



Responsible Editor: Rodrigo de Souza Gonçalves
Andrea de Oliveira Gonçalves
Associate Editor: Juliano Lima Soares
Evaluation Process: Double Blind Review pelo SEER/OJS

Institutional Logic in Measurement and Cost Management in Accredited Hospitals

ABSTRACT

Objective: analyze the influence of institutional logic in adopting measurement and cost management practices in accredited Brazilian hospitals.

Method: uses as a strategy the survey, through a questionnaire. The sample comprised 85 responses, and it used descriptive statistics and structural equation modeling performing data analysis.

Originality/Relevance: there were few survey studies on the subject. Still, there is little theoretical-empirical research on costs in the national literature and the lack of theoretical guidance in existing ones (Ramalho, 2016), with no studies that address cost accounting from the perspective of institutional logic.

Results: the motivations that lead to cost measurement and management are related to professional issues (involving quality and excellence in the service provided), market (requiring financial sustainability), bureaucratic (setting standards and protocols), and community (considering accessibility and transparency). The statistical analysis points out that the market logic influences the adoption of more cost practices than the others, followed by the community logic.

Theoretical/Methodological contributions: considering that concurrent logics, acting in the same field, contribute to the management as a whole, meeting the demand for quality, accessibility, and cost reduction, this study contributes to the understanding of what may be influencing or not the use of measurement and cost management practices, which are essential for the control and management of hospitals.

Keywords: Costs; Cost management in hospitals; Institutional logic; Hospital accreditation.

Beatriz Negrelli da Silva

Universidade Estadual de Maringá, Paraná,
Brasil
beatriznegrelli@hotmail.com

Katia Abbas

Universidade Estadual de Maringá, Paraná,
Brasil
katia_abbas@yahoo.com.br

João Marcelo Crubellate

Universidade Estadual de Maringá, Paraná,
Brasil
jmcrubellate@uem.br

Received: July 15, 2021

Revised: October 26, 2021

Accepted: November 08, 2021

Published: December 30, 2021



How to Cite (APA)

Silva, B. N., Abbas, K., & Crubellate, J. M. (2021). Institutional Logic in Measurement and Cost Management in Accredited Hospitals. *Journal of Accounting, Management and Governance*, 24 (3), 349-369.
http://dx.doi.org/10.51341/1984-3925_2021v24n3a6

1 INTRODUCTION

Institutional logics aim to shape the means to achieve the goals established by organizations (Martin, Bushfield, Siebert, Howieson, 2021); therefore, they direct, motivate, and legitimize the behavior of actors in the field, justifying their actions (Scott Ruef, Mendel, & Caronna, 2000). When trying to understand the behavior of the individual and the organization in the social context (Friedland & Alford, 1991), it is possible to verify the connection between institutional logics and organizational practices, helping to understand how to produce, reproduce, modify, and extinct some practices (Silva, 2016).

The context of Brazilian hospitals, which is not different from the American one, according to Ferreira and Ryngeblum (2020), has undergone several transformations over time. Changes in payment methods, competition for patients, and increased privatization led to the inclusion of business practices, increasing market orientation, and, consequently, the contracts and behavior of these organizations began to have a more commercial character (Scott *et al.*, 2000). According to Arndt and Bigelow (2006), various changes in the health field occur through "reinstitutionalization," which is the departure of an institutional logic and the entrance of another one.

The more complex the organizational context, the greater its plurality is and, consequently, the more distinct the logic that influences it (Goodrick & Reay, 2011; Raynard, 2016; Araújo, 2017). The health field, therefore, encompasses multiple institutional logics due to the various actors in the field and their conflicts of interests, prioritizing one logic over another (Ferreira & Ryngeblum, 2020) and due to its services, which incorporate a range of resources: human, financial, material and technological. In addition to the relationship with social, cultural, and educational components (Santos, Martins, & Leal, 2013; Martins, Portulhak, & Voese, 2015).

This complexity leads hospitals to work in a context of high and scarce costs, which cannot compromise the quality of services provided (Dallora & Forster, 2008; Santos, Martins, & Leal, 2013; Neder, 2015). Thus, hospitals face two paradigms that increase their concern with controlling their costs: i) the appearance of new technologies, leading to increased costs; and ii) the provision of services with the desired quality (Xavier & Rodrigues, 2012).

According to Silva (2016), hospital accreditation can increase quality and efficiency in health services, which is a seal of quality, as a way to attest and legitimize the services offered by hospitals. Better management of resources is among the benefits that hospital accreditation can generate (Viana, Sette, Rezende, Botelho, & Poles, 2011).

Hospitals face difficulties in controlling and containing their costs due to the changes with modern medical techniques, and consequently, the increase in expenses (Neriz, Núñez, & Ramis, 2014). In addition, the constant pressure for quality (Dallora & Forster, 2008; Neder, 2015) demands the adoption of advanced cost management techniques (Popesko, 2013) to support management control, decision-making, hospital efficiency, and transparency (Mercier & Naro, 2014). Thus, it is possible to observe the relationship between hospital cost management, institutional logic, and hospital accreditation. This study aims to analyze the influence of institutional logic in adopting measurement and cost management practices in accredited hospitals in Brazil.

In the national literature, there is a lack of theoretical guidance in existing research on the subject (Bitti, Aquino, & Cardoso 2011; Ramalho, 2016), showing the relevance of doing work on management accounting practices "linked" to theory (Berry, Coad, Harris, Otley, & Stringer, 2009). Therefore, this study sought to contribute by identifying and analyzing the measurement and cost management practices used from the perspective of institutional logics,

whose main precursors are Friedland and Alford (1991), Thornton and Ocasio (1999) and Scott *et al.* (2000), using as the basis of the work, in addition to these, national studies such as Silva's (2016). Thus, it can provide the enrichment of theory, identifying institutional logics in the context of hospital cost management and how they can influence the use of cost practices for measurement, control, and management decision making

Cost management is essential for hospitals' survival (Abbas & Leoncine, 2014); therefore, it is pertinent to discuss the measurement and cost management practices to score the main ones in hospitals and their possible motivations and relationship with institutional logic.

2 LITERATURE REVIEW

2.1 Cost management and hospital accreditation

The peculiarities that involve the hospital area require a cost management system to manage results and decision-making (Cardoso, Souza, Reis, & Palha, 2020). In this context, factors such as the increasing age of the population reveal the need to apply new technologies, which generate a consequent increase in the costs involved in health care and the need to contain these costs (Neriz *et al.*, 2014). Such considerations about the increase in costs are essential "within a system whose underfunding has been identified as the main cause of the lack of quality service provision to the population" (Blanski, 2015, p.17).

Regarding quality, besides helping in fundraising, Bandeira and Bandeira (2021) emphasize that quality certifications should provide excellence. Therefore, according to Nascimento, Gravena, and Machinski Junior (2020), hospital service quality is essential. Some hospitals use "quality seals," such as hospital accreditation, which in turn is a system for evaluating and certifying the quality of health services, which is voluntary, periodic, and reserved (ONA, 2018). The National Accreditation Organization (ONA) is a Brazilian non-governmental and nonprofit entity, which certifies hospitals that meet the quality and safety requirements relevant to health services and which can have three levels (Table 1) (ONA, 2018).

Table 1
ONA accreditation levels

Accreditation levels	Certification	Focus
Level 1	Accredited	Patient safety, considering structural and care aspects.
Level 2	Fully accredited	In addition to security requirements, it features an integrated management process between activities.
Level 3	Accredited with Excellence	Junction of the two levels, presenting an institutional maturity of them.

Note. Source: adapted from National Accreditation Organization (ONA) (2018).

