-Rossi et al., 2018). In order that this information can match stakeholder knowledge expectations, it is essential to consider all key stakeholder groups and their different knowledge needs.

Performance measurement, performance management and performance reporting systems have gained growing attention in healthcare organizations in an attempt to improve the quality of healthcare services and levels of accountability to stakeholders (Smith et al., 2009; Gigli and Tieghi, 2012; Ashton, 2015; Giovanelli et al., 2015; Shahian et al., 2016; Spanò et al., 2018). The issue of patient and stakeholder involvement in healthcare decision-making and service supply has been much addressed by the literature (Culyer, 2005; Vahdat et al., 2014; Van Eijk and Steen, 2014; Castro et al., 2016; Chambers and Storm, 2019) and different levels of participation have been identified (Ocloo and Matthews, 2016). The participation ladder ranges from a mere consultation role, to full control; the latter, which is the highest level and derives from interactive collaboration with patients, citizens and other key stakeholders, requires feedback about decisions made, leading to better public accountability (Charles and DeMaio, 1993). In other words, performance reporting systems are called upon to consider the key stakeholder relationships and their informational needs. Through stakeholder involvement, more precise information about how the outcomes are achieved and what value is created can be passed on. This enhancement of accountability is necessary to allow health systems to perform better (Brinkerhoff, 2004). Likewise, effective stakeholder communication and relationships in public healthcare

organizations are indispensable since they support the sustainability of the mission to ensure public health protection and improvement (Longest and Rohrer, 2005). Building constructive relationships with a multiplicity of stakeholders implies that public healthcare organizations implement an overall stakeholder management process which includes the identification of the relevant stakeholder groups, their main different accountability expectations, the performance gaps, and the stakeholder interests that must be prioritized (Fottler et al., 1989; Preble, 2005; Bierbooms et al., 2016). However, as evidenced by Bierbooms et al. (2016: 643), taking into account (and responding to) different stakeholder expectations and building strategic relationships with each of them is not yet standard practice for most healthcare providers. Moreover, in public healthcare organizations, and more generally in the public sector, the political nature of public policy can lead to an heterogenous perception of stakeholder importance, where relations with particular stakeholders are given more importance than others (Riege and Lindsay, 2006).

Regarding the context of UHs, although the issue of performance measurement for reporting has proved to be of interest to scholars (Backman et al., 2016), the involvement of stakeholders in the performance reporting systems of these hospitals appears to have received less scholarly attention. And yet, stakeholder influence is one of the major distinctive characteristics of UHs. Thus, integrating the consideration of stakeholders into UH strategies is important (Langabeer and Napiewocki, 2000) in order to face their educational, therapeutic, and research challenges (Safarani et al., 2018). Specific studies that have addressed performance measurement issues in UHs have highlighted the fact that traditional performance measurement systems focus only on financial dimensions, which is inadequate for assessing the multifaceted performance of these complex healthcare institutions (Mauro et al., 2012; Trotta et al., 2013). Such studies have applied the 'balanced scorecard model' in UHs, emphasizing the need to employ more appropriate multidimensional performance measurement systems due to the plurality of stakeholders who have differing views on performance and require specific accountabilities (Minvielle et al., 2008; Mauro et al., 2014).

These studies have analyzed some cases of European UHs including Italian UHAs. It is noteworthy that some university hospitals in Italy, as well as other Italian hospitals, adhere to structured multidimensional performance evaluation systems developed at national or at regional levels in order to monitor and assess clinical and organizational outcomes. Furthermore, to improve the quality of care and hospital efficiency, specific audits have been carried out in certain areas of activity or relevant clinical conditions (such as some oncological treatments and clinical pathways for obstetrics, femoral fractures and heart failure for example) using various performance measures and indicators (Nuti et al., 2016).

Specific cases of Italian UHAs have also been analyzed in a previous study, which showed how mission-based reporting is able to improve stakeholder relationships and accountability in UHAs, by integrating the poor and technical disclosure of traditional financial statements with more readable, non-financial data (Del Gesso, 2017). These data are related to the manifold dimensions (such as health, scientific, financial, social and environmental) that characterize university hospital performance outcomes linked to the tripartite mission of patient care, education and research. Indeed, as Davies and Smith (2004) have highlighted UHs, "need to focus on communicating their contribution to society in all its dimensions" because of the complexity of their service provision, which is influenced by the intensity of teaching and research (Davies and Smith, 2004: 67). Thus, as assumed in this study, UH performance reporting systems need to consider multi-stakeholder relationships and take into account what information disclosure concerning impacts the different stakeholder groups would need. This is essential to better meet and manage the plurality of interests that shape institutional performance.

METHODOLOGY

In order to investigate whether and to what extent Italian UHAs involve key stakeholder groups in their APRs, a careful examination of these documents was performed using the research method of content analysis. This rigorous method allowed the author to check whether, how many, and which stakeholders received the most attention within the APRs. Indeed, content analysis, which is defined as "a research technique for the objective, systematic, quantitative description of the manifest content of communication" (Berelson, 1952: 519), is also known as a method for examining documents. Deriving from the communication sciences, it is widely used today in various scientific domains, for both qualitative and quantitative research, to interpret and quantify phenomena (Elo and Kyngäs, 2008; Gaur and Kumar, 2018). Thus, the content analysis of the APRs helped this study to understand and measure the ability of UHAs to involve stakeholders in the reporting of their performance information. It should be highlighted that content analysis has already been effectively employed in many empirical studies in the field of accounting to collect data on social, environmental and intellectual capital disclosures in annual reports (Guthrie and Abeysekera, 2006). To carry out the analysis of APRs using this method, sixteen keywords to be sought within these documents were chosen. Thus, the number of instances that these keywords (which referred to the sixteen identified stakeholder groups) were cited in the body of the text of each APR was manually counted.

More precisely, the research was developed as follows: First, the key stakeholder groups with an interest in the performance reporting of UHAs were mapped with the help of the literature and an analysis of the peculiarities of the Italian context. Following this, each related relationship was defined by attempting to outline the main information each stakeholder group would need to perceive through performance reporting. This latter phase promoted an understanding of the different roles that each stakeholder plays in Italian UHAs and, as a consequence, why they should be involved in performance reports. Subsequently, as already mentioned above, the content analysis of the APRs of the UHAs was

performed by reading and counting the number of times that the words corresponding to the identified stakeholders appeared within each document. The results of the content analysis gave rise to a dual distribution data matrix (32x16) containing a total number of 4,585 occurrences (or total counted citations). The data matrix represented the thirty-two Italian UHAs on the rows and the sixteen identified key stakeholder groups on the columns. This set of data collected through content analysis was subsequently analyzed using common descriptive statistics that helped to summarize and interpret whether, how many, and which stakeholder groups are involved in the APRs of Italian UHAs. In particular, the following measures of descriptive statistics were calculated by processing stakeholder citations data: frequencies, mean, minimum and maximum values, standard deviation and coefficient of variation. Stata software (version 12) helped with this calculation.

The documents being content analyzed in this study were the APRs relating to 2017. These documents were the most recent reports available in the "transparency administration" section of the institutional websites of the thirty-two Italian UHAs. Indeed, as established by decree no. 33/2013 on public administration publicity and transparency, APRs must be published in this section, under the heading "performance", together with other documents and information related to the performance management cycle. Thus, the path generally followed to obtain each individual document was: UHA website/ transparency administration/ performance/ performance report of 2017. This path was repeated for all thirty-two Italian public UHAs; thus, the sample size has a representativeness of 100%. However, only twenty-seven performance reports of 2017 could be downloaded, as in four cases this document was not available on the UHA website; hence, the representativeness of reports analyzed was 27/32 equivalent to 84%. Moreover, it is important to note that two public university hospitals in the Umbria region (in Perugia and Terni) were included among the thirty-two UHAs, despite them not having yet acquired the formal name of UHA as planned in the Protocol of Agreement signed in 2013 by the region and the related university. Furthermore, the public university hospitals of the Lombardy region were not considered, since this region's organizational model of university centers does not include the presence of UHAs. The informed consent of UHAs to analyze their documents was not obtained and their anonymity was not preserved, due to the transparent and public nature of APRs. This means they are open access files, freely usable and accessible to all.

The analysis of APRs was chosen because this is the mandatory document within which Italian UHAs report their performance results to stakeholders, in addition to the traditional annual financial statements. As is well known, traditional financial statements have many informational limits because they only report the economic dimension of sustainability by including mere financial information. In contrast, the annual performance report should also include non-financial information, since it must be produced in the final phase of the performance management cycle for disclosing the performance results of Italian UHAs. In line with the performance management principles and stages, this cycle (which was mandatorily introduced in all Italian public sector organizations by decree no. 150/2009) begins with: i) the definition of the performance objectives (or expected results) to be assigned to each head of department or structure to be linked to the related budget resource allocations; ii) the ongoing monitoring and adjustment to be carried out; and iii) the measurement and evaluation of both organizational and individual performance (or achieved results) to be reported to internal and external stakeholders (decree no. 150/2009, paragraphs 4 and 10). Thus, APRs should report performance outcomes to stakeholders of Italian UHAs in order to enhance accountability, develop stakeholder relationships and enable their active participation in the management process. It follows that these documents should include reference to all key stakeholder groups, something this article aims to verify.

