

“Do accreditation and managerial innovative capabilities influence Indonesian public hospital performance? The mediating role of service quality”

AUTHORS	Dahlia 
	
	Nurkholis 
	Abdul Ghofar 
	
	Yeney Widya Prihatiningtias 
	
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Yeney Widya Prihatiningtias, 2026

Dahlia, M.Si., Doctoral Candidate,
Doctoral Program of Accounting
Science, Department of Accounting,
Faculty of Economics and Business,
Universitas Brawijaya [Brawijaya
University], Indonesia; Assistant
Professor, Department of Accounting,
Universitas Sulawesi Barat, [West
Sulawesi University], Indonesia.
(Corresponding author)

Nurkholis, Ph.D., Professor,
Department of Accounting, Faculty of
Economics and Business, Universitas
Brawijaya [Brawijaya University],
Indonesia.

Abdul Ghofar, DBA, Associate
Professor, Department of Accounting,
Faculty of Economics and Business,
Universitas Brawijaya [Brawijaya
University], Indonesia.

Yeney Widya Prihatiningtias, DBA,
Assistant Professor, Department of
Accounting, Faculty of Economics
and Business, Universitas Brawijaya
[Brawijaya University], Indonesia.



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Yeney Widya Prihatiningtias (Indonesia)

DO ACCREDITATION AND MANAGERIAL INNOVATIVE CAPABILITIES INFLUENCE INDONESIAN PUBLIC HOSPITAL PERFORMANCE? THE MEDIATING ROLE OF SERVICE QUALITY

Abstract

The performance of public hospitals in Indonesia is becoming critical amid demands for high-quality care and resource constraints. The role of accreditation and managerial innovative capabilities (MIC) in driving performance, including through quality of care, still requires empirical evidence. This study aims to examine the influence of accreditation and MIC on Indonesian public hospital performance through service quality as a mediating variable. This study uses a quantitative survey-based approach, involving 136 respondents from various Public Service Agency hospitals in Indonesia. Data were collected from September 2024 to January 2025 using a combination of Google Forms and direct surveys conducted at public hospitals. Data were analyzed using SMART-PLS. The findings show that accreditation has a positive and significant influence on hospital performance ($\beta = 0.499$, $t = 6.367$, $p = 0.000$), as well as on service quality ($\beta = 0.724$, $t = 20.477$, $p = 0.000$). Service quality has a positive effect on performance ($\beta = 0.417$, $t = 5.689$, $p = 0.000$). Testing of indirect effects revealed partial mediation, meaning that accreditation influences hospital performance through service quality ($\beta = 0.302$, $t = 6.046$, $p = 0.000$). Surprisingly, however, MIC did not have a significant effect on hospital performance ($\beta = 0.002$, $t = 0.035$, $p = 0.486$). The R -squared value of 0.726 indicates moderate-to-substantial explanatory power. Thus, these findings confirm that the impact of accreditation becomes more meaningful when standards are internalized into continuous service quality improvements, making service quality important for enhanced hospital performance.

Keywords

accreditation, managerial capabilities, service quality,
performance, hospital, mediation

JEL Classification

M12, I18, I11, M48

INTRODUCTION

Hospital accreditation programs have grown rapidly and have become one of the main quality assurance instruments for assessing health service compliance and patient safety (Alhawajreh et al., 2025). Accreditation is also often viewed as a managerial and regulatory approach to drive performance improvements in healthcare organizations, including operational and financial performance (Hussein et al., 2021; Vega & Cunha, 2023). However, despite accreditation's widespread adoption, debates persist regarding whether accreditation truly yields measurable performance improvements or primarily drives administrative compliance with standards (Greenfield et al., 2019; Zhang et al., 2023).

An unresolved scientific issue in this field is the lack of clarity regarding the mechanisms that explain how accreditation translates into actual performance outcomes. Variations in previous findings

suggest that the impact of accreditation on performance is not always direct but depends on changes in operational service practices. In this context, service quality can be viewed as a potential mediating pathway; however, empirical evidence regarding its role has yet to yield consistent conclusions (Conceição et al., 2024).

In addition to accreditation, hospitals also face a dynamic environment, requiring managerial capabilities to respond to change, while managing resources innovatively (Vrontis et al., 2022). Managerial innovative capabilities (MIC) are considered relevant for explaining variations in organizational capabilities to improve processes and enhance performance. However, the contribution of MIC to performance still requires more robust empirical evidence, particularly when linked to service quality as a performance metric.

In Indonesia, accreditation is increasingly emphasized as a Ministry of Health policy mandate and a credentialing requirement by the National Health Insurance Agency (Wardhani et al., 2019). However, in practice, accreditation in public hospitals is often perceived as a document-oriented administrative process rather than as an instrument for improving service quality, thereby risking symbolic compliance (Broughton et al., 2015). The effectiveness of accreditation is also reported to tend to decline after several accreditation cycles if improvement routines are not sustained (Baksh et al., 2025). These conditions underscore the importance of clarifying the relationship among accreditation, MIC, service quality, and performance in the context of hospital Public Service Agency (PSA) status in Indonesia to address the existing evidence gap.