Furthermore, the ONA manual (2018) points out that the hospital should use a management model, indicating among its "standard requirements," the cost management policy, thus, falls on the need for accredited hospitals to manage the costs. In this perspective, Cardoso and Martins (2012, p. 60) argue that "hospital accreditation influences the cost improvement of health organizations," pointing out that cost information can help managers control expenses to improve the quality and performance of the hospital.

Therefore, there is a need for studies that explore the factors related to the use of management methods and cost measurement in hospitals, not limited to the feasibility of applying a specific practice in a hospital.

2.2 Institutional logics in the hospital context

Works by Friedland and Alford (1991), Thornton and Ocasio (1999), and Scott *et al.* (2000) brought institutional logic to give meaning to institutions, thus removing the focus only from institutional isomorphism when dealing with the heterogeneities of organizations. On the other hand, Teixeira (2012, p. 2) states that institutional logics have become a significant trend for Institutional Theory researchers, however, "not opposing, but complementing previous views of change, such as, for example, isomorphism and institutional entrepreneurship," and analyzing the sources of heterogeneity from the contradictions between institutional logics.

Institutional logics can be understood as material and symbolic practices constructed to constitute organizational and individual principles (Friedland & Alford, 1991). Similarly, Scott *et al.* (2000) refer to institutional logic as beliefs associated with practices that predominate in an organization's field and provide organizational principles that support the practices guided by the participants. The same authors emphasize that the actors/participants in the organizational field can be defined as the creators of logic, considering that they participate and receive demands from the institutional environment in which they work.

Table 2 presents the institutional logic, listed by the authors of the theme.

Table 2

Institutional logics

Institutional logics	Institutional Logic Characteristics
Market	Increased efficiency and profit; competitiveness; relationships shaped by competition; investments; cost reduction; capital accumulation; opportunism; greater costs and targets control.
Community	Cooperativism; reciprocity; popular participation; equity.
Professional	Professional expertise; quality of services and structure offered; better patient/customer service; dedication; increased status and reputation; formalization of knowledge.
Religion	Religious symbolism.
Science	Search for truth.
Bureaucratic State	Group interest; regulation of activities through the bureaucracy; standardization of activities; organization of services; discipline.
Family	Family as a firm; family reputation; loyalty among members.

Note. Source: adapted from Friedland and Alford. (1991), Thornton, Ocasio and Lounsbury (2012). Friedland, Mohr, Roose, and Gardinali (2014), Silva (2016).

Empirical studies in institutional logic focus on decision makers' attention to problems and solutions that are consonant with the dominant logic (Lounsbury, 2007; Picheth, 2016). Silva (2016, p. 29) adds that "in fact, institutional logics have a direct influence and impact on practices that are produced and reproduced by organizations."

Scott *et al.* (2000) discuss the institutional logic in the field of American health, in the state of California, in order to understand the changes arising in this sector, initially highlighting the professional domain, then that of the state and, finally, that of the market, indicating the need for management of this sector. In this perspective, Reay and Hinings (2009) investigated an organizational field through the analysis of institutional logic in the area of health care in Alberta, Canada, in 1994, when the government introduced a new logic of health care, being seen as a business, to increase efficiency, doing more with less.

Other studies cite institutional logic, such as market, professional and bureaucratic, as the most present in the hospital environment (Scott *et al.*, 2000; Reay & Hinings, 2009; Baly, Kletz, & Sardas, 2015; Blomgren & Waks, 2015). These logics are the same established in national studies, such as Silva (2016) and Araújo (2016), and the latter also added the community logic in his study. In the results of the studies that address the theme, the

pluralities of institutional logic become evident; that is, even if there is a dominant one, they can coexist in the same organizational environment. Institutional logics exist in several contexts, their local conditions and respective cultures can shape them, and each system can have a different number, type, and interaction of logics (Gümüşay, Claus, & Amis, 2020).

Therefore, it is worth noting that institutional logics are not replaced but continue to operate simultaneously, even if sometimes one prevails over the other; there may be evidence of one, even if the other is dominant (Scott *et al.*, 2000; Silva, 2016). Likewise, Reay and Hinings (2009) conclude that actors' interests in the field may be linked to different institutional logics, which are coexisting, supported by established agreements.

Dunn and Jones (2010) mention that it is inappropriate to establish a single logic in a pluralistic environment such as hospitals. Such a statement indicates that one logic can strengthen another, as well as, there can be additive relationships in which a single activity can be influenced by more than one logic (Waldorff, Reay, & Goodrick, 2013). These findings highlight the possibility of hybridizing plural logic in work practices (Baly *et al.*, 2015).

Thus, there is a close relationship between institutional logics and organizational practices, thus considering the pertinent institutional logics to support the use or not of measurement and cost management practices.

2.3 Research Hypotheses

Scott *et al.* (2000) discussed the changes in the American health field through institutional logic, pointing out that with the growing competition for patients, they started using management practices such as marketing, cost-benefit analysis, strategic planning, identification, and management of health centers cost (Scott *et al.*, 2000). Several authors, both in the international and national context, indicate that the market or capitalist logic presupposes this more significant concern with cost management when seeking to reduce costs and increase profit (Scott *et al.*, 2000; Blomgren & Waks, 2015; Silva, 2016; Araújo, 2016). Furthermore, the accreditation process leads to the need for investments to restructure departments, human and financial resources (Bandeira & Bandeira, 2021). Thus, the hypothesis is suggested:

H1: The market logic has a positive influence on the adoption of management practices and cost measurement.

Studies indicate that when there is more significant concern about the quality of services provided by health professionals, they do not treat costs as a priority (Silva, 2016), with resistance to implementing a management practice due to the predominance of professional logic, especially medical (Koelewijn, Ehrenhard, Groen, & van Harten, 2012; Blomgren & Waks, 2015). Therefore, the hypothesis is suggested:

H2: Professional logic has a negative influence on the adoption of management practices and cost measurement.

Borgert, Alves, and Schultz (2010) show that one of the main factors that hinder the implementation of a cost system is the lack of protocols, which is in line with the bureaucratic logic, which aims to establish protocols and standards, being evidenced in the hospital context in the study by Silva (2016), for example. Protocols are pointed out as necessary to collect information (Borgert *et al.*, 2010). On the other hand, Yereli (2009) highlights that the difficulty in accounting for hospital costs lies in the lack of necessary data. Therefore, the hypothesis is suggested:

H3: Bureaucratic logic has a positive influence on the adoption of management practices and cost measurement.

Although they have been pressured to manage their resources better, the national historical context points out that hospitals, mainly public and philanthropic, have an assistance role: a bias towards the community and equity. However, there is a standard (NBC T 16.11) that imposes on public bodies the use of a cost system, yet many have not yet adopted it, as evidenced by Cardoso and Martins (2012), whose study took place in accredited hospitals and by Martins *et al.* (2015), who studied federal university hospitals. In the meantime, the hypothesis is established:

H4: Community logic has a positive influence on the adoption of cost management and measurement practices.

Thus, Figure 1 represents the relationships present in the hypotheses.

