HEALTH SERVICES MANAGEMENT

ORGANISATIONAL STRUCTURE, GOVERNANCE, AND INTEGRATION OF CLINICAL AND ADMINISTRATIVE SERVICES IN HEALTHCARE INSTITUTIONS

An Analytical Report on Hospital Structure, Decision-Making Centralisation, and Patient-Centred Care Coordination (Option 1)

Student Name: Vaghani Paras Hareshbhai

Student ID: DE240399

Module Title: Health Services Management

Assignment Task: Option 1 — Organisational Structure & Governance Integration

Submission Deadline: 19/10/2026

Institution: EIIET (European Institute of Innovation)

TABLE OF CONTENTS

Section TitlePage

1. Abstract 2

2. Introduction 3

3. Literature Review 4

4. Methodology 5

5. Analysis of Organisational Structures in Healthcare 6

6. Role of Governance Organs and Clinical Accountability 7

7. Case Studies of Clinical and Administrative Integration 8

8. Proposed Governance & Coordination Model for Midsize Hospitals 9

9. Conclusion 10

10. References 11

11. Appendices 12

1. ABSTRACT

This assignment examines how organizational structures and governance models shape the coordination of resources, clinical staff, and administrative services in healthcare institutions. Hospitals face increasing pressure to deliver safe, cost-effective, and patient-centered care. However, traditional functional silos often create communication gaps between doctors, nurses, and hospital managers. This report analyzes four primary organizational structures—functional, divisional, matrix, and service-line—and evaluates decision-making centralisation and decentralisation in clinical environments.

Using secondary research and case study evaluation, the paper investigates the role of governing boards, medical executive committees, and administrative leaders in maintaining clinical quality and financial accountability. Real-world hospital examples are analyzed to highlight what works and what fails when combining clinical and support functions. Finally, a practical hybrid service-line governance model is proposed specifically for a midsize hospital (200-300 beds) to enhance team coordination while keeping the patient at the centerpiece of care.

2. INTRODUCTION

Healthcare institutions are complex social and technical systems that must balance multiple competing priorities. On one side, clinical teams focus on delivering individual patient care, preserving medical safety, and adopting advanced clinical treatments. On the other side, administrative leaders manage financial budgets, government regulations, facility operations, and staff scheduling (Shortell & Kaluzny, 2012). How a hospital is structured and governed directly influences how these two sides interact and make daily operational decisions.

Historically, many hospitals operated under rigid functional silos where medical departments (such as cardiology or surgery) worked separately from administrative departments (such as finance or human resources). This separation often created communication gaps, slow decision-making, and friction between doctors and management (Glouberman & Mintzberg, 2001). To address these problems, modern health services management has introduced new organizational forms like matrix structures and service-line management to improve cross-functional teamwork.

This report addresses Option 1 of the Health Services Management assessment. The main objective is to critically evaluate organizational forms, assess the role of governance organs in protecting patient quality, analyze real hospital integration cases, and propose a working governance and coordination model for a midsize hospital. The paper aims to demonstrate how proper management structures can bring clinical and administrative teams together to deliver better patient outcomes.

3. LITERATURE REVIEW

The theoretical foundation of healthcare management draws heavily on organizational theory, governance models, and health policy literature. Understanding how hospitals coordinate work requires looking at structural design and decision-making authority.

3.1 Organizational Structures and Professional Bureaucracy

Mintzberg (1993) described hospitals as typical "professional bureaucracies." In this structural form, power is divided between operational professionals (physicians and nurses) who hold high expertise and administrative staff who control financial and physical resources. Shortell and Kaluzny (2012) noted that while functional structures promote specialization, they frequently lead to organizational silos. To overcome this, many healthcare organizations shifted toward divisional and service-line structures, grouping staff around specific patient conditions or medical specialties rather than professional functions (Villa et al., 2014).

3.2 Centralisation versus Decentralisation in Healthcare

Centralisation refers to concentrating decision-making power at top management levels, which helps maintain tight financial control and standardized institutional policies (Emanuel & Fuchs, 2012). However, highly centralized decision-making can delay urgent clinical choices. Decentralisation pushes authority down to department heads and frontline clinical leaders, allowing faster adaptation to patient needs. Research indicates that hybrid governance—combining centralized strategic oversight with decentralized clinical decision-making—yields higher patient safety and employee satisfaction (Saltman et al., 2011).

4. METHODOLOGY

This study uses a qualitative secondary research methodology to investigate health services management, hospital governance structures, and clinical-administrative integration. Secondary research allows for a thorough synthesis of academic literature, health policy frameworks, and published hospital case studies (Saunders et al., 2019).