RESULTS AND DISCUSSION

Mapping the key stakeholders' relationships of Italian UHAs

In university hospitals, many stakeholders have some involvement "in the medical, economical, political, educational, and social outcomes confronting academic healthcare" with a different degree of influence (Langabeer and Napiewocki, 2000: 16; Fottler et al., 1989). The key stakeholder groups that can influence, or are influenced by the performance of UHAs were mapped drawing on the Langabeer and Napiewocki (2000)'s list of a dozen stakeholders (patients, payers, boards of trustees, the community, governments, faculty, staff, educational accreditation groups, medical associations, various consumer advocates, private business, and suppliers). This list was adapted to the UHA context, by considering the specificities of the Italian health system (Ferré et al., 2014) and the UH model (such as the emphasis on the decentralized decision-making power at the regional level, or the difficult coexistence of hospital and university staff within UHA organizations). Moreover, additional stakeholder groups (such as medical students, labor unions and the natural environment) were identified from the literature (Fottler et al., 1989; Ryan-Fogarty et al., 2016; Kiessling et al., 2017). Following this, sixteen different stakeholder groups (external and internal) were identified for Italian UHAs. Once these stakeholders were singled out, an attempt was made to delineate their main performance information needs, both financial and non-financial. The results are described in Table 1, which summarizes the key relationships and the main information that could be disclosed to each stakeholder, for accountability reasons, through performance reports. Hence, the theoretical importance of each relationship for the UHAs, which could justify stakeholder consideration within their APRs, is defined.

Relationship with the patients

Patients represent the primary stakeholders of UHAs since they are the users of the hospital services and thus, the core recipients of the institutional activity (Langabeer and Napiewocki, 2000: 16). Given the central place patients occupy in healthcare, UHAs need to promote their active involvement in organizational choices and in the evaluation of services (Culyer, 2005; Ocloo and Matthews, 2016) through specific projects and mechanisms. The latter might include: surveys to gauge perceptions of the quality of the care; initiatives to overcome barriers to access treatment; the activation of working groups on specific relevant healthcare topics; the management of emerging issues and complaints etc.; and collaboration with voluntary associations and patient advocacy organizations. Indeed, as highlighted in the literature, patient participation in healthcare decisions

Table 1. Mapping of the main performance information needs of the key stakeholder groups of Italian UHAs.

Key stakeholder relationships	Main performance information needs
Patients	(i) Supply structure of care services: variety and specialization of care, innovative and peak treatments, areas of excellence, advanced competences and technologies, integrated care pathways etc.; (ii) Care performance outcomes: volume and quality of delivered care services, timeliness of care, effectiveness and continuity of care, appropriateness, accessibility, safety and risks, equity, reliability, organizational and management efficiency, satisfaction etc.; (iii) Sustainability of care services: efficient management of financial, human, instrumental and natural resources, rational use of public funds; (iv) Relevant patient projects to ensure the security, equity and accessibility of care services.
Citizens	(i) Supply structure of care services: variety and specialization of care, innovative and peak treatments, areas of excellence, advanced competences and technologies, integrated care pathways etc.; (ii) Care performance outcomes: volume and quality of delivered care services, timeliness of care, effectiveness and continuity of care, appropriateness, accessibility, safety and risks, equity, reliability, organizational and management efficiency, satisfaction etc.; (iii) Sustainability of care services: efficient management of financial, human, instrumental and natural resources; rational use of public funds; (iv) Relevant citizen projects to ensure communication about hospital decisions and activities that involve the general community.
Medical Students	(i) Supply structure of medical education and available facilities; (ii) Quality of teaching; (iii) Organizational efficiency of teaching services.
Hospital Staff	(i) Personnel features (types, roles, gender, age classes, internal and external mobility etc.); (ii) Working conditions and staff policies (safety, evaluation, benefits and incentives, satisfaction, involvement, enhancement etc.); (iii) Projects/activities for the development of professional skills; (iv) Autonomy and attribution of professional responsibilities; (v) Staff integration policies.
University Staff	(i) Personnel features (types, roles, gender, age classes, internal and external mobility, etc.); (ii) Working conditions and staff policies (safety, evaluation, benefits and incentives, satisfaction, involvement, enhancement etc.); (iii) Projects/activities for the development of professional skills; (iv) Autonomy and attribution of professional responsibilities; (v) Staff integration policies.
University	(i) Collaborative relationships and processes of integration between the care and academic objectives; (ii) Productivity, results of research and teaching activities (i.e. number of published articles, research topics addressed, pathologies studied, and number of students enrolled in medical degree courses); (iii) Hospital facilities and personnel involved in teaching and research activities; (iv) Development of scientific culture, medical knowledge and technological innovation (i.e. ability to attract research funding, international relevance of ongoing research projects, effectiveness of experiments conducted, and introduction of new medical technologies).
Central Government	(i) Role and functions of the hospital within the national health system; (ii) Achievement of healthcare and organizational objectives identified in health planning at central level; (iii) Development of the tripartite mission within the national health system; (iv) Achievement and maintenance of the state of budget balance.
Decentralized Governments	(i) Role and functions of the hospital within the local healthcare network system; (ii) Achievement of healthcare and organizational objectives identified in health planning at regional and local levels; (iii) Development of the tripartite mission within the local healthcare system; (iv) Achievement and maintenance of the state of budget balance.

Table 1. Cont'd.

Public Healthcare Providers	(i) Policies, typesetting and dimensions of the care services supply; (ii) Inter-organizational collaboration processes and healthcare supply agreements.
Private Healthcare Providers	(iii) Policies, typesetting and dimensions of the care services supply; (iv) Inter-organizational collaboration processes and healthcare supply agreements.
Suppliers	(i) Investment and purchasing policies, average payment times etc. (ii) Supply relationships; (iii) Degree of innovation of health and scientific technologies and medical devices.
Labor Unions	(i) Working conditions, hours and shifts, workplace health and safety, pay and benefits, leave, work wellbeing etc.
Voluntary and Advocate Associations	(i) Care provision: specializations, treatments, experimental therapies, individual and family services, prevention campaigns, innovations, technologies, access to information, staff experience, facilities, risks etc.; (ii) Care outcomes: quality of treatments, effectiveness and continuity of care, timeliness, appropriateness, accessibility, safety, equity, reliability, efficiency, satisfaction etc.; (iii) Research outcomes: novel findings, success/failure of experimental treatments, risks, facilities etc.; (iv) Education and research for the prevention and treatment of specific diseases; (v) Activities that promote health and wellbeing for population; (vi) Ongoing collaborations initiatives with the various associations.
Payers and Private Business	(i) Kind of hospital services offered and related performance outcomes; (ii) Research projects undertaken and related social impacts; (iii) Sustainability of services: efficient management of financial, human, instrumental and natural resources, rational use of public funds.
Natural Environment	(i) Contribution to the protection and improvement of environmental conditions; (ii) Appropriate medical waste disposal; (iii) Sustainable consumption of energy, water and natural resources.
Managers	(i) Performance results of the activity as a whole: achieved outcomes in relation to the planned goals for the integrated development of care, education and research.

Source: Own construction adapting UH stakeholder identification of Langabeer and Napiewocki (2000: 16-17).

allows patient-centered care, empowers patients and contributes to improving healthcare outcomes and services (Vahdat et al., 2014; Castro et al., 2016; Chambers and Storm, 2019). Moreover, performance reporting systems must be able to meet the information needs of patients. Their interests in UHA performance can be related to the configuration and outcomes of care services such as: areas of excellence, for which UHAs act as referral centers within healthcare networks; experimental and innovative treatments; specializations; quality; effectiveness; continuity; appropriateness; accessibility; safety and risks; equity; and reliability and efficiency etc. Additionally, patients' interests can also refer to the UHA's ability to meet healthcare needs using the available resources (financial, human, instrumental and natural) in a sustainable way. Therefore, patients deserve to be given priority in UHA performance reports.

Relationship with citizens

Citizens, or the community as a whole, represent the potential users of care services and are collectively interested in protecting and improving public health conditions (Langabeer and Napiewocki, 2000, p. 17). Their power in public health organization relationships and their role as co-producers of services to promote better care are considered to be increasingly relevant, according to the literature in this area (Van Eijk and Steen, 2014; Ocloo and Matthews, 2016). Accordingly, like patients, citizens are primary stakeholders who need to be involved by the UHAs. Citizens are also the effective 'payers' for the activities of UHAs through general taxation, since the Italian national health insurance system is administered by the public sector. Thus, their expectations and needs concerning performance can be linked to both the improvement of the overall health status of their surroundings and the efficient allocation of resources. It follows that the performance reporting systems of UHAs need to address citizens as well as patients and provide multifaceted financial and non-financial information. It would also be appropriate for reports to be able to disclose data about the configuration of care services, the related performance outcomes and the way in which not only funds but all the available resources are managed to

provide sustainable patient care. Indeed, providing information of public interest enables UHAs to increase transparency and accountability to the recipients of their activities. This is essential to overcome self-referentiality and to encourage the involvement and empowerment of the community in decisions that impact on their healthcare rights.