1. LITERATURE REVIEW AND HYPOTHESES

This study is grounded in the resource-based view (RBV) and institutional theory to explain hospital performance in the context of accreditation, managerial innovative capabilities (MIC), and service quality. From the RBV perspective, organizational performance is influenced by valuable internal resources and capabilities that are embedded in work routines, thereby driving efficiency, service quality, and hospital reputation (Barney, 1991). In the context of this study, accreditation and MIC are positioned as organizational capabilities that have the potential to strengthen service standardization, cross-functional coordination, and quality discipline. This emphasis is relevant because the core activities of hospitals are oriented toward patient-centered care. Differences in the quality of process improvement routines across hospitals are linked to patient safety, as well as other financial and non-financial outcomes (Dobrzykowski et al., 2016; Kosiol et al., 2023).

While RBV emphasizes internal capabilities, institutional theory highlights that public organizations such as hospitals can respond to regulatory pressures and public demands by adjusting be-

tween structures and organizational practices that are considered legitimate (DiMaggio & Powell, 1983; Meyer & Rowan, 1977). For public hospitals, accreditation can be positioned as an institutional norm that encourages compliance with standards of service, governance, and patient safety. This framework also helps explain the role of MIC, as effective innovative capabilities are in an environment that provides space for creativity and process improvement, rather than merely formal compliance (Krenyacz & Revesz, 2025; Oliver, 1991; Scott, 2014; Tenggono et al., 2025).

Hospital performance is a key benchmark for evaluating the success of healthcare organizations; therefore, its definition and measurement must be clearly articulated. Performance measurement in healthcare management is complex, as it encompasses both financial and non-financial aspects (Ibrahim et al., 2025). Therefore, a set of concise, measurable, and continuously monitored key performance indicators is essential for performance evaluation (Talebpour et al., 2025). In general, hospital organizational performance reflects revenue generation, operational efficiency, clinical outcomes, and various other NFP indicators (Dubas-Jakóbczyk et al., 2024; Asaria et al., 2022).

One factor that conceptually influences hospital performance is accreditation. Accreditation refers to public recognition by a healthcare accreditation body of the achievement of accreditation standards, as demonstrated through an independent external assessment of an organization's compliance with requirements (Abdurabuh et al., 2024; Alhawajreh et al., 2023; Greenfield et al., 2019). This study is grounded in the understanding that accreditation can play a strategic role in enhancing service quality and patient satisfaction through collaborative practices during the accreditation process (Conceição et al., 2024; Pasinringi et al., 2021).

An issue that needs to be considered regarding accreditation in Indonesian PSA public hospitals is that the audit culture inherent in accreditation has the potential to foster a "safe during assessment" ceremonial compliance, that is, a focus on the completeness of evidence and neatness of documents, while practices in the field do not always change substantively. Consequently, the energy and time of both clinicians and managers are absorbed by administrative documentation tasks, while quality improvements in critical service units risk receiving insufficient attention. This issue also aligns with the view that accreditation can enhance transparency through audit trails and indicators (Vega & Cunha, 2023). However, such transparency can simultaneously lead to reputational consequences when non-compliance is identified, political pressure from local governments and regional legislative councils (namely DPRD), as well as reputational pressure through social media scrutiny.

Several empirical studies show a strong relationship between accreditation and performance, particularly through enhanced patient safety and improved service quality. These effects tend to emerge as hospitals implement changes during the preparation, implementation, and post-accreditation phases (Abdurabuh et al., 2024; Conceição et al., 2024; Ghareeb et al., 2018). These findings are consistent with the view that accreditation strengthens clinical governance and patient safety through risk control, more routine incident reporting, and enhanced public trust (Greenfield & Braithwaite, 2009; Schmaltz et al., 2011). Consistent with this mechanism, several studies report that accredited

hospitals perform better than non-accredited ones, particularly in terms of operational efficiency, service quality, and patient satisfaction, particularly when followed by tangible improvement interventions (Hussein et al., 2021; Swathi et al., 2020; Vega & Cunha, 2023; Zhang et al., 2023). However, several other studies also emphasize that accreditation is not always followed by significant performance improvements due to the costs of meeting standards and the high burden of implementation, so the benefits may vary among hospitals depending on the depth of practice changes within service units (Abdurabuh et al., 2024; Greenfield et al., 2019).

In addition to serving as an institutional incentive, MIC can also influence hospital performance. MIC reflects management's capacity to identify opportunities, exploit them, and transform resource and internal structures to support innovative strategies that can improve organizational efficiency and competitiveness (Vrontis et al., 2022). In the context of dynamic capabilities, MIC is typically comprehended through three primary dimensions: sensing, seizing, and reconfiguration (Teece, 2007; Vrontis et al., 2022). In the setting of PSA hospitals, managerial innovation can be reflected through the digitization of service workflows, such as online registration and queuing, as well as the online delivery of laboratory results. Innovation can also be realized through cross-institutional partnerships, for example, collaboration with universities or the police, to introduce new, efficient service schemes for specific examination needs. Such practices have the potential to enhance organizational value and revenue (Binsar et al., 2026; Dubas-Jakóbczyk et al., 2025; Rosko et al., 2020; Tenggono et al., 2025).