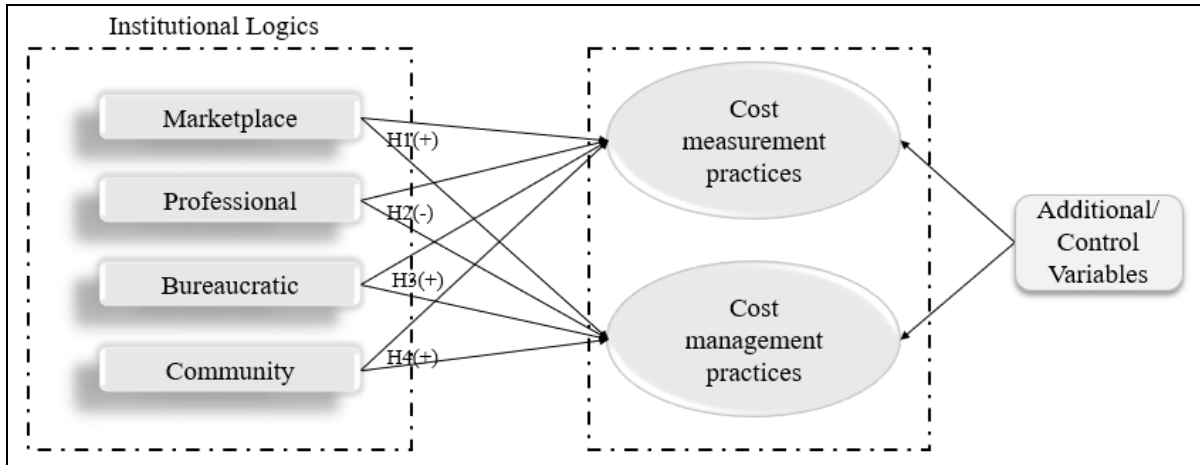


Figure 1. Relationships of hypotheses

3 METHODOLOGICAL PROCEDURES

The study has a quantitative approach with an applied purpose (Gil, 1999). The purpose of the study is descriptive research because it seeks to describe the "characteristics of a given population or phenomenon or the establishment of relationships between variables" (Gil, 1999, p. 44), which is consistent with the purpose of this study. Its strategy is survey research, using a questionnaire as a technique for data collection, which presents structured questions to obtain opinions (Gil, 1999).

3.1 Population and Sample

The population of this study consists of hospitals accredited in Brazil by the National Accreditation Organization (ONA), which has 263 hospitals (ONA, 2017). 157 or 71, respectively (figure 2). The sample size was calculated using the equation:

$$n = \frac{N \cdot Z^2 \cdot p \cdot (1 - p)}{(N - 1) \cdot e^2 + Z^2 \cdot p \cdot (1 - p)}$$

Where:

n = number of individuals in the sample;

N = population size;

Z = critical value that corresponds to the desired degree of confidence, and for a confidence level of 95%, the z value corresponds to 1.96;

p = population proportion of individuals belonging to the category studied. According to Levine, Berenson, and Stephan (2000) can be replaced by 0.5 when the sample value is unknown;

e = maximum margin of error allowed in the estimate, and two calculations were performed: the first with maximum error admitted of 0.05 (5%) and the second of 0.10 (10%).

Thus, using the Excel spreadsheet resource to perform the calculation, Figure 2 presents the sample calculation for the study.

Data			Legend		
N	263,00	263,00	Population size		
Trust rating	95%	95%	Confidence Interval Probability Contains True Value		
$\alpha/2$	0,025	0,025			
Area between x and y	0,475	0,475			
$Z_{\alpha/2}$	1,955	1,955	Critical value corresponding to the desired degree of confidence		
Margin of error	5%	10%	Difference between the sample proportion and the true population proportion		
			Sample (n)		
			5%	10%	
Determination of sample size (n) based on estimated population proportion - Finite			157	71	
Determination of sample size (n) based on estimated population proportion - Infinite			383	96	

Figure 2. Sample calculation

3.2 Instrument and Data Collection

Previously, a pilot study was carried out in a private hospital undergoing accreditation, located in Paraná, to verify the consistency and coherence of the institutional logics studied and this relationship between institutional logics and cost practices and hospital accreditation. Through an interview with the finance director, the market, professional and bureaucratic logics became evident. The market logic is evident when considering improving management, negotiating with health plans, and improving the hospital's remuneration; the professional, aiming at the quality and efficiency of services and managing them; and bureaucratic, for adopting protocols to gather helpful information for cost reporting. The community logic, as well as others presented in the literature, was not so evident. However, the community logic will still be part of the research since the pilot interview took place in a private hospital, different from what can happen in a public or philanthropic hospital. Bossy, Knutsen, Rogers, and Foss (2016) argue that private nonprofit organizations emphasize community and moral responsibility.

A pre-test was applied with five hospitals to validate and verify the consistency of the questionnaire. The questions were shown to be consistent, and the reliability test of Cronbach's Alpha of 0.89 was also measured, and from 0.70 onwards, the data are considered reliable. The questionnaire proved to be valid for the official application of the survey.

The sample hospitals were contacted by telephone to verify the respondents who could take the questionnaire for data collection. Then, through the Google Forms feature, the questionnaire was sent by email to the respondents. Data collection was carried out from December 2017 to May 2018, obtaining 85 valid responses.

The questionnaire, divided into four blocks, has 38 questions, namely: i) referring to management practices and cost measurement (questions 1, 2, and 5), as listed in table 3; ii) aimed at identifying the institutional logics present (question 6) and the relationship with the adoption of cost practices; iii) referring to the characteristics of the hospital and the respondent (questions 22-38); iv) auxiliaries on the use of measurement and cost management practices, logics and accreditation (questions 3 and 4; 7-21).

3.3 Data Analysis

Initially, with the information from the questionnaire, a descriptive analysis was performed, and to test the established hypotheses, Structural Equation modeling was used with the aid of the SmartPLS 3 program. Structural equation modeling is "a classic combination of Factor Analysis - which defines a measurement model that operationalizes latent variables or constructs - and Linear Regression - which establishes the relationship between different variables under study" (Marôco, 2010, p. 3). The logics were measured through several observable variables, being necessary to carry out the factor analysis, transforming items that explain the same thing into a single factor (Hair Jr. *et al.*, 2009), and verifying how much the observable variables represent the logic, and then analyze its relationship with measurement and cost management practices. The measurement and cost management practices and the institutional logic considered in this study are presented in Table 3, which also shows the measures of the variables.

Table 3
Research constructs and variables

Constructs 1st order	Constructs 2nd order	Variables	References basis	Measures of variables	Questions
Cost management and measurement	Cost measurement practices	Absorption Costing (Full and Partial)		5-point scale: does not adopt (1); evaluated and discarded (2); under evaluation (3); initial adoption (4); full adoption (5)	1
		Variable Costing Homogeneous Sections Method (RKW)			
	Cost management practices	Activity-based costing (ABC)	Abbas (2001); Matos (2005); Saraiva (2006); Popesko (2013); Martins <i>et al.</i> (2015)		2 and 5
		Cost Volume Profit Analysis (CVP); Contribution Margin (CM); Equilibrium Point (EP); Safety Margin (SM); Degree of Operational Leverage (DOL)			
Institutional logics	Market logic (capitalist)	Reduce costs; Get more profit; Stay ahead of the competition; Does not use practice as it is considered a high cost	Scott <i>et al.</i> (2000); Blomgren and Waks (2015); Silva (2016); Araújo (2016)		
	Professional logic	Operational efficiency (services); Quality of services; Professionalization (courses)	Scott <i>et al.</i> (2000); Koelewijn <i>et al.</i> (2012); Blomgren and Waks (2015); Silva (2016); Araújo (2016)	Likert scale of 5 points: (1) Totally disagree; (2) Disagree; (3) indifferent; (4) agree; (5) I totally agree.	6
	Bureaucratic/ State Logic	Establish protocols; Standardization of costs and services; external requirements	Scott <i>et al.</i> (2000); Blomgren and Waks (2015); Silva (2016); Araújo (2016)		
	Community Logic	Fair/affordable prices; Accessible service; Transparency	Baly <i>et al.</i> (2015); Araújo (2016)		

To measure the variables (cost measurement practices; cost management practices; and institutional logics) and after performing the structural equation, one question was asked to indicate the degree of adoption of the measurement practices and another one to indicate the degree of adoption of each of the cost management practices, to measure the degree of institutionalization in organizations and the level of adoption (does not adopt full adoption). Concerning Institutional Logic, a question was asked addressing each aspect established for each logic, where the respondent should indicate the degree of the reason for using the measurement and cost management practices.