Relationship with medical students

Medical students represent future health professionals (physicians, nurses and other health professional roles) who need to practice their profession as trainees. Like patients and citizens, medical students are also key stakeholders who need to be involved by the UHAs, since the latter, in addition to satisfying patient care needs, host the university degree courses for the training of future health professionals. Indeed, the medical student perspective is relevant because it contributes to the improvement of the quality of the learning environment (Kiessling et al., 2017). Medical students can also benefit first-hand by learning from the knowledge and experimental results of research activity (Safarani et al., 2018). In other words, the relevance of the relationship with medical students lies in the fact that UHAs are central players in preparing the next generation of clinicians to meet the community healthcare needs by developing their professional skills. Therefore, the information of interest for future professionals concerning UHA performance mainly refers to areas of educational activity and research: the supply structure of the medical education; the facilities made available; the quality of teaching services; and the organizational efficiency of teaching services. Hence, performance reporting systems of UHAs need to be able to disclose information about teaching programs, medical courses of study that are running and those that have been withdrawn, traineeships, master's degrees, doctorates and postgraduate specializations. It would also be appropriate to highlight the collaboration needed for the achievement of the university's training objectives, through the contribution of personnel, facilities and other resources.

Relationship with the hospital staff

The staffs, essential to the functioning of healthcare organizations, are among the most powerful stakeholders of UHAs (Fottler et al., 1989; Langabeer and Napiewocki, 2000: 17; Chambers and Storm, 2019). The well-being of staff needs great attention, as the staff represents a key factor that is able to influence the organizational and managerial efficiency of services and thus, the achievement of UHA performance goals and objectives. UHA staff is divided into two groups: hospital staff and university staff (or faculty employees). Hospital staffs include health professionals (physicians, nurses and other hospital health personnel) and technical and administrative staff who work at Italian UHAs as National Health Service employees (Ferré et al., 2014: 79). The coexistence of these two groups, especially between hospital physicians and university physicians, may produce problems for coordination and integration of the different roles and clinical specialties (Kastor, 2004). This may generate tensions in the governance of UHA activities. Indeed, in Italy, the difficult relationships between hospital and university staff represents one of the main critical aspects of the integration process (between the national health system and the university) leading to the establishment of the UHA. In the context of UHAs, therefore, personnel management and integration policies play a decisive role in determining a harmonious working environment. It follows that UHAs need to place great emphasis on staff policies and consider human resources as fundamental for the improvement of care, teaching and research. Thus, the performance reporting systems should disclose specific information relevant to staff from both groups. This can include: personnel features; working conditions and policies concerning staff integration, safety and evaluation etc.; activities for the development of skills; and a system for the assignment of tasks and responsibilities.

Relationship with the university staff

University staff refers to faculty employees and includes researchers, teaching staff, administrative staff and all personnel affiliated with the university in which the medical school is based. The importance of the relationship with university staff is connected to their academic experience that can promote the quality of care and student training within UHs (Safarani et al., 2018). Indeed, university staffs are engaged in medical research and educational activities, and frequently, are also involved in patient care. In Italian UHAs, where university staff are also called 'personnel in convention' to distinguish them from hospital employees, university physicians often take on the role of directors of hospital departments. Thus, like hospital staff, university staff represents a relevant stakeholder group to be considered in reporting teaching hospital performance.

Relationship with the university

The university or the university medical school is the institution concerned with the training of future doctors and healthcare personnel (Langabeer and Napiewocki, 2000: 17). Indeed, medical schools must refer to UHs in order to teach their medical students and conduct clinical research. For this reason, the UH role was and will continue to be important in the academic medicine of the

future (Fottler et al., 1989: 538; Raus et al., 2019). The relationship with the university is crucial, even though it represents the main factor that makes governance complex, especially when this relationship also includes the state or the federal government that may control the hospital and/or the medical school (Kastor, 2004). This is the case for Italian UHAs, where the way by which they realize the integration of care, research and educational activities is defined by both the regional government and the university through a protocol of agreement signed by the two institutions. Indeed, the university chancellor and the president of the region jointly appoint the general manager of the UHA who is then accountable for their actions both to the region and the university. The directors of the departments which perform the integrated activity are also jointly appointed by these two institutions. Therefore, the university is a stakeholder that is very interested in the teaching hospital performance and is institutionally involved in the management of its activities. The information needs of the university, which, most appropriately, could be met by performance reporting systems, concern the processes of integration between the care and academic objectives. In particular, these needs include the results of the university teaching activities and research performed within the hospital (that is, the number of articles published, the research topics addressed, the pathologies studied, and the number of students enrolled in the medical degree courses). The information disclosure may also concern some planning elements that involve the synergy between the hospital and the university that is agreements and collaborative projects; hospital facilities; and personnel involved in teaching and research activities. This synergy is fundamental for the development of medical knowledge and disclosure may relate to the ability to attract research funding, the international relevance of ongoing research projects and the effectiveness of experiments conducted etc.

Relationship with the central government

Central government represents the state, national government or the Ministry of Health. The relationships UHs have with central government vary among countries according to the way in which the national healthcare system is organized and financed (Ferré et al., 2014: 16). In Italy, the national health service (SSN), which follows a Beveridge model, is structured in three levels of government (state, regions, and public healthcare providers) where the region is the stakeholder with the greatest interest in the performance of UHAs (Nuti et al., 2016; Spanò et al., 2018). The state only defines and coordinates the general planning of health policies, through the identification of a set of activities and services provided by the SSN, or *essential levels of care* (*livelli essenziali di assistenza* - LEA), and through the allocation of (public) health funds to the regions on a corrected capitation basis. In addition, following a correct capitation formula, each region reallocates the health funds to local health authorities (LHAs) - the main public healthcare providers - to finance the LEA supply. Regions play a fundamental decision-making role with a high level of power. They are responsible for the organization and provision of healthcare services in their territories, as well as for the performance of all public healthcare providers, including UHAs (Ferré et al., 2014; Giovanelli et al., 2015). Thus, UHAs contribute to the achievement of regional healthcare planning goals and objectives and are accountable for the related clinical and financial performance. This is because the region, which in turn is accountable to the Ministry of Health, is also responsible for the financial balance to all public providers that make up the regional healthcare system. It follows that the Italian Ministry of Health is interested in UHA performance in relation to: the important role they play within the SSN while carrying out their tripartite mission; how they meet their care objectives; and clearly, their ability to work within their allocated budget.

Relationship with the decentralized governments

Decentralized governments are a group of stakeholders which may include all those government levels positioned below the state government (regions, provinces, territories, municipalities and other forms of local government). In Italy, although the Ministry of Health and the regions are collectively responsible for providing national healthcare services, the region is the most authoritative body of the SSN (Ferré et al., 2014: 21). Each Italian region enjoys considerable autonomy in organizing its own regional health system (or regional health service) by deciding which and how many providers are to be included in it (Giovanelli et al., 2015; Spanò et al., 2018). The UHAs are among these providers and there are also some private health organizations (including private UHs) which collaborate on the basis of a service provision agreement with the region. Each region also establishes the criteria for determining the financial resources to be assigned to public healthcare providers which, consequently, must deliver healthcare services within the limits of the (public) funds received and in compliance with a pre-established financial budget (Mauro et al., 2014). Thus, Italian UHAs must achieve the corporate budget balance that is ensured when there is a balance between revenue (which includes the resources allocated by the region) and costs. As already stated above, the region also appoints (jointly with the university) both the general manager and the directors of the departments that perform the integrated activity. For these reasons, the relationship with the region assumes a leading political role among the various stakeholder relationships of Italian UHAs. Consequently, the region is one of the main Interlocutors to be involved in performance reporting

(Gigli and Tieghi, 2012). However, the region's informational needs do not exclusively refer to financial dimensions. They also include non-financial disclosure concerning for example, the role and the functions that UHAs have within the local healthcare network system; how they contribute to delivering quality care; how they achieve the care and organizational objectives planned at local level; and how they develop the tripartite mission within the regional health service.

Relationship with the public healthcare providers

Public healthcare providers include all the public health organizations that contribute to the delivery of healthcare services. In Italy, the main public providers at regional level are the LHAs (local health authorities) that deliver primary care, hospital care and all other healthcare services including those related to social care. There are also public hospital authorities (HAs), which are autonomous general hospitals that deliver hospital care but are not directly managed by the LHAs (Ferré et al., 2014: 16). Both the LHAs and the HAs are managed by a general manager appointed by the president of the region. Moreover, public hospital care in Italy is also delivered by scientific institutes for research and healthcare (SIRHs), which are specialized biomedical research hospitals, by UHAs, on which this study focuses, as well as by several private providers (such as the private HAs, the private SIRHs and the private UHs). While the LHAs are financed by the region through capitation-based funding, the UHAs, like the others autonomous public hospital providers are financed by different mechanisms depending on regional policies (Nuti et al., 2016). Usually, they are remunerated by the LHAs through the payment of tariffs based on the volume and typology of the services delivered; moreover, the region may also assign to UHAs additional resources for their specific functions (i.e. research and teaching activities, organizational complexity, high specialization, special experiments and rare diseases etc.).

Italian UHAs and other public healthcare providers collaborate to deliver healthcare services which are also supported by private providers according to network and integration logics. Thus, the other healthcare providers are interested in UHA performance in relation to the important role they play within the regional and local healthcare network. The related information disclosures may concern: policy; the typology and volume of the care service supply; the processes of inter-organizational collaboration for the joint management of some activities and services; and the existing supply agreements.