A number of prior studies have indicated that the sensing and seizing indicators are positively and significantly associated with organizational performance and effectiveness, including hospitals (Mandal, 2017; Widiyanto et al., 2021). However, the success of seizing cannot be supported solely by investment in technology and complementary assets, because business model development must be able to maintain and utilize new opportunities (Persis, 2024). Furthermore, healthcare organizations with leaders who are able to reconfigure, create, and implement innovative

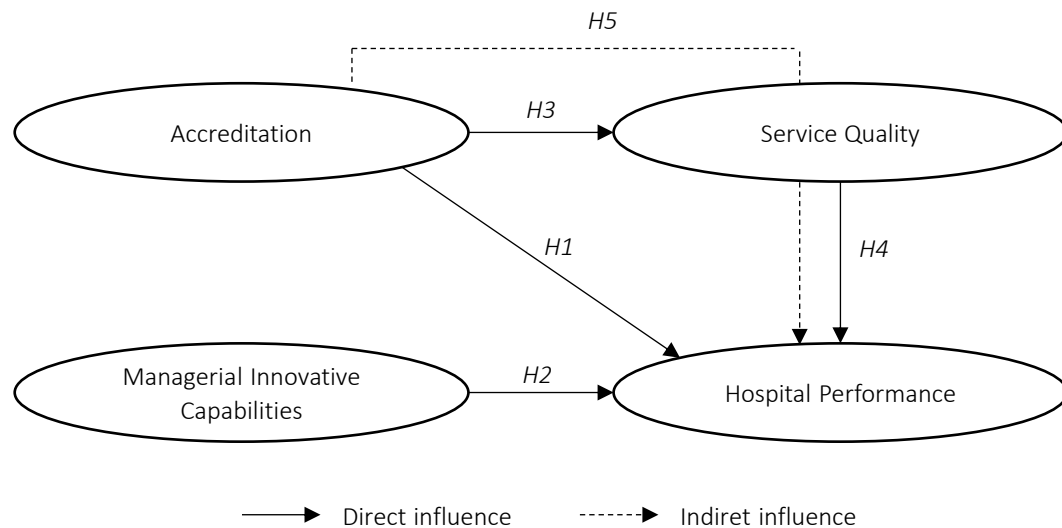


Figure 1. Research model

strategies can improve operational efficiency (Fainshmidt et al., 2017) and are better prepared to face regulations and evolving medical service demands (Betts et al., 2020). From the same perspective, organizational performance tends to be better when service innovation initiatives are sustained over the long term, and strategies are adapted to changes in the market, technology, and patient demand. The literature emphasizes that hospitals must have processes and competencies that enable them to reconfigure their resource base, and several empirical studies support the positive impact of these dimensions on hospital performance (Hsiao, 2024; Kindström et al., 2013; Manfrini & Bäckström, 2024).

In the context of accreditation, service quality is relevant for explaining how applied standards can translate into improved performance. Service quality refers to an organization's ability, like a hospital, to meet and exceed what its customers expect (Akdere et al., 2020; Parasuraman et al., 1988). The quality of hospital services is a major factor that can influence institutional performance, as high and consistent patient-centered service standards tend to enhance trust from patients and other stakeholders (Lovemore & Esthery, 2023; Pasinringi et al., 2021). Several studies have supported the positive relationship between service quality and performance both directly and indirectly (Akdere et al., 2020; Alhawajreh et al., 2025; Amos et al., 2022; Lim et al., 2018).

However, findings regarding the effectiveness of accreditation are not always consistent. Some studies found no significant difference between accredited and non-accredited hospitals, while others concluded that accreditation can enhance a hospital's reputation and performance when implemented effectively (Algunmeeyn et al., 2020; Oweidat et al., 2024). This variation in findings suggests that the effect of accreditation on performance may be indirect, although empirical evidence remains limited (Sughayir, 2016). Therefore, service quality has the potential to act as a mediator linking the effect of accreditation to hospital performance. This mediation mechanism is reflected when hospitals consistently implement accreditation standards, thereby improving service quality before contributing to overall performance improvement.

Unlike previous studies, which generally only analyzed the direct effect of accreditation on performance, this study simultaneously examines the role of service quality as a mediating variable in the accreditation-performance relationship, a perspective that remains relatively under-explored in the context of public hospitals with PSA status in Indonesia. Furthermore, empirical evidence regarding the impact of managerial innovative capabilities on performance in public hospitals still requires further testing.