4 RESULTS AND DISCUSSIONS

4.1 Descriptive Statistics

In Brazil, they have hospitals accredited by the ONA, except for Acre, Rondônia, Roraima, and Tocantins. The state of São Paulo has the most significant number of accredited hospitals. In this research, responses were obtained from 18 states, with 18 responses from the south region, 51 from the southeast region, six from the midwestern region, two from the north region, and eight from the northeast, totaling 85 valid responses, representing about 32% of the study population.

Regarding the characteristics of hospitals, 62.4% are "General Hospitals," private (55%), and nonprofit (54.1%). Most hospitals are medium (over 50 beds) and large (over 150 beds). Therefore, about 75% of hospitals have more than 100 beds, and of these, four hospitals have more than 400 beds. About the hospital command, it was observed that about 75% have professionalized administration, while 15% have doctors themselves in the command.

Respondents are primarily trained in administration and accounting, and when not (only three respondents) indicate specializations in the area of management and controllership. The positions held by them are assistants and analysts (accounting or cost, or both), managers or managers (financial or administrative), controllership, coordination and supervision (accounting, financial or cost), accountants, and financial directors.

To meet the objective of this study, and through descriptive statistics, the measurement and cost management practices used by accredited hospitals and their degree of adoption were initially identified. Table 4 presents the frequencies (NP e 1 = No plans for adoption; AD e 2 = Assessed and discarded; UE e 3 = Under evaluation; IA e 4 = Initial adoption; FA e 5 = Full adoption) and the means of measurement practices and cost management, respectively.

The most used measurement method was the Integral/Full absorption costing by 93% of responding hospitals, which is already incorporated into the hospital's routine. Moreover, as for the costing by Partial absorption, only 28.2% of hospitals fully adopt the method. The least used is activity-based costing (ABC).

As for management practices, the most used are the contribution margin (MC) and the break-even point (PE), with full use by 64% and 49% of hospitals, respectively. This result may be because these practices are better known and disseminated in the business field.

In the next topic, the analysis of the structural equation model is carried out. It is noteworthy that the control variables are included in the model, which also aims to explain the use of practices. These variables include those referring to the choices of certain practices (recommended in the literature; recommended by external consultants; external requirements; used in other hospitals; and tax requirements).

Table 4
Panel A - Cost measurement practices

Measurement practices	Absolute Frequency						Average	Standard deviation
	NP (1)	AD (2)	UE (3)	IA (4)	FA (5)	Total		
Partial Absorption	30 35,3%	14 16,5%	5 5,9%	12 14,1%	24 28,2%	85 100%	2,84	0,804
Integral/Full Absorption	2 2,4%	3 3,5%	1 1,2%	6 7,1%	73 85,9%	85 100%	4,71	1,675
Homogeneous Sections Method	46 54,1%	10 11,8%	6 7,1%	5 5,9%	18 21,2%	85 100%	2,28	1,683
Variable Costing	13 17,6%	0 0%	1 1,2%	16 21,2%	55 58,8%	85 100%	4,18	1,424
Activity-Based Costing	37 43,5%	11 12,9%	15 17,6%	7 8,2%	15 17,6%	85 100%	2,44	1,539

Panel B - Cost management practices

Standard Costing	19 22,4%	7 8,2%	4 4,7%	19 22,4%	36 42,4%	85 100%	3,54	1,622
Contribution Margin	7 8,2%	1 1,2%	8 9,4%	14 16,5%	55 64,7%	85 100%	4,28	1,211
Breakeven point	11 12,9%	1 1,2%	14 16,5%	17 20%	42 49,4%	85 100%	3,92	1,373
Safety Margin	20 23,5%	4 4,7%	22 25,9%	12 14,1%	27 31,8%	85 100%	3,26	1,536
Degree of Operational Leverage	30 35,3%	3 3,5%	23 27,1%	15 17,6%	14 16,5%	85 100%	2,76	1,501
Target Costing	41 48,2%	4 4,7%	14 16,5%	13 15,3%	13 15,3%	85 100%	2,45	1,570
Budget	9 10,6%	1 1,2%	9 10,6%	17 20%	49 57,6%	85 100%	4,13	1,298

Note. Source: Survey Data (2018).

4.2 Analysis of the Structural Equation Model

First, the data were submitted to a normality test, which, according to Marôco (2010), the maximum limits for asymmetry and kurtosis measures are, respectively, 3 and 10. All items met this condition. Subsequently, the adequacy of the moderation model was analyzed, verifying the convergent and discriminant validity. The convergent validity is analyzed using the following indicators: (a) factor loadings; (b) average variance extracted or average variance extracted (AVE); and (c) composite reliability (CR) (Hair, Anderson, Tatham, & Black, 2009).

The factor loadings indicate how much the observable variable represents the latent (logical) variable, presenting a value greater than 0.5 (Hair Jr. *et al.*, 2009; Marôco, 2010). Thus, according to the items that represent each institutional logic, as shown in Table 3, the variable "high investment" was excluded from the market logic factor, which presented a factorial load of only 0.203, that is, this model did not present, together with the other variables, the market logic, due to the low level of agreement between the respondents in terms of cost management. From the professional logic, the following variables had to be excluded: (a) "The hospital prioritizes quality over cost" (-0.502); (b) "Afraid to reduce quality by focusing on reducing costs and limiting the way the service is provided" (-0.500); and (c) "The hospital promotes/encourages courses to improve services" (0.425). The variable indicating whether the hospital "has difficulty collecting data to prepare cost information" was

excluded (-0.247). Moreover, as for the community logic, there was no need to exclude any variables. After all these exclusions, the model presented the necessary adequacy (Table 5).

Table 5
Factor loadings of latent variables

Institutional Logics	Items	Factor loading
Marketplace	Get more profit	0,829
	Reduce costs	0,585
	Being ahead of the competition	0,837
	More customers (higher profit) with lower cost	0,863
Professional	Higher quality and efficiency of services provided	0,971
	Show excellence and quality of services to the population	0,941
Bureaucratic	Standardize prices and services	0,852
	Comply/meet regulatory requirements	0,884
	Adopts protocols to collect and improve cost information	0,793
Community	Provide transparency to the service user	0,837
	Make service more accessible to the user by properly committing costs	0,763
	Provide a more affordable service price for patients	0,869

Note. Source: Survey Data (2018).

Table 5 does not show loads of cost practices and control variables because they are represented by only one factor, with a value equal to 1.

The average variance extracted (AVE – Average Variance Extracted) consists of a "measure of convergence in a set of items that represents a latent construct" (Hair et al., 2009, p.589). A variance above 0.5 represents an adequate convergence. Reliability (CR – Composite Reliability) is a measure of the internal consistency of the measured variables representing a latent construct and considering above 0.7 a good value (Hair Jr. et al., 2009), as well as Cronbach's Alpha (Table 6).