Relationship with private healthcare providers

Private healthcare providers are private healthcare organizations that collaborate to provide healthcare services. In Italy these organizations are accredited private facilities that have entered into a supply agreement with the region in order to deliver healthcare services within the regional and local healthcare network (Ferré et al., 2014: 16). Thus, like the relationship with public healthcare providers, the relationship with private healthcare providers is also important for Italian UHAs.

Relationship with suppliers

Suppliers fall into a general category, which includes suppliers of medical devices, medical and scientific technologies and pharmaceutical products etc. (Langabeer and Napiewocki, 2000: 17). Usually, materials and technologies have a highly specialized profile in UHs, since they are also needed for the development of innovative treatments, experimental research activities and other scientific purposes. Thus, the relevance of the relationship with suppliers lies in the latter's role as input providers in UHs (Fottler et al., 1989: 527). For this role they are placed among the numerous stakeholder groups with an interest in UHA performance reporting systems. In particular, information of interest for them would be: investment and purchasing policies; average payment times; supply relationships; and the degree of innovation of medical devices and technologies.

Relationship with the labor unions

Labor unions are the organizations that represent the staff. Labor unions constitute an important external stakeholder group for their special interest in corporate functioning, which can lead to a conflictual relationship with the UH (Fottler et al., 1989: 528). Indeed, this interest in UHA performance concerns all work conditions affecting the staff and may include: hours and shifts; health and safety; pay and benefits; leave; wellbeing at work; and other work-related issues.

Relationship with voluntary and advocate associations

Voluntary and advocate associations include various typologies of association and organization, such as associations representing citizens and patients, voluntary non-profit organizations, various consumer advocates, medical associations and philanthropic foundations etc. (Langabeer and Napiewocki, 2000: 17). They can be considered a secondary and external stakeholder group, as they interact with the organization but are not essential to its corporate survival (Chambers and Storm, 2019). However, the relationship with voluntary and advocate associations is important within the system of UHA

relationships because their influence aims to improve health and wellbeing among people in civic society. Their interest in UHA performance covers many different aspects, like those related to care provision (that is, treatment, individual and family services, prevention campaigns and experimental therapies etc.). Their interest also concerns the results of care and research activities (that is quality, accessibility, safety and timeliness of care and novel medical findings etc.) and specific activities and collaborations in place to promote the health of communities.

Relationship with payers and private business

Payers and private business are both important stakeholder groups as they are respectively involved in the funding of hospital services and in the subsidizing of projects or activities (Langabeer and Napiewocki, 2000: 17). Payers, in particular, include private insurance companies that pay providers for healthcare services in order to help people to sustain medical costs and they play a fundamental role in countries that do not have universal healthcare programs. For the purposes of this study, payers and private business are considered as a unique group because of the role they play in the relationship with the Italian UHAs.

In Italy, the SSN provides universal coverage through general taxation. As a result, public healthcare services are free of charge for citizens at the point of service; they are asked only to pay a public contribution (*ticket*) (Ferré et al., 2014: 15). Citizens, however, may freely choose to take out private health insurance cover in addition to the basic state coverage so that they can also be treated at private healthcare facilities. UHAs, thus, are financed through public fund allocation mechanisms; moreover, private business may finance specific medical research projects and activities through donations and contributions. These funds received from private business (as well as from associations, citizens and foundations) are a sign of the social legitimacy the UHA mission has among local communities. Therefore, performance reporting systems could include information that would interest private investors, such as the kind of hospital services and the related performance outcomes; the research projects undertaken and the related social impact; and the efficient management of available resources for the sustainability of activities.

Relationship with the natural environment

The activities of university hospitals can determine economic, social and environmental impacts on the territories within which they operate. In particular, the natural environment can be considered a relevant stakeholder because “the provision of healthcare creates significant environmental impacts” (Ryan-Fogarty et al., 2016). The relationship with the natural environment, in terms of reducing these impacts, is becoming increasingly crucial in every domain including healthcare, and demands sustainability reporting (Romero and Carnero, 2019). Thus, it is important that the performance reporting systems of UHAs include disclosure about their contribution to the protection and improvement of environmental conditions, such as the sustainable consumption of energy, water and natural resources. In addition, information could be disclosed concerning the measures taken to ensure the appropriate disposal of medical waste to reduce the impact on the environment and to protect the safety of staff and users.

Relationship with the managers

Managers (or boards of trustees) represent the governing body of UHs. They are key individuals that have overall responsibility for decisions and results (Langabeer and Napiewocki, 2000: 17). Italian UHAs are managed by a general manager who is also supported in his functions by other bodies, such as the management board which puts forward proposals and opinions regarding the integration of care and academic activities. The general manager makes strategic decisions and choices regarding the organization and development of services, although the influence of local politics can limit their managerial potential (Ferré et al., 2014: 151). Moreover, the general manager operates within the financial limits established by the central government and the region. Management also includes the directors of departments who may be both hospital medical staff and medical professors of the related university. The general manager and the directors of departments represent one of the main internal stakeholder groups, because as leaders of the UHAs they are essential to its corporate existence (Chambers and Storm, 2019). In addition, they are accountable for performance to the region and university that appointed them. Thus, the performance reporting systems need to foster disclosure concerning achieved outcomes of planned goals, because it is fundamental that the results of the activity as a whole are measured and reported (Dumay, 2016). Such a disclosure could also be useful for: sharing strategic goals and results among all the individuals involved in management; enhancing the integrated development of care, education and research; and supporting the decentralization of decision-making and promoting participatory leadership.

Stakeholder involvement in the APRs of Italian UHAs

To investigate which of the sixteen key stakeholder groups are taken into consideration by the APRs of Italian UHAs, the corresponding following words was searched for and counted within the reports: patients; citizens; students; hospital staff; university staff; university;

Table 2. Distribution of the overall stakeholders mentioned in the APRs for 2017 of Italian UHAs (N = 4,585).

Italian UHAs	Absolute frequency	Percentage
UHA of Novara	95	2.07
UHA of Turin	0	0
UHA of Orbassano	3	0.07
UHA of Verona	194	4.23
UHA of Padova	105	2.29
UHA of Trieste	604	13.17
UHA of Udine	21	0.46
UHA of Bologna	1180	25.74
UHA of Parma	589	12.85
UHA of Ferrara	243	5.30
UHA of Modena	59	1.29
UHA of Pisa	94	2.05
UHA of Siena	108	2.36
UHA of Florence Careggi	28	0.61
UHA of Florence Meyer	16	0.35
UHA of Perugia	37	0.81
UHA of Terni	-	-
UHA of Ancona	139	3.03
UHA of Rome Tor Vergata	133	2.90
UHA of Rome Umberto I	-	-
UHA of Rome Sant' Andrea	109	2.38
UHA of Naples Federico II	178	3.88
UHA of Naples Vanvitelli	128	2.79
UHA of Salerno	55	1.20
UHA of Bari	16	0.35
UHA of Foggia	98	2.14
UHA of Catanzaro	-	-
UHA of Catania	107	2.33
UHA of Messina	96	2.09
UHA of Palermo	36	0.79
UHA of Cagliari	114	2.49
UHA of Sassari	-	-

Source: Data analyzed from the results of content analysis.

ministry (for central government); region (for decentralized governments); public providers; private providers; suppliers; labor unions; associations; private business; environment; and directors (for managers). Table 2 summarizes the total number of stakeholder citations (or total frequencies) resulting from the content analysis of each APR, which saw a total of 4,585 citations collected from all the APRs analyzed. As can be seen in this table, the number of times that one or more stakeholders appeared in the documents is the highest in the UHA of Bologna, while in some UHAs it is very low, equals zero or is not available. Indeed, in four cases (in the UHAs of Terni, Rome Umberto I, Catanzaro and Sassari) it was not possible to download the APRs for 2017 as they were not available in the online section of the respective UHA websites. In four cases, moreover, the APRs contained very limited disclosures that only concerned the assignment of the health and economic objectives of the hospital departments and verified the related achievement by allowing the assessment of staff performance (in the UHAs of Turin, Orbassano, Udine, and Perugia). In contrast, the APRs of the remaining UHAs provided greatly detailed disclosures of performance results with different degrees of stakeholder contemplation. Some documents also reserved a specific section which included information addressed to some stakeholders (patients, citizens, the region etc.).

However, there was considerable heterogeneity among the various UHAs in terms of stakeholder involvement, and most reports did not involve all sixteen actor groups.

A picture summarizing whether and how many stakeholder groups are involved in the performance reports of the Italian UHAs can be gathered from Table 3, which synthesizes the level of this involvement through five class intervals. It emerges that: 5 UHAs (the four UHAs whose documents were not available online were included) do not involve stakeholders in reporting performance results (meaning that 16% present an absent involvement); 4 UHAs involve at most 4 stakeholder groups (meaning that 13% present a scarce involvement); 6 UHAs involve from 5 to 9 stakeholder groups (meaning that 19% present a weak involvement); and 16 UHAs involve at least 10 stakeholder groups but not all 16 groups (meaning that 50% present an ample involvement). Only one UHA involves all 16 stakeholder groups (full involvement) in its reporting performance results (the UHA of Bologna).