This study aims to examine the influence of accreditation and managerial innovative capabilities

ties on Indonesian public hospital performance through service quality as a mediating variable. The conceptual model is shown in Figure 1. Based on this literature review, the proposed hypotheses are as follows:

- H1: Accreditation has a positive and significant influence on hospital performance.*
- H2: Managerial innovative capabilities have a positive and significant influence on hospital performance.*
- H3: Accreditation has a positive and significant influence on service quality.*
- H4: Service quality has a positive and significant influence on hospital performance.*
- H5: Service quality mediates the positive influence of accreditation on hospital performance.*

2. METHODS

This study used a quantitative approach with a survey method. The research procedure was conducted in several stages. First, we developed and adapted research instruments from previous validated studies, then performed a translation-back-translation process that was adjusted to the context of public hospitals in Indonesia. This step was crucial to minimize language bias. Second, this study conducted a pilot test on 33 medical graduate students to assess the readability of the items, the clarity of the instructions, and the ease of completion. Feedback from the initial test was used to refine the wording of several items (especially grammar and terminology accuracy) without changing the substance of the constructs being measured. The reliability test result at this stage showed that the Cronbach's alpha values for all variables were in the range of 0.82 to 0.96, indicating that the internal consistency was at an acceptable level (Hair et al., 2019). Third, the primary data collection phase was conducted through the distribution of questionnaires from September 2024 to January 2025. Fourth, data were screened to ensure they met criteria, such as the absence of incomplete or duplicate responses, before being included in the main analysis. Fifth, the data were analyzed using SmartPLS.

Data were collected from provincial and district public hospitals with Public Service Agency (PSA) status in various regions of Indonesia. Questionnaires were distributed in two ways: online by sharing links via email and WhatsApp, and offline by distributing printed copies, particularly during Regional Hospital Association (ARSADA) training events. The respondents who answered the questions were directors/deputies, heads of service departments, heads of finance departments, doctors, and nurses directly involved in the accreditation process at the hospital. Inclusion criteria were respondents at government hospitals with PSA status, holding specific managerial positions (e.g., unit heads), and having at least 12 months of service at the hospital. A total of 136 questionnaires were returned from 65 hospitals eligible for inclusion in the analysis. Table 1 presents the demographic characteristics of the surveyed respondents by gender, age, education level, work experience, and position. The majority were women (66.2%), with the largest share in the 40–49 age group. In terms of education, 52.2% were bachelor's degree graduates, with 37.5% having 1–5 years of work experience, reflecting active involvement in the organization's work processes. In terms of position, nurses were the largest group (38.2%), followed by healthcare service managers (23.5%). This composition reflects the diversity of relevant professionals in the context of hospital management, as these roles intersect directly with the implementation of accreditation standards and innovations that have the potential to affect performance.

This paper builds upon the survey data previously collected for a specific analysis of the managerial innovative capabilities (MIC) construct by extending the data collection period, thereby increasing the sample size compared to the previous study. While the other constructs and model specifications (independent, dependent, and mediating variables) differ, its contribution differs from that of the previous publication.

This study has undergone an ethical evaluation process and has been approved by the Research Ethics Committee and the Health Research Ethics Committee (number 08766/UN10.F0201/B/PT/2024), as a guarantee that it complies with national ethical guidelines. This study ensured impartiality through neutral instructions for com-

pleting the survey, voluntary participation without coercion, and the provision of information regarding the study's objectives, benefits, and procedures. Respondents were also given the option to complete the survey anonymously, and the data were analyzed in aggregate.

Table 1. Characteristics of respondents

Item	Frequency	Percentage (%)
Gender		
Male	46	33.8
Female	90	66.2
Age category (years)		
20–29	11	8.1
30–39	36	26.5
40–49	57	41.9
50–59	32	23.5
Level of Education		
Diploma	16	11.8
Bachelor's degree	71	52.2
Master's degree	48	35.3
Doctoral	1	0.7
Years of experience (years)		
1–5	51	37.5
6–10	27	19.9
11–15	15	11.0
16–20	20	14.7
>20	23	16.9
Position		
Director	16	11.8
Doctor	19	14.0
Nurse	52	38.2
Healthcare Services Manager	32	23.5
Finance Manager	17	12.5

To ensure the validity and reliability of the instrument, this study adapted questions from previous studies. All constructs were measured using a five-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). Hospital accreditation was operationalized using six indicators, namely overall impact, preparation, recommendations, internal changes, externally oriented changes, and valuable tools, comprising a total of six items (Ghareeb et al., 2018). MIC consists of nine questions representing its core capability indicators, namely sensing, seizing, and reconfiguration (Kindström et al., 2013; Teece, 2007; Vrontis et al., 2022). Hospital performance includes 15 questions adapted from Aboramadan et al. (2021) and Ilangakoon et al. (2022) and aligned with the Indonesian Public Service Agency Performance

Assessment Guidelines for Health Services No. 36 of 2016. Financial performance is measured using indicators such as growth in revenues, low process costs, competitive costs, and PSA financial management. Meanwhile, non-financial performance is measured by patient satisfaction, retention, and resource utilization. Service quality comprises 15 questions (Akdere et al., 2020; Alfatafta et al., 2025; Parasuraman et al., 1988; Singh et al., 2020).