Table 6
Convergent validity

Latent Constructs	AVE	CR	Cronbach's Alpha	R ²
Marketplace	0,61	0,87	0,79	-
Professional	0,91	0,95	0,90	-
Bureaucratic	0,71	0,88	0,80	-
Community	0,68	0,87	0,77	-
Full Absorption Costing	-	-	-	0,24
Cost by Partial Absorption	-	-	-	0,18
Homogeneous Sections Method	-	-	-	0,10
Activity-Based Costing	-	-	-	0,17
Variable Costing	-	-	-	0,35
Contribution Margin	-	-	-	0,33
Break-even point	-	-	-	0,24
Safety Margin	-	-	-	0,32
Degree of Operational Leverage	-	-	-	0,30
Standard Costing	-	-	-	0,14
Target Costing	-	-	-	0,22
Budget	-	-	-	0,34
Reference values	> 0.5	> 0.7	> 0.7	2% (small), 13% (medium) and 26% (large)

Note. Source: Survey Data (2018).

The model presented the necessary adequacy, and because the cost practices present only one factor, the AVE, and the model validity indexes (CR and Cronbach's Alpha), equal

to 1. Consequently, the discriminant validity was verified (Table 7), which consists of verifying how the construct is different from the others and should not present a strong correlation with the other constructs, and for this, the correlation value should not be greater than the square root of the AVE (Hair Jr. *et al.*, 2009).

Table 7

Discriminating validity

	Marketplace	Professional	Bureaucratic	Community
Marketplace	0,787			
Professional	0,486	0,956		
Bureaucratic	0,457	0,602	0,844	
Community	0,580	0,724	0,604	0,824

Note. Source: Survey Data (2018).

It was observed that the latent variables met the condition of discriminant validity, showing the roots of the AVEs (highlighted in bold) superior to the correlations between the constructs. Thus, the model met all validity criteria, and the structural analysis could be continued.

In addition, the standardized root means square residual or standardized root mean square residual (SRMR) index was verified, which is an adjustment criterion that seeks to analyze the difference between observed and expected correlations, considering values less than 0.1 as good for the model (SmartPLS, 2016), with the smaller representing a better fit (Hair Jr. *et al.*, 2009). The SRMR obtained was 0.065 and the estimated 0.092, therefore, meets the criteria. The predictive validity (Q²) was not analyzed, as the latent variables were presented only as independent in the model. The values referring to the Q² for these variables were not generated. As for the effect size (f²), the variables obtained the effect size with great capacity of the model's utility, as they present values above 35%, as follows: 0.370 for market logic, 0.556 for professional logic, 0.380 for bureaucratic logic, and 0.350 for community logic.

Subsequently, we sought to evidence the descriptive measures of the latent variables (Table 8), according to the variables appropriate to the model, to verify, on average, which was the most prevalent among the hospitals in the sample. Araújo (2016, p. 38) stated that it is "relevant to know if a logic dominates the professionals' attention or if multiple logics receive relatively equal attention." When analyzing each response in the database, it was noted that at least 65% of the hospitals had the same means in different logics, showing the hybridity of institutional logics in hospital cost management. The most predominant logics, on average, were professional (4.44), bureaucratic (4.14), and market (4.13), and bureaucratic logic can be considered as a complementary logic to these two and not a competitor, as it assists in the execution of the others.

After validating the measurement model, the Bootstrapping method was used to test the influence between the variables. The path coefficients (influence relationship - Table 9), based on the test t of *student*, whose objective was to answer the hypotheses established in this study. Due to the sample size, 5% and 10% errors were considered significant (Table 9).

It was found that the market logic had a significant influence on the adoption of costing by complete/total absorption (p 0.09); that is, the more this logic is present in the institution, the more they adopt this practice. The institutional logic of the market also had a positive influence on the adoption of the contribution margin, degree of operating leverage, and budget. Thus, hypothesis 1 of the study was confirmed.

The community logic had a significant and positive influence on the adoption of practices such as the safety margin (p0.07), the break-even point (p0.10), and the degree of

operational leverage (p0.05); the last one also influenced by market logic. Thus, hypothesis 4 of the study was confirmed.

Table 8

Description of institutional logics

Institutional Logics	Absolute Frequency					Total	Avg	SD
	1	2	3	4	5			
Market Logic								
Get more profit	6 7,1%	5 5,9%	14 16,5%	31 36,5%	29 34,1%	85 100%	3,85	1,170
Reduce costs	0 -	1 1,2%	0 -	31 36,5%	53 62,4%	85 100%	4,60	0,561
Being ahead of the competition	4 4,7%	1 1,2%	20 23,5%	30 35,3%	30 35,3%	85 100%	3,95	1,034
More customers (higher profit) with lower cost	2 2,4%	3 3,5%	13 15,3%	33 38,8%	34 40%	85 100%	4,11	0,951
Professional Logic								
Higher quality and efficiency of services provided	1 1,2%	0 -	2 2,4%	33 38,8%	49 57,6%	85 100%	4,52	0,666
Show quality/ excellence service to the whole population	1 1,2%	0 -	6 7,1%	39 45,9%	39 45,9%	85 100%	4,35	0,719
Bureaucratic Logic								
Standardize prices and services	2 2,4%	4 4,7%	6 7,1%	38 44,7%	35 41,2%	85 100%	4,18	0,928
Comply/meet regulatory requirements	3 3,5%	6 7,1%	23 27,1%	32 37,6%	21 24,7%	85 100%	3,73	1,028
Adopts protocols to collect and improve cost information	2 2,4%	4 4,7%	2 2,4%	54 63,5%	23 27,1%	85 100%	4,08	0,834
Community Logic								
Provide transparency to the service user	1 1,2%	2 2,4%	12 14,1%	34 40%	36 42,4%	85 100%	4,20	0,856
Make service more accessible to the user by properly committing costs	0 -	2 2,4%	8 9,4%	42 49,4%	33 38,8%	85 100%	4,25	0,722
Provide a more affordable service price for patients	3 3,5%	3 3,5%	18 21,2%	30 35,3%	31 36,5%	85 100%	3,98	1,023

Note. Source: Survey Data (2018).

Table 9

Hypothesis Test Results

Hypotheses (IV -> DV)	T statistic	p Value	Hypothesis
Lot. comu -> Degree of Operational Leverage (DOL)	1,90	0,05*	H4
Lot. comu -> Safety Margin (SM)	1,82	0,07**	
Lot. comu -> Equilibrium Point (EP)	1,61	0,10**	
Lot. Merc -> Cost for integral /full absorption	1,66	0,09**	H1
Lot. Merc -> Degree of Operational Leverage (DOL)	2,37	0,02*	
Lot. Merc -> Contribution Margin (CM)	2,74	0,00*	
Lot. Merc -> Budget	1,82	0,07**	

Note. Source: survey data (2018).

The * symbol indicates that the variable is significant at 5%; **10% significant.

The bureaucratic and professional logic, on the other hand, did not show significant influence (positive or negative), statistically, in any specific practice. However, concerning the bureaucratic logic, its presence can be seen helping the execution of other logic through the adoption of protocols, standardization, and organization of services. Therefore, hypotheses 2 and 3 of the study were not confirmed.

Finally, Table 10 demonstrates the influence of the other (control) variables included in the model to verify and complement the results brought by the relationship with institutional logic, that is, to indicate whether the literature recommendation also influences the use of practices; by external consultants; by external requirements; by tax/legal requirements; and for use in other hospitals.

Table 10

Test results with control variable

Control Variables (CV ->DV)	<i>T statistic</i>	<i>p Value</i>
External Consultancies -> Activity-Based Costing (ABC)	1,80	0,07**
External Consultancies -> Costing by partial absorption	2,64	0,00*
External Consultancies -> Safety Margin	3,42	0,00*
External requirements -> Cost for integral/full absorption	3,01	0,00*
External Requirements -> Degree of Operational Leverage (DOL)	1,79	0,07**
External requirements -> Budget	2,46	0,01*
Tax/legal requirements -> cost for integral/full absorption	2,02	0,04*
Tax/legal requirements -> Degree of Operational Leverage (DOL)	1,84	0,07**
Used in other hospitals -> Activity-Based Costing (ABC)	1,96	0,05*
Used in other hospitals -> Target Costing	2,16	0,03*
Used in other hospitals -> Standard Costing	1,76	0,07**
Used in other hospitals -> Degree of Operational Leverage (DOL)	1,99	0,04*
Used in other hospitals -> Safety Margin (SM)	2,56	0,01*

Note. Source: survey data (2018).