Indeed, as emerged from Table 4, which shows the analysis of data from the content analysis using common descriptive statistics, the maximum value of stakeholder citations was found at the UHA of Bologna, followed by the UHAs of Trieste and Parma. In these UHAs the maximum values refer respectively to patients (391 citations), directors (298 citations) and patients again (203 citations). Thus, these UHAs appear to be those that include the most stakeholders in their performance reports. Yet, by observing the minimum values of stakeholder citations in Table 4, it emerges that almost all the UHAs have at least one stakeholder who is never mentioned in their reports, even though the others are mentioned; only the UHA of Bologna makes exception, referring to all sixteen stakeholders at least once. Moreover, the coefficient of variation (CV), which measures the dispersion of a frequency distribution (or variability in relation to the mean), helps to define whether Italian UHAs involve the different stakeholder groups in their reports in a homogeneous way or not. As the value of this coefficient is always greater than the value *1* (CV > 1, except for the UHA of Turin, which never names stakeholders in its APR), a high-variance emerged. This means that twenty-seven Italian UHAs (or those which include at least one stakeholder in their reports) do not involve all their stakeholders in a homogeneous way. In other words, they do not give the same importance to each stakeholder in their reports but favor one or more stakeholders over others. This variability is the greatest in the UHA of Orbassano (= 4) and is also high in the UHAs of Udine (= 3.60) and Perugia (= 3.34). Indeed, these UHAs involve only one stakeholder in their reports (directors by the UHA of Orbassano) or three stakeholders (hospital staff, region and directors by the UHA of Udine; and hospital staff, labor unions and directors by the UHA of Perugia). Conversely, the variability is the least in the UHA of Cagliari (= 1.19); the variability is also below the value of 1.50 in the UHAs of Siena (= 1.24), Rome Sant' Andrea (= 1.30), Novara (= 1.39), Verona (= 1.42) and Parma (= 1.43). This means that these UHAs involve stakeholders in their reports in a less heterogeneous way than the others (Table 4).

How Italian UHAs involve the sixteen stakeholder groups in their reports can be seen better in Table 5, which shows the percental distribution of each group involved in the APRs. Here, it is clear each UHA accords to each stakeholder group a different degree of importance. Table 5 also highlights which are the three stakeholder groups that are named the most among those UHs that name at least one stakeholder in their documents. It emerged that: patients are the first relevant stakeholder group in ten UHAs; directors are the first relevant stakeholder group in eight UHAs; and the region is also the first relevant stakeholder group in eight UHAs. Only in one UHA was the first relevant stakeholder group the university. Therefore, there are three stakeholder groups that were involved more than others in Italian UHA performance reports: patients, directors, and the region (Table 5). This is better evident in Figure 1, which shows the cumulative values of the stakeholder involvement in APRs. Indeed, this figure allows a comparison of the sixteen stakeholder groups based on the total number of times that each group is cited in the reports analyzed (cumulative frequency); this number is also expressed as a cumulative percentage (calculated by dividing the cumulative frequency by the total of 4,585 citations). As can be seen in Figure 1, the three stakeholder groups with the highest cumulative percentages are: patients (26.91%), directors (23.40%) and the region (19.65%). This means that Italian UHAs perceive the relationships with patients, managers and regional government to be more significant than that with other stakeholder groups and hence, they give priority to meeting these needs regarding performance information. Indeed, excluding the university and the public providers whose cumulative percentages are respectively 6.30 and 6.17%, the other stakeholder groups are all below 5% which means that they are poorly involved in the UHA performance reports. Those groups that are mentioned the least by the sixteen stakeholder groups and do not reach a level of 1% are: private business (0.26%), students (0.46%), labor unions (0.92%) and associations (0.94%). The involvement of university staff (1.44%), suppliers (1.50%), the ministry (1.50%), environment (1.57%) and private providers (1.79%) is also very low; moreover, the feeble involvement of hospital staff (3.49%) and citizens (3.64%) is rather surprising given the relevance of both these stakeholder relationships in UHAs (Figure 1).

In summary, this study found that Italian UHA performance reports disproportionately single out three stakeholder groups over the others. The prevalent involvement of patients denotes a widespread awareness among Italian UHAs of the need to enhance the relationship with those who are most affected by the outcomes of their integrated activity. The significant

Table 3. The ability of the Italian UHAs to involve stakeholders in their APRs for 2017.

	N. of stakeholders involved	Absolute frequency	Percentage
Class frequency	(Absent) 0	5	16
	(Scarce) 1-4	4	13
	(Weak) 5-9	6	19
	(Ample) 10-15	16	50
	(Full)16	1	3
		32	100

Source: Data analyzed from the results of content analysis.

Table 4. Descriptive statistics of Italian UHA involvement of stakeholders in APRs for 2017.

Italian UHAs	Mean	Standard deviation (SD)	Min	Max	Coefficient of Variation (CV) = SD/Mean
UHA of Novara	5.94	8.24	0	31	1.39
UHA of Turin	0	0	0	0	0
UHA of Orbassano	0.19	0.75	0	3	4.00
UHA of Verona	12.13	17.23	0	60	1.42
UHA of Padova	6.56	10.46	0	39	1.59
UHA of Trieste	37.75	75.97	0	298	2.01
UHA of Udine	1.31	4.73	0	19	3.60
UHA of Bologna	73.75	122.27	5	391	1.66
UHA of Parma	36.81	52.57	0	203	1.43
UHA of Ferrara	15.19	27.01	0	106	1.78
UHA of Modena	3.69	6.25	0	24	1.69
UHA of Pisa	5.88	10.07	0	37	1.71
UHA of Siena	6.75	8.36	0	27	1.24
UHA of Florence Careggi	1.75	3.32	0	13	1.90
UHA of Florence Meyer	1.00	2.10	0	8	2.10
UHA of Perugia	2.31	7.72	0	31	3.34
UHA of Terni	-	-	-	-	-
UHA of Ancona	8.69	14.17	0	50	1.63
UHA of Rome Tor Vergata	8.31	14.20	0	39	1.71
UHA of Rome Umberto I	-	-	-	-	-
UHA of Rome Sant' Andrea	6.81	8.85	0	25	1.30
UHA of Naples Federico II	11.13	19.83	0	77	1.78
UHA of Naples Vanvitelli	8.00	15.18	0	57	1.90
UHA of Salerno	3.44	5.49	0	19	1.60
UHA of Bari	1.00	2.37	0	9	2.37
UHA of Foggia	6.13	9.73	0	32	1.59
UHA of Catanzaro	-	-	-	-	-
UHA of Catania	6.69	10.78	0	42	1.61
UHA of Messina	6.00	10.47	0	40	1.74
UHA of Palermo	2.25	3.94	0	16	1.75
UHA of Cagliari	7.13	8.50	0	26	1.19
UHA of Sassari	-	-	-	-	-

Source: Data analyzed from the results of content analysis.

involvement of managers in APRs may be a consequence of an obligation to report economic and health performance results for which Italian UHAs are accountable to the regional government. This also

Table 5. Percentual distribution of stakeholders involved in the APRs for 2017 of Italian UHAs.