This study employed PLS analysis, which is a comprehensive multivariate statistical analysis approach that can examine the relationships among variables (Hair et al., 2022). The first stage of PLS analysis involved assessing the outer model, which focused on convergent validity, discriminant validity, and reliability testing. Convergent validity was assessed using factor loading values. An indicator was acceptable when its factor loading exceeded 0.70 for the intended construct (Hair et al., 2022). However, in the initial stage of developing a measurement scale, a factor loading value of 0.50 to 0.60 is considered sufficient. Constructs with factor loading values less than 0.50 must be dropped (deleted) in order to produce a good model (Chin, 1998). In addition, the Average Variance Extracted (AVE) value must be greater than 0.5. Discriminant validity is indicated by a Heterotrait-Monotrait Ratio (HTMT) < 0.9 (Hair et al., 2019). Reliability was assessed based on Cronbach's alpha and composite reliability, with values greater than 0.70 indicating acceptable reliability. The inner model was evaluated based on R^2 and f^2 values. Statistical hypothesis testing was based on significance values (Hair et al., 2022).

3. RESULTS

Descriptive statistics, measurement models, and structural models were evaluated. Table 2 presents a descriptive analysis of all research constructs, including minimum, maximum, and average values, as a basis for examining the distribution and variation of respondents' responses.

The measurement model in PLS was evaluated to assess the validity and reliability of the indicators used to measure the construct. The test results are summarized in Table 3. Convergent validity was reviewed using factor loading and average variance

Table 2. Descriptive statistics

Construct	Min	Max	Mean	SD
Accreditation	2.83	5.00	4.05	0.69
Managerial innovative capabilities	2.89	5.00	3.86	0.71
Service quality	2.80	5.00	4.02	0.68
Hospital performance	3.00	5.00	4.12	0.65

extracted (AVE) values. Most items showed a factor loading > 0.70 , with one item having a loading value of 0.568 retained because it had theoretical relevance and an AVE that still met the threshold value > 0.5 in all constructs. Internal reliability was fulfilled, as reviewed by Cronbach's alpha and composite reliability (CR), which showed values > 0.70 in all constructs. This evaluation is a crucial step in PLS before proceeding to structural model testing. Thus, construct validity and reliability in this study have been fulfilled (Hair et al., 2022).

Table 4 presents the results of the discriminant validity assessment using the heterotrait-monotrait ratio (HTMT), which aims to ensure that each construct has adequate discriminant validity in accordance with the recommended values. Based on the analysis results, this study meets the criteria with a value of < 0.9 (Hair et al., 2022; Henseler et al., 2015).

The structural model was assessed by examining the relationships between measurement variables using key figures such as the Variance Inflation

Table 3. Results of model measurement (outer model) using SMART PLS

Construct/item	Loading factor	Cronbach's alpha	CR	AVE
Accreditation		0.920	0.937	0.714
Accred1	0.798			
Accred2	0.876			
Accred3	0.860			
Accred4	0.878			
Accred5	0.816			
Accred6	0.838			
Managerial innovative capabilities		0.911	0.926	0.585
MIC 1	0.810			
MIC 2	0.792			
MIC 3	0.767			
MIC 4	0.680			
MIC 5	0.811			
MIC 6	0.831			
MIC 7	0.692			
MIC 8	0.687			
MIC 9	0.792			
Hospital performance		0.977	0.979	0.758
HP 1	0.888			
HP 2	0.831			
HP 3	0.918			
HP 4	0.873			
HP 5	0.773			
HP 6	0.907			
HP 7	0.914			
HP 8	0.902			
HP 9	0.909			
HP 10	0.853			
HP 11	0.859			
HP 12	0.859			
HP 13	0.838			
HP 14	0.869			
HP 15	0.850			

Table 3 (cont.). Results of model measurement (outer model) using SMART PLS

Construct/item	Loading factor	Cronbach's alpha	CR	AVE
Service quality				
SQ 1	0.786	0.937	0.943	0.524
SQ 2	0.661			
SQ 3	0.568			
SQ 4	0.763			
SQ 5	0.718			
SQ 6	0.687			
SQ 7	0.700			
SQ 8	0.684			
SQ 9	0.739			
SQ 10	0.736			
SQ 11	0.723			
SQ 12	0.784			
SQ 13	0.737			
SQ 14	0.797			
SQ 15	0.738			

Table 4. HTMT–Discriminant validity

	Accred	HP	MIC	SQ
Accred				
HP	0.835			
MIC	0.754	0.579		
SQ	0.725	0.741	0.504	

Note: Accred = Accreditation; MIC = managerial innovative capabilities; HP = hospital performance; SQ = Service quality.