The * symbol indicates that the variable is significant at 5%; **10% significant.

It was found that except for the variable "recommendation in the literature", the other control variables positively influence the adoption of some measurement practice or cost management. The coherence of the results is observed, given the influence of tax requirements in the adoption of absorption costing and that external requirements, for example, influence the practice of budgeting, which in turn is useful for negotiations between the hospital and operators and health plans. On the other hand, activity-based costing is indicated as one of the least used practices; when adopted, it appears to be influenced by consultants or used in other hospitals. Consultants also proved to be influential in the use of the safety margin and partial absorption costing.

4.3 Discussion of Results

The study results show a hybridism in hospital cost management due to the coexistence of institutional logic, even if in different intensities. It is possible to note that management is linked to the operation and mission of the hospital that seeks excellence in its services, offering quality and accessible services to the population (professional and community). Furthermore, ensuring their financial survival (market), which brings back the relationship of the complex and hospitals' highly institutionalized environment, which leads to a greater plurality of institutional logics (Goodrick & Reay, 2011; Raynard, 2016) and that can coexist for an extended period (Lounsbury, 2007) since the different actors in the field can prioritize a logic according to their interest (Ferreira & Ryngelblum, 2020).

The "excellence" and "quality" of services refer to improvements. These lead to hospital accreditation, which has a strong bias of professional and market logic, the last one concerning cost control due to the high expenses for hospital adjustments to accreditation criteria. Thus, the study by Arndt and Bigelow (2006) is confirmed, which points out that the conflicting demands required by hospitals to improve access, introduce technologies, services and contain costs leads to the logic of efficiency, which, in turn, is a problem in hospitals.

When analyzing the relationship of influence of institutional logic in the adoption of measurement and cost management practices (Table 9), it was observed that the market logic influenced the adoption of a greater number of practices. Confirming the studies that indicate that the use market logic leads to greater adoption of practices, aiming to manage and reduce costs and increase profit (Scott *et al.*, 2000; Arndt & Bigelow, 2006; Blomgren & Waks, 2015; Silva, 2016; Araújo, 2016). The market logic had a significant influence on the adoption of full/total absorption costing, which, in turn, is the practice most used by hospitals and disseminated in organizations due to its consistency with tax legislation, noting that "institutional logics unite cultural practices and understanding" (Thornton *et al.*, 2012, p.9). Still, it influenced the adoption of management practices such as contribution margin, degree of operating leverage, and budget, being coherent, given the advantages of these practices for the management and evaluation of results (Matos, 2005).

The community logic, on the other hand, influenced the adoption of the safety margin, the balance point, and the degree of operational leverage, the latter being in common with the market logic, confirming that a single task can reflect the influence of more than one logic (Waldorff *et al.*, 2013). In addition, this result shows the concern of institutions with the public they serve, taking into account, when carrying out better management, transparency with their users, prices, and accessible service. It appears that competitiveness leads to the need for organizations to be more transparent and disseminate more information related to costs (Sousa, Gil, & Santana, 2015).

Thus, it was observed that institutional logic in measurement and management of costs in hospitals is concerned with market assumptions and maintaining the quality of their institution and with the public it serves. This observation is in line with Reay and Hinings' (2009) study, stating that coexisting and competing logics can be sustained in an organizational field, managing the rivalry between them and engaging in obtaining mutually desirable results.

According to the assumptions established in this research, the coexistence of another institutional logic with greater intensity, such as the market or community, has a greater influence on the adoption of certain practices. This finding corroborates Silva (2016), that "different dominant logics can cause different strategic responses," with Scott *et al.* (2000), that the actors in the field use logic according to the problems and how they are going to solve them, and with Gümüşay *et al.* (2020), that their local conditions and respective cultures shape institutional logics.

Finally, with the control variables included in the modeling (Table 10), it was found that the findings of descriptive statistics corroborate the research by Abbas, Marques, Tonin and Sasso (2015), which points out that the method is mainly used in hospitals in Paraná is total absorption costing. However, the research emphasizes more the advantages of ABC costing, when this practice is used, it is due to factors similar to those cited by Aillón (2013), as external consultants or because it is used in other hospitals, and may indicate its use due to normative or mimetic pressure. In addition, it is observed that the influence of legal and tax requirements on the use of absorption costing may show signs of an institutional logic of the state and coercive pressure.

It was found that some factors external to the organization lead to the adoption of certain practices, indicating possible isomorphic pressures in their adoption. As well as indirect relationships that these control variables may have with institutional logic, in the sense that hospitals whose market logic is more prevalent tend to respond more to external requirements and adopt practices such as full absorption costing and budgeting.

The fact that hospitals are organizations considered highly institutionalized and that suffer pressure from different actors explains the results presented and is in line with Teixeira

(2012), who does not exclude homogeneity issues (coming from institutional isomorphism) but rather complements them through the discussion of heterogeneities through the conflicting institutional logics of the field.

5 FINAL CONSIDERATIONS

The objective of the study - to analyze the influence of institutional logic in the adoption of measurement and cost management practices in accredited Brazilian hospitals - was achieved. Regarding the measurement and cost management practices, it was found that costing by full/integral absorption is the most used by hospitals for measurement, while the contribution margin is the most adopted for cost management.

As for the institutional logics researched (market, professional, bureaucratic, and community), it was found that, in hospital cost management, there is the presence of these multiple institutional logics in this environment, and the motivations that lead to the measurement and management of costs, in general, are related to professional issues (involving the quality and excellence of the service provided). Which, in turn, depends on the mission of the hospitals; then to market factors (since the hospital is also a company, it needs financial sustainability); bureaucratic (which help with other logics, establishing standards and protocols); and community (considering accessibility and transparency), also referring to the mission of hospitals as a health provider to society.

In the statistical influence relations of institutional logic in the adoption of certain cost practices, it was found that there is a significantly greater influence of market and community logic, respectively. The bureaucratic and professional logic did not present significant influences on the adoption of practices. Therefore, only research hypotheses H1 and H4 were confirmed.

The professional logic is considered the most present, which can be justified because it is linked to hospitals' mission and hospital accreditation objectives, considering that this logic has among its objectives the achievement of quality and excellence in the services provided. However, it did not present a statistically significant influence on the measurement and cost management practices, as another institutional logic, such as that of the market or community, may coexist with greater intensity, making them, according to the assumptions established in this research, more influencing in the adoption of a particular practice.

Such findings lead to the conclusion, similarly to Scott *et al.* (2000) and Lounsbury (2007) and Picheth (2016), that decision-makers use the dominant logics consonant with the problems they have and how they will solve them. As most hospitals are run by professionals with different but complementary skills (health and finance), there is a need to manage the conflict of interest of the logic. Thus, it is market assumptions that lead to the adoption of practices and the hospital's interest in achieving its social mission by offering quality healthcare services, with accessibility and transparency, and its mission as a company, which needs financial sustainability.

Finally, considering the results and limitations of this research, it is suggested for future studies: to further explore the institutional logics in this field, complementing this study or discovering new logics, or both, and if possible, use together with other research methodologies to enrich the analysis; and investigate whether there is a difference in the regions in which the hospitals are located, as the external pressures, political and cultural aspects can be different in each region.