Italian UHAs	Patients	Citizens	Students	Hospital staff	University staff	University	Ministry	Region	Public providers	Private providers	Suppliers	Labor unions	Associations	Private business	Environment	Directors
UHA of Novara	32.63%	6.32%	0%	4.21%	1.05%	1.05%	3.16%	17.89%	9.47%	6.32%	0%	1.05%	2.11%	2.11%	0%	12.63%
UHA of Turin	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
UHA of Orbassano	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%
UHA of Verona	10.82%	3.61%	0.52%	4.12%	2.06%	5.67%	2.06%	30.93%	8.76%	4.12%	2.58%	1.03%	0%	0%	0%	23.71%
UHA of Padova	20%	6.67%	0.95%	4.76%	2.86%	4.76%	0%	37.14%	4.76%	0%	2.86%	0.95%	0%	0%	0%	14.29%
UHA of Trieste	19.70%	3.97%	0.66%	0.83%	0%	0.99%	1.82%	10.93%	3.31%	3.64%	0.66%	0.17%	3.15%	0%	0.83%	49.34%
UHA of Udine	0%	0%	0%	4.76%	0%	0%	0%	4.76%	0%	0%	0%	0%	0%	0%	0%	90.48%
UHA of Bologna	33.14%	1.10%	0.42%	1.86%	0.68%	4.83%	1.10%	17.71%	6.61%	0.42%	1.27%	0.85%	0.42%	0.68%	1.61%	27.29%
UHA of Parma	34.47%	1.19%	0.17%	1.36%	0.68%	7.30%	1.70%	16.64%	8.83%	2.72%	3.23%	1.70%	1.02%	0%	6.79%	12.22%
UHA of Ferrara	43.62%	2.47%	0%	1.65%	0.41%	2.47%	0.41%	17.28%	10.29%	2.88%	4.53%	0.82%	0.82%	0%	1.23%	11.11%
UHA of Modena	40.68%	11.86%	0%	0%	0%	5.08%	0%	13.56%	10.17%	13.56%	3.39%	0%	0%	0%	0%	1.69%
UHA of Pisa	39.36%	6.38%	3.19%	6.38%	2.13%	0%	1.06%	11.70%	3.19%	1.06%	0%	0%	1.06%	1.06%	0%	23.40%
UHA of Siena	19.44%	10.19%	1.85%	1.85%	0.93%	5.56%	1.85%	25%	13.89%	2.78%	0%	1.85%	1.85%	0%	0%	12.96%
UHA of Florence Careggi	14.29%	3.57%	0%	3.57%	0%	3.57%	3.57%	14.29%	10.71%	0%	0%	0%	0%	0%	0%	46.43%
UHA of Florence Meyer	12.50%	0%	0%	0%	0%	0%	12.50%	18.75%	0%	0%	0%	6.25%	0%	0%	0%	50%
UHA of Perugia	0%	0%	0%	8.11%	0%	0%	0%	0%	0%	0%	0%	8.11%	0%	0%	0%	83.78%
UHA of Terni	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
UHA of Ancona	25.90%	10.79%	0%	5.76%	3.60%	4.32%	3.60%	35.97%	2.88%	1.44%	0.72%	0.72%	0.72%	0%	0%	3.60%
UHA of Rome Tor Vergata	0%	3.76%	0%	7.52%	3.01%	29.32%	0.75%	26.32%	3.01%	0%	0%	0%	0%	0%	0%	26.32%
UHA of Rome Umberto I	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
UHA of Rome Sant'Andrea	16.51%	4.59%	0%	22.02%	12.84%	10.09%	0%	22.94%	2.75%	0%	0.92%	1.83%	0%	0%	0%	5.50%
UHA of Naples Federico II	43.26%	5.06%	0.56%	4.49%	2.25%	8.99%	1.12%	20.22%	2.25%	1.12%	1.69%	0%	1.12%	0%	0%	7.87%
UHA of Naples Vanvitelli	8.59%	0%	1.56%	1.56%	3.13%	23.44%	3.91%	44.53%	3.13%	0%	0%	0.78%	0%	0%	0%	9.38%
UHA of Salerno	34.55%	10.91%	0%	25.45%	1.82%	5.45%	3.64%	7.27%	0%	0%	5.45%	0%	0%	0%	0%	5.45%
UHA of Bari	0%	0%	0%	18.75%	18.75%	0%	0%	6.25%	0%	0%	0%	0%	0%	0%	0%	56.25%
UHA of Foggia	13.27%	2.04%	0%	7.14%	2.04%	15.31%	0%	32.65%	4.08%	0%	0%	0%	0%	0%	0%	23.47%
UHA of Catanzaro	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
UHA of Catania	39.25%	8.41%	0%	5.61%	1.87%	6.54%	0.93%	14.95%	1.87%	0.93%	0.93%	1.87%	0.93%	0%	0.93%	14.95%
UHA of Messina	5.21%	9.38%	0%	3.13%	0%	0%	4.17%	41.67%	14.58%	1.04%	1.04%	1.04%	0%	1.04%	0%	17.71%
UHA of Palermo	44.44%	11.11%	0%	2.78%	2.78%	8.33%	0%	5.56%	2.78%	0%	0%	2.78%	0%	0%	8.33%	11.11%
UHA of Cagliari	14.91%	7.02%	1.75%	4.39%	1.75%	17.54%	1.75%	15.79%	8.77%	0%	0%	0.88%	1.75%	0%	0.88%	22.81%
UHA of Sassari	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

= First relevant stakeholder group; = Second relevant stakeholder group; = Third relevant stakeholder group.
Source: Data analyzed from the results of content analysis.

justifies the great involvement of the region which in turn is responsible to taxpayers for governing the quality and the financial sustainability of the

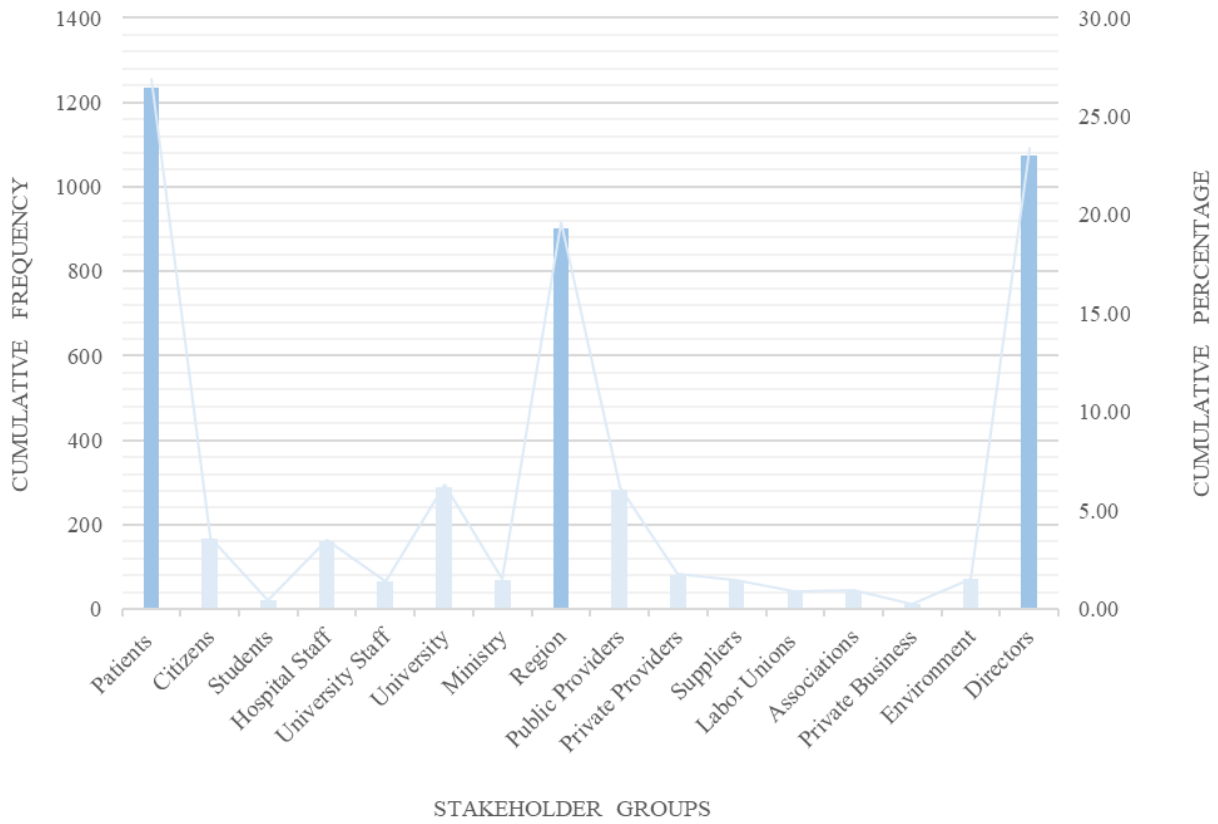

Figure 1. Cumulative values of the stakeholder involvement in the APRs for 2017 of Italian UHAs: the most relevant stakeholder groups.
Source: Data analyzed from the results of content analysis.

local healthcare system to which UHAs contribute. Yet, the exiguous involvement of the other stakeholder groups indicates that Italian UHAs are not very aware of the importance of involving stakeholders in reporting performance results. Therefore, it emerged that the consideration of the different stakeholder interests is not yet a common and widespread practice in the Italian UHAs, confirming the view that this is an issue that currently concerns most healthcare providers (Bierbooms et al., 2016). In addition, as highlighted in the literature, the political nature of public UHAs leads them to perceive some groups of stakeholders as more important than others and, as a consequence, to pay less attention to the relationships they consider less important (Riege and Lindsay, 2006). Conversely, the interests of the all key stakeholders need to be taken into account in order to better manage the multiple actors that influence UHAs. Hence, more consideration must be reserved for each individual relationship according to the power it exerts within the UHA context. In particular, considering (in order to satisfy) different multidimensional information needs through performance reporting can help UHAs to build fruitful accountability relationships and to promote beneficial interactions with their stakeholders (Van de Walle and Cornelissen, 2014; Hall et al., 2015; Miles, 2019; Freudenreich et al., 2019). On the other hand, this performance information is useful for stakeholders, because it enables them to assess and legitimize corporate behavior, to express their needs, to advice on services and to enter into dialogue and collaborate with UHAs. Indeed, such stakeholder empowerment can bring about opportunities to improve performance and tackle UHA sustainability challenges. For these reasons, involving stakeholders in performance reporting needs to be encouraged and fully developed in order for it to become an established practice within UHAs.

Conclusion

This research contributes to the body of knowledge on performance reporting systems in university hospitals, by presenting the current state of stakeholder involvement in performance reporting in Italian public UHAs. In particular, it highlights how it can be strategically important for UHAs to take into account a broader variety of stakeholders in their reporting documents, who have diverse informational needs concerning performance results and governance

issues. The main limitation of the study is that it does not attempt to understand how performance disclosure meets stakeholder interests and their performance information needs.