Factor (VIF), R^2 , and f^2 . The VIF values ranged from 1.99 to 3.07 below the threshold of < 3.3 , so the risk of multicollinearity could be ruled out. Thus, the path coefficient estimates were considered stable and not distorted by high correlations between predictors. The R^2 value is 0.726 for hospital performance and 0.524 for service quality. These figures indicate that the model can explain 72.6% of the variance in PSA hospital performance. In the context of PLS, a value of 72.6% is classified as moderate-to-substantial explanatory power; the remaining 27.4% is explained by other variables outside the scope of this study. The next stage in the analysis process is hypothesis testing.

The bootstrapping procedure was used to test accreditation, MIC, hospital performance, and service quality. Figure 2 and Table 5 present the results of bootstrapping using SMART PLS software.

Based on Table 5, accreditation has a positive and significant influence on hospital performance in Indonesia, with a coefficient value of 0.499 and a P -value of $0.000 < 0.05$ ($H1$ is supported). Meanwhile, managerial innovative capabilities have a positive but insignificant influence on hospital performance, with a coefficient value of 0.002 and a P -value of $0.0486 < 0.05$ ($H2$ is rejected). Furthermore, accreditation has a positive influence on service quality with

Table 5. Results of data analysis on direct and indirect effects

Hypothesis	Relationship	Coefficient	p-values	Description
Direct effect				
H1	Accred $\rightarrow$ HP	0.499	0.000	Supported
H2	MIC $\rightarrow$ HP	0.002	0.486	Rejected
H3	Accred $\rightarrow$ SQ	0.724	0.000	Supported
H4	SQ $\rightarrow$ HP	0.417	0.000	Supported
Indirect effect				
H5	Accred $\rightarrow$ SQ $\rightarrow$ HP	0.302	0.000	Supported

Note: Accred = Accreditation; MIC = managerial innovative capabilities; HP = hospital performance; SQ = Service quality.