4.1 Data Collection and Source Selection

Academic sources were searched using major healthcare and management databases, including PubMed, ScienceDirect, JSTOR, and Google Scholar. The search targeted publications in health service management, hospital administration, and clinical governance. Primary search terms included: *hospital organizational structures*, *service line management in healthcare*, *clinical governance and patient safety*, *centralisation vs decentralisation in hospitals*, and *integrating clinical and administrative services*. Official reports from healthcare quality organizations such as the World Health Organization (WHO) and the NHS Institute for Innovation and Improvement were also reviewed.

4.2 Analytical Evaluation Framework

The collected evidence was evaluated across three main dimensions:

1. **Structural Efficiency:** How well different organizational designs reduce communication friction between doctors and administrators.

2. **Accountability & Quality:** How governance bodies maintain safety standards and financial stability.

3. **Patient Centricity:** Whether structural changes lead to better patient experience and care continuity.

5. ANALYSIS OF ORGANISATIONAL STRUCTURES IN HEALTHCARE

Healthcare institutions utilize different structural designs depending on their size, patient volume, and clinical complexity. The table below compares four major organizational forms found in modern health services.

Structural Form	Key Characteristics	Decision-Making Focus	Main Advantages & Drawbacks
Functional	Grouped by specialized task (e.g., Nursing, Finance, Surgery).	Centralized at executive level.	High technical expertise; creates communication silos between departments.
Divisional	Divided by geographic region or patient group (e.g., Pediatrics, Oncology).	Decentralized to division heads.	Better responsiveness to local needs; duplicates administrative costs.
Matrix	Dual-reporting lines combining functional and project/service managers.	Shared between functional & service managers.	Encourages cross-team collaboration; creates role confusion and staff stress.
Service-Line	Organized around end-to-end clinical care pathways (e.g., Heart & Vascular).	Decentralized to service-line directors.	High patient focus and teamwork; can cause resource competition between lines.

As analyzed, traditional functional models provide strong technical control but slow down cross-departmental coordination. Service-line structures align doctors, nurses, and support staff around specific patient conditions, improving care flow and operational efficiency (Villa et al., 2014).

6. ROLE OF GOVERNANCE ORGANS AND CLINICAL ACCOUNTABILITY

Governance in healthcare refers to the frameworks, policies, and board oversight mechanisms that ensure an organization achieves its strategic goals while protecting clinical safety and financial stability (Saltman et al., 2011).

6.1 Governing Boards and Executive Management

The Hospital Board of Directors holds ultimate legal and ethical responsibility for institutional performance. The board sets strategic goals, approves capital budgets, and monitors compliance with health regulations. Executive management—led by the Chief Executive Officer (CEO)—translates board strategies into daily operations. Effective governance requires boards to contain a balanced mix of financial experts, community representatives, and senior medical leaders to prevent financial goals from undermining care standards (Emanuel & Fuchs, 2012).

6.2 Medical Executive Committees and Clinical Governance

Clinical governance ensures that medical professionals maintain high quality standards. The Medical Executive Committee (MEC) and Medical Audit Committees supervise physician credentialing, clinical peer review, and infection control protocols. By bridging executive management and clinical staff, the MEC establishes clear clinical accountability. When clinical governance operates effectively, medical errors are caught early and care guidelines are updated based on evidence-based medicine (Shortell & Kaluzny, 2012).

7. CASE STUDIES OF CLINICAL AND ADMINISTRATIVE INTEGRATION

Examining real healthcare case studies provides practical insights into what succeeds and what fails when combining clinical and support functions.

7.1 Case Study 1: Mayo Clinic (Integrated Service Model)

The Mayo Clinic is widely recognized as a successful model of clinical and administrative integration. Mayo uses a unique physician-led governance structure where medical directors work directly alongside administrative managers at every organizational level. This "co-leadership" approach ensures that administrative decisions (such as equipment purchases or staffing budgets) directly support patient care needs. As a result, Mayo Clinic consistently achieves high rankings in patient safety, care quality, and staff retention (Shortell & Kaluzny, 2012).

7.2 Case Study 2: NHS Hospital Trust Structural Reorganization

In contrast, an NHS Hospital Trust attempted a rapid transition from a traditional functional structure to a matrix governance model without adequate staff training or consultation. The change created duplicate management layers and conflicting reporting instructions for ward nurses, who had to answer to both functional nursing directors and service managers. This role ambiguity led to staff burnout, increased waiting times in the emergency department, and dropped morale (Glouberman & Mintzberg, 2001). The lesson shows that structural changes fail when imposed without cultural readiness and clear lines of authority.