This study argues that the influence of sixteen key stakeholder groups matters to UHAs and outlines which key multidimensional disclosures in APRs can meet the knowledge needs of each of them in order to promote effective accountability relationships. Indeed, APRs create opportunities for UHAs to provide complete information on organizational and individual performance for their stakeholders. These reports can be a powerful information sharing tool, useful for enhancing stakeholder relationships. Therefore, it is necessary that all groups of stakeholders, each with their own points of view, be considered. Nevertheless, the findings reveal that it is not yet common practice in Italian public UHAs. A great variability in the way in which the sixteen key stakeholder groups are involved in APRs emerged. Greater priority is given to three stakeholder groups (patients, managers and regional government), while all the other mapped groups are poorly contemplated by APRs. Indeed, only one UHA fully involves all stakeholders in its performance report, while sixteen UHAs involve at least ten. The remaining UHAs showed a weak, scarce or even absent involvement for stakeholders. From these results it can be argued that Italian UHAs are not yet fully aware of the importance of involving stakeholders in reporting performance results. It appears, in fact, that the APR is perceived as a normative fulfillment rather than as a performance management tool with which to share findings concerning value creation and achievement to stakeholders. Therefore, full stakeholder involvement needs to be encouraged in order to meet different interests and better manage multiple relationships.

The APR is an important document in the UHA performance management cycle, which is affected by various pressures and the need to respond to stakeholder information requests. In addition, it could be used as a managerial tool with which to integrate the limited disclosures provided by traditional financial statements that merely focus on financial performance. Indeed, multidimensional performance disclosures are needed for stakeholders who want greater accountability by way of a more suitable integrated performance report. However, the suitability of stakeholder information within performance reporting documents is strongly connected to the ability to involve stakeholders in performance management and the reporting processes themselves. Therefore, involving stakeholder is a main prerequisite for developing suitable performance reporting systems; this may become essential for ensuring the sustainability of university hospitals since present and potential stakeholders appear to have a growing influence on their governance.

Further research would be helpful to better understand performance reporting systems in university hospitals. The study of the Italian experience may suggest ideas for future research; it may also help university hospital managers and policymakers to better determine and manage relevant stakeholder relationships, giving them greater awareness of the importance of involving stakeholders in performance reports in order to meet their information needs.

ABBREVIATIONS

UHs, University Hospitals; **UHAs,** University Hospitals Authorities; **APRs,** Annual Performance Reports; **SSN,** National Health Service (*Servizio Sanitario Nazionale*); **LHAs,** Local Health Authorities; **HAs,** Hospital Authorities; **SIRHs,** Scientific Institutes for Research and Healthcare; **LEA,** Essential Levels of Care (*Livelli Essenziali di Assistenza*).

CONFLICT OF INTERESTS

The author has not declared any conflict of interests.

REFERENCES

Adams C (2015). Understanding integrated reporting: the concise guide to integrated thinking and the future of corporate reporting. Abingdon, UK: Routledge. Available at:https://www.crcpress.com/Understanding-Integrated-Reporting-The-Concise-Guide-to-Integrated-Thinking/Adams/p/book/9781909293847

Ali M, Debela M, Bamud T (2017). Technical efficiency of selected hospitals in Eastern Ethiopia. Health Economics Review 7(1):24.

Ashton T (2015). Measuring health system performance: a new approach to accountability and quality improvement in New Zealand. Health Policy 119(8):999-1004.

Ayanian JZ, Weissman JS (2002). Teaching hospitals and quality of care: a review of the literature. The Milbank Quarterly 80(3):569-593.

Backman C, Vanderloo S, Forster AJ (2016). Measuring and improving quality in university hospitals in Canada: The collaborative for excellence in healthcare quality. Health Policy 120(9):982-986.

Berelson BL (1952). Content analysis in communication research. New York, USA: Free Press. Available at: https://psycnet.apa.org/record/1953-07730-000

Bevan G, Rutten F (1987). The organisation and functions of university hospitals in different countries. Financial Accountability and Management 3:77-115.

Bierbooms J, Van Oers H, Rijkers J, Bongers I (2016). Development of a comprehensive model for stakeholder management in mental healthcare. Journal of Health Organization and Management 30(4):630-647.

Bingham LB, Nabatchi T, O'Leary R (2005). The new governance: Practices and processes for stakeholder and citizen participation in the work of government. Public Administration Review 65(5):547-558.

Bovaird T (2005). Public governance: balancing stakeholder power in a network society. International Review of Administrative Sciences 71(2):217-228.

Bovens M, Goodin RE, Schillemans T (2014). The Oxford handbook public accountability. Oxford, UK: Oxford University Press.

Brinkerhoff DW (2004). Accountability and health systems: toward conceptual clarity and policy relevance. Health Policy and Planning 19(6):371-379.

Caffi S (2013). The vocation of a University Hospitals. Dolentium Hominum Journal 81(1):63. Available at: http://www.humandevelopment.va/en/risorse/archivio/salute-e-

operatori-sanitari/dolentium-hominum-n-1.html
Castro EM, Van Regenmortel T, Vanhaecht K, Sermeus W, Van Hecke A (2016). Patient empowerment, patient participation and patient-centeredness in hospital care: a concept analysis based on a literature review. Patient Education and Counseling 99(12):1923-1939.
Chambers M, Storm M (2019). Resilience in healthcare: A modified stakeholder analysis. In: Wiig S, Fahlbruch B (eds.), Exploring Resilience. A scientific journey from practice to theory. Cham, Switzerland: Springer pp. 113-119.
Charles C, DeMaio S (1993). Lay participation in health care decision making: a conceptual framework. Journal of Health Politics, Policy and Law 18(4):881-904.
Culyer AJ (2005). Involving stakeholders in health care decisions–the experience of the National Institute for Clinical Excellence (NICE) in England and Wales. Healthcare Quarterly 8(3):54-58.
Davies S, Smith T (2004). Managing university clinical partnership: Learning from international experience. Higher Education Management and Policy 16(2):63-72.
Del Gesso C (2017). L'interdipendenza tra public governance e accountability nelle aziende ospedaliero-universitarie. [The Interdependence between Public Governance and Accountability in Teaching Hospitals]. Milano, Italy: FrancoAngeli.
Doberstein C (2016). Designing collaborative governance decision-making in search of a 'collaborative advantage. Public Management Review 18(6):819-841.
Donaldson T, Preston LE (1995). The stakeholder theory of the corporation: Concepts, evidence, and implications. Academy of Management Review 20(1):65-91.
Dumay J (2016). A critical reflection on the future of intellectual capital: from reporting to disclosure. Journal of Intellectual Capital 17(1):168-184.
Dumay J, Bernardi C, Guthrie J, Demartini P (2016). Integrated reporting: a structured literature review. Accounting Forum 40(3):166-185.
Dumay J, Frost G, Beck C (2015). Material legitimacy: blending organisational and stakeholder concerns through non-financial information disclosures. Journal of Accounting and Organizational Change 11(1):2-23.
Elms H, Berman S, Wicks AC (2002). Ethics and incentives: An evaluation and development of stakeholder theory in the health care industry. Business Ethics Quarterly 12(4):413-432.
Elo S, Kyngäs H (2008). The qualitative content analysis process. Journal of Advanced Nursing 62(1):107-115.
Emerson K, Nabatchi T, Balogh S (2012). An integrative framework for collaborative governance. Journal of Public Administration Research and Theory 22(1):1-29.
Ferré F, de Belvis AG, Valerio L, Longhi S, Lazzari A, Fattore G, Ricciardi W, Maresso A (2014). Italy: Health system review. Health Systems in Transition 16(4):1-168.
Fottler MD, Blair JD, Savage GT, Whitehead CJ, Laus MD (1989). Assessing key stakeholders: who matters to hospitals and why? Hospital and Health Services Administration 34(4):525-547.
Freeman RE (2010). Strategic management: A stakeholder approach. Cambridge, UK: Cambridge University Press.
Freeman RE (2017). Five challenges to stakeholder theory: A report on research in progress. In. Wasieleski DM, James Weber J (eds.), Stakeholder Management. Bingley: Emerald Publishing Limited pp. 1-20.
Freeman RE, Harrison JS, Wicks AC, Parmar BL, De Colle S (2010). Stakeholder theory: The state of the art. Cambridge, UK: Cambridge University Press.
Freudenreich B, Lüdeke-Freund F, Schaltegger S (2019). A Stakeholder theory perspective on business models: Value creation for sustainability. Journal of Business Ethics 2019:1-16.
Gaur A, Kumar M (2018). A systematic approach to conducting review studies: An assessment of content analysis in 25 years of IB research. Journal of World Business 53(2):280-289.
Gigli S, Tieghi M (2012). The purposes of social accounting in Italian public health organizations. Economic Research 25(3):846-868.
Giovanelli L, Marinò L, Rotondo F, Fadda N, Ezza A, Amadori M (2015). Developing a performance evaluation system for the Italian public healthcare sector. Public Money and Management 35(4):297-302.
Grossi G, Steccolini I (2014). Guest editorial: Accounting for public governance. Qualitative Research in Accounting and Management 11(2):86-91.
Grosskopf S, Margaritis D, Valdmanis V (2004). Competitive effects on teaching hospitals. European Journal of Operational Research 154(2):515-525.
Guthrie J, Abeysekera I (2006). Content analysis of social, environmental reporting: what is new? Journal of Human Resource Costing and Accounting 10(2):114-126.
Hall M, Millo Y, Barman E (2015). Who and what really counts? Stakeholder prioritization and accounting for social value. Journal of Management Studies 52(7):907-934.
Hayanga AJ, Mukherjee D, Chang D, Kaiser H, Lee T, Gearhart S, Ahuja N, Freischlag J (2010). Teaching hospital status and operative mortality in the United States: tipping point in the volume-outcome relationship following colon resections?. Archives of Surgery 145(4):346-350.
Hörisch J, Freeman RE, Schaltegger S (2014). Applying stakeholder theory in sustainability management: Links, similarities, dissimilarities, and a conceptual framework. Organization and Environment 27(4):328-346.
Huttin C, De Pouvourville G (2001). The impact of teaching and research on hospital costs. The European Journal of Health Economics (HEPAC) 2(2):47-53.
Kastor JA (2004). Governance of teaching hospitals: Turmoil at Penn and Hopkins. JHU Press.
Key S (1999). Toward a new theory of the firm: a critique of stakeholder "theory". Management Decision 37(4):317-328.
Kiessling A, Roll M, Henriksson P (2017). Enhanced hospital-based learning at a medical school through application of management principles-a case study. BMC Medical Education 17(1):185.
Kupersmith J (2005). Quality of care in teaching hospitals: a literature review. Academic Medicine 80(5):458-466.
Langabeer JR, Napiewocki J (2000). Competitive business strategy for teaching hospitals. USA: Greenwood Publishing Group.
Letza S, Sun X, Kirkbride J (2004). Shareholding versus stakeholding: A critical review of corporate governance. Corporate Governance: An International Review 12(3):242-262.
Liu LL, Forgione DA, Younis MZ (2012). A comparative analysis of the CVP structure of nonprofit teaching and for-profit non-teaching hospitals. Journal of Health Care Finance 39(1):12-38.
Loeb JM (2004). The current state of performance measurement in health care. International Journal for Quality in Health Care 16(suppl_1):i5-i9.
Longest Jr. BB, Rohrer WM (2005). Communication between public health agencies and their external stakeholders. Journal of Health and Human Services Administration 28(2):189-217.
Manes-Rossi F, Tiron-Tudor A, Nicolò G, Zanellato G (2018). Ensuring more sustainable reporting in Europe using non-financial disclosure-De facto and de jure evidence. Sustainability 10(4):1162.
Matei A, Drumasu C (2015). Corporate Governance and public sector entities. Procedia Economics and Finance 26:495-504.
Mauro M, Cardamone E, Cavallaro G, Minvielle E, Rania F, Sicotte C, Trotta A (2014). Teaching hospital performance: Towards a community of shared values? Social Science and Medicine 101:107-112.
Mauro M, Cardamone E, Cavallaro G, Talarico G, Trotta A (2012). Performance evaluation in Italian teaching hospitals: a case study. World Review of Business Research 2(6):183-199.
Miles S (2019). Stakeholder Theory and accounting. In: Harrison JS, Barney JB, Freeman RE, Phillips RA (eds.), The Cambridge Handbook of Stakeholder Theory. Cambridge, UK: Cambridge University Press pp. 173-188.
Minvielle E, Sicotte C, Champagne F, Contandriopoulos AP, Jeantet M, Préaubert N, Bourdil A, Richard C (2008). Hospital performance: Competing or shared values? Health Policy 87(1):8-19.
Mitchell RK, Van Buren III HJ, Greenwood M, Freeman RE (2015). Stakeholder inclusion and accounting for stakeholders. Journal of Management Studies 52(7):851-877.
Nuti S, Grillo Ruggieri T, Podetti S (2016). Do university hospitals perform better than general hospitals? A comparative analysis among