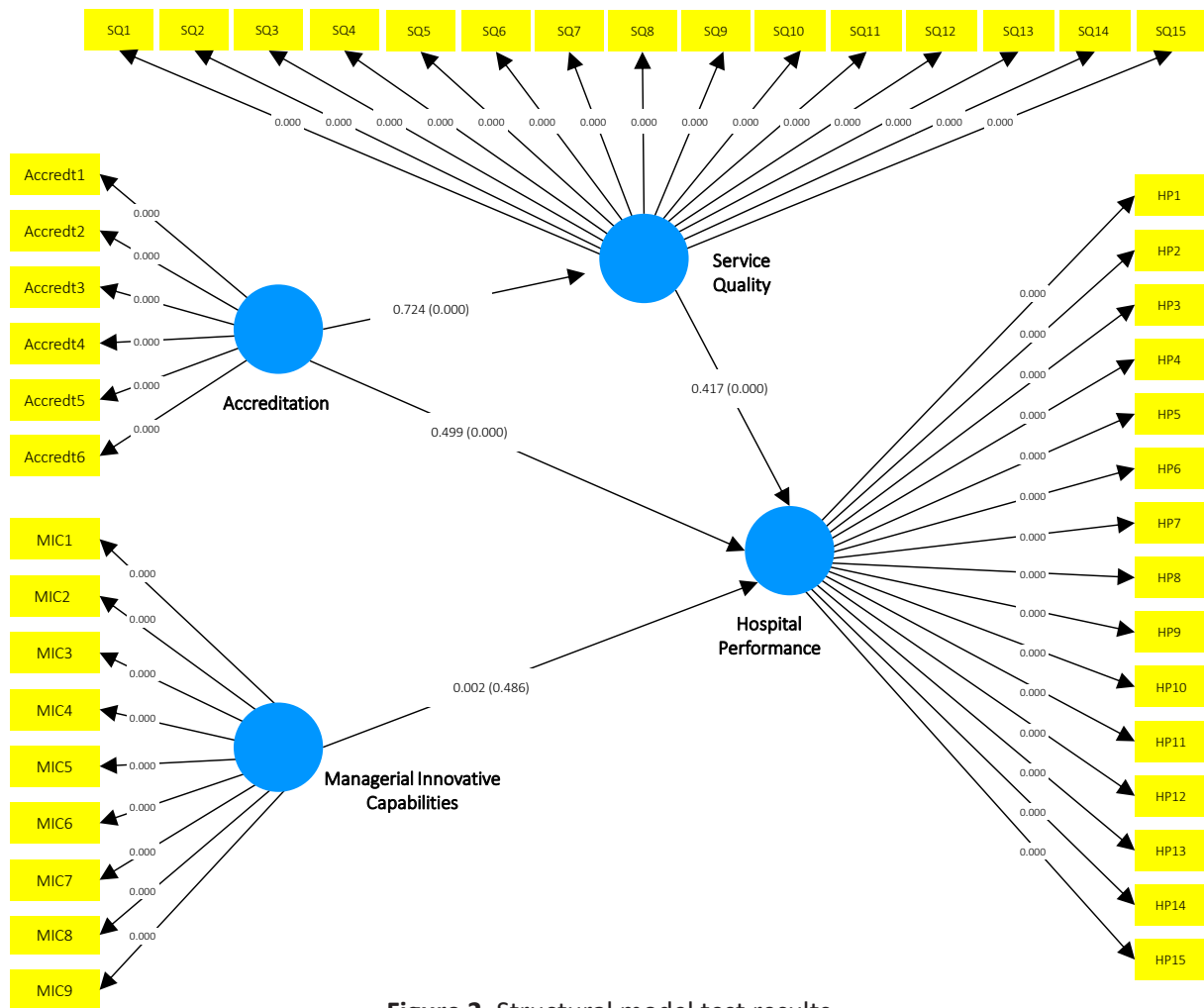


Figure 2. Structural model test results

a coefficient value of 0.724 and a P -value of 0.000 < 0.05 (H3 is supported). Service quality also has a positive effect on hospital performance, with a coefficient value of 0.417 and a P -value of 0.000 < 0.05 (H4 is supported). In addition, accreditation has a positive influence on hospital performance through service quality with a coefficient value of 0.302 and a P -value of 0.000 < 0.05 (H5 is supported).

The effect size is represented by f^2 , referring to Cohen's (1988) criteria of 0.02 (low), 0.15 (moderate), and 0.35 (high). The f^2 test result shows that accreditation contributes moderately to hospital performance (0.295), while service quality relatively slightly stronger contribution (0.303) to hospital performance.

4. DISCUSSION

Most of the relationships tested in the model obtained empirical support (H1, H3, H4, and H5). Meanwhile, one pathway did not show statistical

support (H2). A notable finding was the positive and significant influence of accreditation on hospital performance, which in this study was measured through financial indicators, including compliance with Public Service Agency (PSA) financial management, and non-financial indicators. These findings are consistent with previous studies that position accreditation as a quality assurance tool capable of strengthening clinical governance and patient safety, thereby contributing to improved hospital performance (Hussein et al., 2021; Vega & Cunha, 2023). From an RBV perspective, accreditation is viewed as a capability that should be reflected in routine practices and standardized procedures (clinical pathways), operational compliance, and quality discipline relevant to performance achievements. At the same time, it is also driven by regulatory pressure and demands for legitimacy.

At Indonesian public hospitals, accreditation status carries institutional weight, as a mark-

er of quality and credentials integrated with the Indonesian national health insurance program. Achieving a certain level of accreditation, such as plenary accreditation, increases public trust and strengthens government support and healthcare ecosystems (Wardhani et al., 2019). This context indicates that accreditation is linked to stability of service demand, strengthening compliance with PSA financial management, and ultimately leading to revenue growth and efficiency.

These findings are consistent with studies reporting that accredited hospitals are more motivated to make improvements in various areas than non-accredited hospitals. These areas include organizational structure, enhancement of medical staff competencies, nursing management, physical facilities, and patient safety, as well as improvements in financial and non-financial performance and promotional campaigns (Algunmeeyn et al., 2020; Alhawajreh et al., 2025; Swathi et al., 2020; Sughayir, 2016; Swain et al., 2025). However, several studies also emphasize that the impact of accreditation cannot be uniform because it depends on implementation across different service units (Alhawajreh et al., 2023, 2025). Taking these characteristics into account, the findings of this study indicate that accreditation and performance tend to be positively correlated when standards are effectively translated into improvement tools that promote governance discipline and operational efficiency. Conversely, these benefits tend to be sub-optimal when implementation stops at mere administrative compliance (Conceição et al., 2024; Hussein et al., 2025).

The paucity of empirical support substantiating the second hypothesis indicates that managerial innovative capabilities (MIC) have not been systematically transformed into tangible hospital performance achievements within the context of the PSA hospitals examined, despite the positive trend. It aligns with studies reporting that innovative capabilities do not always have a direct impact on performance (Homauni et al., 2023; Stock & McDermott, 2023). In essence, these findings show that budgetary limitations, onerous administrative burdens, and relatively rigid bureaucratic procedures often hinder the conversion of innovative management ideas into productive and quantifiable operational improvements. Consequently,

in such circumstances, MIC manifests as a non-exhaustive or intermittent initiative. It lacks the necessary potency to be reflected in performance indicators that are responsive to efficiency and governance. These include process costs, PSA financial management compliance, and non-financial indicators.

From an institutional theory perspective, compliance pressures and the need to maintain legitimacy can encourage organizations to prioritize stability and procedural conformity, resulting in limited space for managerial creativity and experimentation, particularly in PSA hospitals. At the same time, limitations in environmental scanning also hinder the contribution of MIC. In public hospitals, environmental scanning activities often take a back seat to daily operational demands. As a result, external information, including patient feedback and competitor service practices, is slower to be captured, processed, and translated into a consistent innovation agenda that has the potential to influence performance. Thus, MIC becomes more difficult to function as a direct driver of performance in the observed study horizon. This pattern is in line with a number of studies, which also found no significant effect of MIC on (financial) performance in the healthcare sector (Alves & Toporowski, 2019; Lake et al., 2025; Pulkkinen et al., 2025; Vrontis et al., 2022). This implies that organizational capabilities tend to contribute to performance when supported by adequate process integration and implementation readiness.