8. PROPOSED GOVERNANCE & COORDINATION MODEL FOR MIDSIZE HOSPITALS

For a midsize general hospital (200 to 300 beds), an overly complex matrix structure causes confusion, while a rigid functional hierarchy creates silos. Therefore, a **Hybrid Service-Line Governance Model** is proposed to integrate clinical and administrative functions effectively.

8.1 Structure and Co-Leadership Setup

The hospital should be organized into major Service-Line Units (e.g., Emergency & Critical Care, Surgical Services, Maternal & Child Health, Outpatient Care). Each Service Line is led by a dual-management team consisting of a **Clinical Service Director** (a senior doctor) and an **Operations Manager** (an administrative professional). This pair shares joint responsibility for quality targets, staff scheduling, and budget management.

8.2 Joint Coordination Council and Patient Advisory Panel

To prevent service lines from competing for hospital resources, a monthly **Joint Operations Council** chaired by the CEO meets to align hospital-wide strategy. Support services (such as Pharmacy, Radiology, IT, and Maintenance) assign dedicated liaison staff to each service line. In addition, a **Patient Advisory Committee** reports directly to the board, ensuring patient feedback actively shapes hospital policies.

9. CONCLUSION

In conclusion, how a healthcare institution structures its departments and governs its operations plays a vital role in determining service quality, clinical safety, and institutional efficiency. Rigid functional hierarchies often isolate clinical professionals from administrative teams, leading to communication delays and operational friction. Moving toward integrated service-line models allows hospitals to align support services directly around patient pathways.

Furthermore, strong health services management requires effective governance structures. Hospital boards and medical executive committees must work together to maintain joint accountability for financial budgets and patient care outcomes. Real-world case studies prove that integration succeeds when clinical leaders and administrative managers share decision-making authority through co-leadership models, as seen in institutions like the Mayo Clinic.

The proposed hybrid service-line governance model offers a practical framework for midsize hospitals. By establishing co-led service units, joint coordination councils, and dedicated administrative liaisons, healthcare managers can foster genuine teamwork, streamline resource allocation, and ensure that high-quality patient care remains the centerpiece of hospital operations.

10. REFERENCES

Emanuel, E. J. and Fuchs, V. R. (2012). 'The perfect storm of overutilization', *Journal of the American Medical Association*, 299(23), pp. 2789–2791.

Glouberman, S. and Mintzberg, H. (2001). 'Managing the care of health and the cure of disease—Part I: Differentiation', *Health Care Management Review*, 26(1), pp. 56–69.

Mintzberg, H. (1993). *Structure in Fives: Designing Effective Organizations*. Upper Saddle River, NJ: Prentice-Hall.

Saltman, R. B., Duran, A. and Dubois, H. F. (2011). *Governing Public Hospitals: Reform Strategies and the Movement Towards Institutional Autonomy*. Copenhagen: World Health Organization (Regional Office for Europe).

Saunders, M., Lewis, P. and Thornhill, A. (2019). *Research Methods for Business Students*. 8th edn. Harlow: Pearson Education.

Shortell, S. M. and Kaluzny, A. D. (2012). *Health Care Management: Organization Design and Behavior*. 6th edn. Clifton Park, NY: Delmar Cengage Learning.

Villa, S., Barbieri, M. and Kane, N. (2014). 'Managing healthcare operations through service line management: A conceptual framework', *Health Services Management Research*, 27(1-2), pp. 12–21.

World Health Organization (WHO). (2018). *Integrated Health Services: What and Why?*. Geneva: World Health Organization.

11. APPENDICES

Appendix A: Structural Matrix for Proposed Midsize Hospital Governance

Service Line Unit	Clinical Co-Leader	Administrative Co-Leader	Primary Key Performance Indicator (KPI)
Emergency & Critical Care	Chief Emergency Physician	Emergency Operations Manager	Triage time < 15 mins; zero safety incidents.
Surgical Services	Head of Surgery	Surgical Suite Manager	OR utilization rate > 85%; infection rate < 0.5%.
Maternal & Outpatient	Lead Obstetrician / Clinic Head	Outpatient Services Director	Patient wait time < 20 mins; satisfaction > 90%.

Appendix B: Declaration of Originality

I declare that this report represents my own original academic work for the module Health Services Management (Option 1). All secondary literature, management theories, and hospital case studies cited in this document have been properly acknowledged using the APA 7th edition referencing standard. No part of this work has been plagiarized.