Italian regions. BMJ Open 6(8):1-11.
Ocloo J, Matthews R (2016). From tokenism to empowerment: progressing patient and public involvement in healthcare improvement. BMJ Quality and Safety 25(8):626-632.
Osborne SP (2010). The new public governance: Emerging perspectives on the theory and practice of public governance. Abingdon, UK: Routledge.
Ovseiko PV, Heitmueller A, Allen P, Davies SM, Wells G, Ford GA, Darzi A, Buchan AM (2014). Improving accountability through alignment: the role of academic health science centres and networks in England. BMC Health Services Research 14(1):24.
Palm W, Glinos IA, Rechel B, Garel P, Busse R, Figueras J (2013). Building European Reference Networks in Health Care. Exploring concepts and national practices in the European Union. Observatory Studies Series No. 28. Copenhagen: WHO and European Observatory on Health Systems and Policies.
Parmar BL, Freeman RE, Harrison JS, Wicks AC, Purnell L, De Colle S (2010). Stakeholder theory: The state of the art. The Academy of Management Annals 4(1):403-445.
Pestoff V (2011). New public governance and accountability: some jewels in a treasure chest. Lecture on May 3, 2011 at the CIES program on Corporate Social Responsibility and Social Enterprise in Atlanta, Georgia. CIES Centro de Investigación de Economía y Sociedad 91:2-22.
Phillips R (2003). Stakeholder theory and organizational ethics. San Francisco, USA: Berrett-Koehler Publishers.
Piña IL, Cohen PD, Larson DB, Marion LN, Sills MR, Solberg LI, Zerzan J (2015). A framework for describing health care delivery organizations and systems. American Journal of Public Health 105(4):670-679.
Preble JF (2005). Toward a comprehensive model of stakeholder management. Business and Society Review 110(4):407-431.
Raus K, Mortier E, Eeckloo K (2019). Past, present and future of university hospitals. Acta Clinica Belgica 2019:1-8-10. Available at: https://www.tandfonline.com/doi/abs/10.1080/17843286.2019.1590024
Riege A, Lindsay N (2006). Knowledge management in the public sector: stakeholder partnerships in the public policy development. Journal of Knowledge Management 10(3):24-39.
Robertson PJ, Choi T (2012). Deliberation, consensus, and stakeholder satisfaction: A simulation of collaborative governance. Public Management Review 14(1):83-103.
Romero I, Carnero MC (2019). Environmental assessment in health care organizations. Environmental Science and Pollution Research 26(4):3196-3207.
Ryan C, Ng C (2000). Public sector corporate governance disclosures: an examination of annual reporting practices in Queensland. Australian Journal of Public Administration 59(2):11-27.
Ryan-Fogarty Y, O'Regan B, Moles R (2016). Greening healthcare: Systematic implementation of environmental programmes in a university teaching hospital. Journal of Cleaner Production 126:248-259.
Safarani S, Ravaghi H, Raeissi P, Maleki M (2018). Challenges and Opportunities Faced by Teaching Hospitals in the Perception of Stakeholders and Hospital System Managers. Education in Medicine Journal 10(4):9-21.
Schillemans T (2016). Calibrating Public Sector Accountability: Translating experimental findings to public sector accountability. Public Management Review 18(9):1400-1420.
Schwartz RW, Pogge C (2000). Physician leadership is essential to the survival of teaching hospitals. The American Journal of Surgery 179(6):462-468.
Shahian DM, Nordberg P, Meyer GS, Blanchfield BB, Mort EA, Torchiana DF, Normand SLT (2012). Contemporary performance of U.S. teaching and nonteaching hospitals. Academic Medicine 87(6):701-708.
Shahian DM, Normand SLT, Friedberg MW, Hutter MM, Pronovost PJ (2016). Rating the raters: the inconsistent quality of health care performance measurement. Annals of Surgery 264(1):36-38.
Smith PC, Mossialos E, Papanicolas I, Leatherman S (2009). Performance measurement for health system improvement: experiences, challenges and prospects. New York, USA: Cambridge University Press.
Smith T, Whitchurch C (2002). The future of the tripartite mission. Higher Education Management and Policy 14(2):39-52.
Spanò R, Cicellin M, Scuotto A (2018). Performance measurement design: a contingency perspective from the Italian regional healthcare services. Journal of Economic and Administrative Sciences 35(1):16-27.
Trotta A, Cardamone E, Cavallaro G, Mauro M (2013). Applying the balanced scorecard approach in teaching hospitals: a literature review and conceptual framework. The International Journal of Health Planning and Management 28(2):181-201.
Vahdat S, Hamzehgardeshi L, Hessam S, Hamzehgardeshi Z. (2014). Patient involvement in health care decision making: a review. Iranian Red Crescent Medical Journal 16(1):e12454.
Van de Walle S, Cornelissen F (2014). Performance reporting. In. Bovens M, Goodin RE, Schillemans T (eds.), The Oxford Handbook on Public Accountability. Oxford, UK: Oxford University Press pp. 441-455.
Van Eijk CJ, Steen TP (2014). Why people co-produce: Analysing citizens' perceptions on co-planning engagement in health care services. Public Management Review 16(3):358-382.
van Helden J, Uddin S (2016). Public sector management accounting in emerging economies: A literature review. Critical Perspectives on Accounting 41:34-62.
van Rossum TR, Scheele F, Scherpbier AJ, Sluiter HE, Heyligers IC (2016). Dealing with the complex dynamics of teaching hospitals. BMC Medical Education 16(1):104.
Yeo HL, Kaushal R, Kern LM (2018). The adoption of surgical innovations at academic versus nonacademic health centers. Academic Medicine 93(5):750-755.
Zafar SN, Shah AA, Hashmi ZG, Efron DT, Haut ER, Schneider EB, Schwartz D, Velopulos CG, Cornwell EE, Haider AH (2015). Outcomes after emergency general surgery at teaching versus nonteaching hospitals. Journal of Trauma and Acute Care Surgery 78(1):69-77.
Zakhem A (2008). Stakeholder management capability: A discourse–theoretical approach. Journal of Business Ethics 79(4):395-405.