REFERENCES

- Abbas, K. (2001). *Gestão de custos em organizações hospitalares*. Dissertação de mestrado, Universidade Federal de Santa Catarina, Florianópolis, SC, Brasil.
- Abbas, K., & Leoncine, M. (2014). Cálculo dos custos dos procedimentos médicos hospitalares em hospitais brasileiros. *Revista de Administração Hospitalar e Inovação em Saúde*, 11(1), 1-11.
- Abbas, K., Marques, K. C. M., Tonin, J. M. F., Sasso, M., & Leoncine, M. (2015). Os métodos de custeio discutidos na literatura são os mesmos usados na prática em hospitais? *ABCustos*, 10(1), 73-93. <https://doi.org/10.47179/abcustos.v10i1.306>
- Aillón, H. S. (2013). *A desinstitucionalização do custeio baseado em atividades sob a ótica da nova sociologia institucional*. Dissertação de mestrado, Universidade de São Paulo, São Paulo, SP, Brasil.
- Araújo, L. G. (2017). *Lógicas institucionais e respostas estratégicas em organizações híbridas: o caso das empresas juniores*. Dissertação de Mestrado, Universidade Federal do Paraná, Curitiba, PR, Brasil.
- Araújo, Z. C. D. (2016). *As múltiplas lógicas institucionais atuantes na atual reforma do HC UFPE*. Dissertação de Mestrado, Universidade Federal do Pernambuco, Recife, PE, Brasil.
- Arndt, M., & Bigelow, B. (2006). Toward the creation of an institutional logic for the management of hospitals: efficiency in the early nineteen hundreds. *Medical Care Research and Review*, 63(3), 369-394. <https://doi.org/10.1177/1077558706287044>
- Baly, O., Kletz, F., & Sardas, J. C. (2015). *Designs of an organizational response to institutional complexity in healthcare: A focus group and statistical study of management control in French hospitals*. Retrieved on jul 09, 2016, from <https://hal-mines-paristech.archives-ouvertes.fr/hal-01127785>
- Bandeira, J. A. Á., & Bandeira, M. Á. (2021). Gestão Hospitalar: os desafios na implementação com qualidade. *Revista Científica do UBM*, 103-114.
- Berry, A. J., Coad, A. F., Harris, E. P., Otley, D. T., & Stringer, C. (2009). Emerging themes in management control: a review of recente literature. *The British Accounting Review*, 41(1), 2-20.
- Bitti, E. J. S., Aquino, A. C. B., & Cardoso, R. L. (2011). Adoção de sistemas de custos no setor público: reflexões sobre a literatura nacional veiculada em periódicos acadêmicos. *Revista Universo Contábil*, 7(3), 6-24.
- Blanski, M. B. S. (2015). *Gestão de custos como instrumento de governança pública: um modelo de custeio para os hospitais públicos do Paraná*. Dissertação de mestrado, Universidade Tecnológica Federal do Paraná, Curitiba, PR, Brasil.
- Blomgren, M., & Waks, C. (2015). Coping with contradictions: hybrid professionals managing institutional complexity. *Journal of Professions and Organization*, 2(1), 78-102. <https://doi.org/10.1093/jpo/jou010>
- Borgert, A., Alves, R. V., & Schultz, C. A. (2010). Processo de implementação de um sistema de gestão de custos em hospital público: um estudo das variáveis intervenientes. *Revista Contemporânea de Contabilidade*, 7(14), 97-120.
- Bossy, D., Knutsen, I. R., Rogers, A., & Foss, C. (2016). Institutional logic in self-management support: coexistence and diversity. *Health & social care in the community*, 24(6), 191-200.
- Cardoso, S. M., & Martins, V. F. (2012). Sistemas de custos estão presentes nos hospitais brasileiros que passaram pelo processo de acreditação hospitalar? *Revista GeTeC*, 1(2), 59-78.

- Cardoso, A. A. B., Souza, L. M., Reis, A. O., & Palha, V. M. (2020). Gestão de custos em organizações hospitalares: sistemática por centro de custos. *Semina: Ciências Sociais e Humanas*, 41(1), 123-138.
- Dallora, M. E. L., & Forster, A. C. (2008). A importância da gestão de custos em hospitais de ensino-considerações teóricas. *Medicina (Ribeirão Preto. Online)*, 41(2), 135-142. <https://doi.org/10.11606/issn.2176-7262.v41i2p135-142>
- Dunn, M. B., & Jones, C. (2010). Institutional logics and institutional pluralism: The contestation of care and science logics in medical education, 1967–2005. *Administrative Science Quarterly*, 55(1), 114-149. <https://doi.org/10.2189/asqu.2010.55.1.114>
- Ferreira, V. C., & Ryngeblum, A. L. (2020). A relação entre lógicas institucionais e práticas estratégicas organizacionais: o papel da agência nacional de saúde suplementar na regulação dos reajustes do setor. *Brazilian Journal of Development*, 6(7), 42217-42236.
- Friedland, R., & R. R. Alford. (1991). *Bringing society back in: symbols, practices, and institutional contradictions*. In the new institutionalism in organizational analysis, edited by W. W. Powell and P. J. DiMaggio, 232-63. Chicago: University of Chicago Press.
- Friedland, R., Mohr, J. W., Roose, H., & Gardinali, P. (2014). The institutional logics of love: measuring intimate life. *Theory and Society*, 43(3-4), 333-370. <https://doi.org/10.1007/s11186-014-9223-6>
- Gil, A. C. (1999). *Como elaborar projetos de pesquisa*. (4a Ed.) São Paulo: Atlas.
- Goodrick, E., & Reay, T. (2011). Constellations of institutional logics: Changes in the professional work of pharmacists. *Work and Occupations*, 38(3), 372-416. <https://doi.org/10.1177/0730888411406824>
- Gümüşay, A. A., Claus, L., & Amis, J. (2020). Engaging with grand challenges: An institutional logics perspective. *Organization Theory*, 1(3), 2631787720960487.
- Hair, J. F., Anderson, R. E., Tatham, R. L., & Black, W. C (2009). *Análise multivariada de dados*. São Paulo: Bookman.
- Koelewijn, W. T., Ehrenhard, M. L., Groen, A. J., & van Harten, W. H. (2012). Intra-organizational dynamics as drivers of entrepreneurship among physicians and managers in hospitals of western countries. *Social Science & Medicine*, 75, 785-800. <https://doi.org/10.1016/j.socscimed.2012.03.055>
- Levine, D. M., Berenson, M. L., & Stephan, D. (2000). *Estatística: teoria e aplicações usando Microsoft Excel Português*. São Paulo: LTC.
- Lounsbury, M. (2007). A tale of two cities: competing logics and practice variation in the professionalizing of mutual funds. *Academy of Management Journal*, 50, 289–307. <https://doi.org/10.5465/amj.2007.24634436>
- Marôco, J. (2010). *Análise de equações estruturais: fundamentos teóricos, software e aplicações*. ReportNumber: Pêro Pinheiro.
- Martin, G., Bushfield, S., Siebert, S., & Howieson, B. (2021). Changing logics in healthcare and their effects on the identity motives and identity work of doctors. *Organization Studies*, 42(9), 1477-1499.
- Martins, D. B., Portulhak, H., & Voese, S. B. (2015). Gestão de custos: um diagnóstico em hospitais universitários federais. *Revista de Administração Hospitalar e Inovação em Saúde*, 12(3), 59-75. <https://doi.org/10.21450/rahis.v12i3.2461>
- Matos, A. J. (2005). *Gestão de custos hospitalares: técnicas, análises e tomada de decisão*. (3a Ed.) São Paulo: editora STS.
- Mercier, G., & Naro, G. (2014). *Costing hospital surgery services: the method matters*. *PloS one*, 9(5), e97290. <https://doi.org/10.1371/journal.pone.0097290>
- Nascimento, J. C. M., Gravena, A. A. F., & Machinski Junior, M. (2020). Acreditação hospitalar como ferramenta para a gestão da qualidade no brasil: características, avanços

- e desafios. *RAHIS-Revista de Administração Hospitalar e Inovação em Saúde*, 17(4), 1-10.
- Neder, A. L. G. (2015). *Melhores práticas de gestão na cadeia de suprimentos: um estudo de caso em uma rede de hospitais privados*. Dissertação de Mestrado, Universidade Federal do Rio de Janeiro, RJ, Brasil.
- Neriz, L., Núñez, A., & Ramis, F. (2014). A cost management model for hospital food and nutrition in a public hospital. *BMC Health Services Research*, 14(1), 542. <https://doi.org/10.1186/s12913-014-0542-0>
- Organização Nacional de Acreditação (ONA). (2017). *Mapa de Acreditações*. Retrieved on Oct 10, 2017, from <https://www.ona.org.br/mapa-de-acreditacoes>.
- Organização Nacional de Acreditação (ONA). (2018). *Manual das organizações prestadoras de serviços de saúde*. Brasília: ONA.
- Picheth, S. (2016). *Lógicas institucionais e estrutura discursiva: um estudo no maternati – grupo de gestantes e mães*. Dissertação de mestrado, Universidade Estadual de Maringá, Maringá, PR, Brasil.
- Popesko, B. (2013). Specifics of the activity-based costing applications in hospital management. *International Journal of Collaborative Research on Internal Medicine & Public Health*. 5(3), 179-186.
- Ramalho, L. D. F. (2016). *Estudo sobre sistemas de custos gerenciais de subsidiárias alemãs em operação no Brasil: um enfoque da nova teoria institucional*. Tese de doutorado, Universidade de São Paulo, São Paulo, SP, Brasil.
- Raynard, M. (2016). Deconstructing complexity: configurations of institutional complexity and structural hybridity. *Strategic Organization*, n. Special Issue, 1–26. <https://doi.org/10.1177/1476127016634639>
- Reay, T., & Hinings, C. R. (2009). Managing the rivalry of competing institutional logics. *Organization studies*, 30(6), 629-652. <https://doi.org/10.1177/0170840609104803>
- Santos, M. E., Martins, V. F., & Leal, E. A. (2013). Avaliação da gestão de custos nas entidades hospitalares: um estudo na cidade de Uberlândia MG. *Revista de Administração Hospitalar e Inovação em Saúde*, 10(1), 3-17. <https://doi.org/10.21450/rahis.v10i1.1771>
- Saraiva, M. (2006). *Investigação da mensuração de custos na formação dos preços dos serviços hospitalares: um foco na diária hospitalar*. Dissertação de mestrado, UNB, UFPB, UFPE, UFRN. Natal, RN.
- Scott, W. R., Ruef, M., Mendel, P. J., & Caronna, C.A. (2000). *Institutional change and healthcare organizations: from professional dominance to managed care*. University of Chicago Press.
- Silva, T. M. R. D. (2016). *Lógicas institucionais e as respostas estratégicas diante da prática de acreditação hospitalar nos hospitais do Estado do Rio de Janeiro*. Dissertação de mestrado, Universidade do Grande Rio “Prof. José de Souza Herdy”, Rio de Janeiro, RJ, Brasil.
- Sousa, C. M. M. G., Gil, E. P., & Santana, L. C. (2015). Custeio por absorção como instrumento de informação gerencial no ramo hospitalar. Caderno de Administração. *Revista da Faculdade de Administração da FEA*, 9(1), 73-84.
- Teixeira, M. G. (2012). *A influência do hibridismo de lógicas institucionais no processo decisório de adoção de prática de governança corporativa: o caso Cooperativa Veiling Holambra*. Tese de doutorado, Universidade Federal do Paraná, Curitiba, PR, Brasil.
- Thornton, P. H., & Ocasio, W. (1999). Institutional logics and the historical contingency of power in organizations: Executive succession in the higher education publishing industry, 1958-1990 1. *American Journal of Sociology*, 105 (3), 801-843.

- Thornton, P. H., Ocasio, W., & Lounsbury, M. (2012). *The institutional logics perspective: A new approach to culture, structure, and process*. Oxford University Press on Demand.
- Viana, M. F., Sette, R. S., Rezende, D. C., Botelho, D., & Poles, K. (2011). Processo de acreditação: uma análise de organizações hospitalares. *Revista de Administração Hospitalar e Inovação em Saúde*, 3(6),35-45. <https://doi.org/10.21450/rahis.v0i6.1116>
- Waldorff, S. B., Reay, T., & Goodrick, E. (2013). A tale of two countries: how different of logics impact action. In *Institutional logics in action, Part A*, Emerald Group Publishing Limited, 99-129.
- Xavier, F. J. L. J., & Rodrigues, R. A. (2012). Gerenciamento de custos hospitalares: um estudo de caso em uma instituição. *Anais de Congresso USP de Iniciação Científica em Contabilidade*, São Paulo, SP, Brasil, 9.
- Yereli, A. N. (2009). Activity-based costing and its application in a Turkish university hospital. *AORN Journal*, 89(3), 573-591. <https://doi.org/10.1016/j.aorn.2008.09.002>

Lógicas Institucionais na Mensuração e Gestão de Custos em Hospitais Acreditados

RESUMO

Objetivo: analisar qual a influência das lógicas institucionais na adoção das práticas de mensuração e gestão de custos em hospitais acreditados brasileiros.

Método: utiliza como estratégia o levantamento, por meio de um questionário. A amostra compreende 85 respostas e a análise dos dados foi feita por meio da estatística descritiva e modelagem de equações estruturais.

Originalidade/Relevância: verificou-se poucos estudos surveys acerca da temática. Ainda, na literatura nacional há poucas pesquisas teórico-empíricas acerca do tema de custos, além da ausência de orientação teórica nas existentes (Ramalho, 2016), não sendo identificado estudos que abordam a contabilidade de custos sob ótica das lógicas institucionais.

Resultados: as motivações que levam a fazer a mensuração e gestão de custos estão relacionadas às questões profissionais (envolvendo qualidade e excelência do serviço prestado); de mercado (necessitando sustentabilidade financeira); burocráticos (estabelecendo padrões e protocolos); e comunidade (considerando acessibilidade e transparência). A análise estatística aponta que a lógica de mercado influencia na adoção de mais práticas de custos que as demais, seguida da lógica de comunidade.

Contribuições teóricas/metodológicas: ao considerar que as lógicas concorrentes, atuando no mesmo campo, contribuem para a gestão como um todo, atendendo a demanda por qualidade, acessibilidade e redução de custos, este estudo contribui para o entendimento sobre o que pode estar influenciando ou não a utilização das práticas de mensuração e gestão de custos, que são importantes para controle e gerenciamento dos hospitais.

Palavras-chave: Custos; Gestão de custos em hospitais; Lógicas institucionais; Acreditação hospitalar.

Beatriz Negrelli da Silva 

Universidade Estadual de Maringá, Paraná,
Brasil
beatriznegrelli@hotmail.com

Katia Abbas 

Universidade Estadual de Maringá, Paraná,
Brasil
katia_abbas@yahoo.com.br

João Marcelo Crubellate 

Universidade Estadual de Maringá, Paraná,
Brasil
jmcrubellate@uem.br

Recebido: Julho 15, 2021

Revisado: Outubro 26, 2021

Aceito: Novembro 08, 2021

Publicado: Dezembro 30, 2021