The third hypothesis was confirmed, meaning that accreditation has a positive effect on service quality. This empirical evidence reinforces the view that accreditation helps hospitals deliver services in a more structured and integrated manner through process standardization, role clarity, and continuous quality monitoring (Hussein et al., 2021; Mutlu & Mat, 2025). It is not merely a formal supervisory instrument. The standards established through accreditation at the service level and the consistency of these processes correlate with patient experience and safety, so patients treated in accredited hospitals are more likely to receive higher-quality care than those in non-accredited hospitals. These findings reinforce evidence from various healthcare contexts that show the effect of accreditation on

quality tends to emerge when standards do not stop at documents, but are used as a basis for routine evaluation and feedback for improvement that is actually followed up, not merely symbolic (Alhawajreh et al., 2023; Alraimi & Al-Nashmi, 2024; Ghareeb et al., 2018). However, the literature also warns that the effectiveness of accreditation can decline over time if improvement routines are not maintained; the most noticeable impact often occurs in phase 3 of the initial cycle (3–10 years) (Pomey et al., 2010).

Support for the fourth hypothesis shows that service quality is positively and significantly associated with hospital performance. This relationship can be elucidated because service quality not only reflects clinical quality but also reflects the orderly implementation of standard operational procedures (SOP), inter-functional coordination, and the hospital's ability to respond appropriately to patient needs. Conceptually, when these elements improve, the effects are evident in non-financial outcomes (e.g., patient satisfaction and retention). At the same time, operationally, it can also be related to cost efficiency and potential revenue growth. These findings are in line with several recent studies that identify service quality as a pivotal factor in improving operational and financial performance, as well as patient satisfaction, in hospitals (Akinleye et al., 2019; Han et al., 2024; Lovemore & Esthery, 2023; S. Zehir & C. Zehir, 2023). Thus, improving service quality is seen as a strategy that works in two parallel ways: it has an impact on clinical aspects and supports financial stability and cost control.

The fifth hypothesis in this study was supported, indicating that service quality partially mediates the relationship between accreditation and the performance of PSA hospitals. This means

that part of the contribution of accreditation to performance works through improvements in service quality, while the other part remains apparent through a direct channel that is not fully explained by the service quality variable. These findings support the view that accreditation provides a systematic framework for organizing service processes, ranging from strengthening clinical governance (clinical audits, SOP compliance) and implementing clinical pathways to standardizing triage between units (especially in critical units such as the emergency department, inpatient, and outpatient units) and strengthening patient safety risk management. Thus, improvements in service quality ultimately become an important channel related to improving overall hospital performance (Algunmeeyn et al., 2020; Chen et al., 2024; Chocknakawaro & Pusaksrikit, 2025; Rauf et al., 2024; Sughayir, 2016; Swain et al., 2025). Thus, the value of accreditation lies not solely in the status of the certificate, but in the extent to which standards become routine services; it is this internalization that makes its contribution to performance more likely to be sustained than administrative compliance, which is temporary.

Overall, this insight confirms that the benefits of accreditation for PSA hospitals do not end with obtaining a certificate. In other words, the quality agenda needs to be maintained so that it remains strong not only in the initial implementation phase but also in subsequent phases. Although the influence of MIC is not significant, these findings cannot be ignored. This is because it actually indicates the need for MIC actualization, setting realistic innovation priorities, and clearly defining process owners. Thus, MIC initiatives can be converted and have an impact on performance.

CONCLUSION

This study aims to examine the influence of accreditation and managerial innovative capabilities on Indonesian public hospital performance through service quality as a mediating variable. The results show that accreditation has a significant positive effect on the performance of supported regional public hospitals, while managerial innovative capabilities have a positive but insignificant effect. In addition, service quality partially mediates the relationship between accreditation and the performance of regional public hospitals. Thus, accreditation will have a tangible impact by leading to measurable improvements in the quality of care that are felt by patients and stakeholders of public hospitals.

This study still has limitations that need to be noted. First, all constructs were measured through questionnaires, including financial and non-financial performance indicators, so the findings are more representative of respondents' assessments and may differ from document-based measures, such as financial reports. Next, the research sample focused on Public Service Agency (PSA) status in public hospitals; because the incentive structure, governance, and decision-making flexibility in private hospitals may differ, the application of findings to the private context should be done with caution. Future research could employ a comparative design involving public and private hospitals or multi-group analysis to examine whether the relationships among variables differ across ownership structures. In addition, future studies could incorporate other theoretically relevant mediating variables for the healthcare context, such as digitalization, regulatory pressure, and resource availability.

AUTHOR CONTRIBUTIONS

Conceptualization: Dahlia, Nurkholis, Abdul Ghofar, Yeney Widya Prihatiningtias.

Data curation: Dahlia.

Formal analysis: Dahlia.

Funding acquisition: Dahlia.

Investigation: Dahlia, Nurkholis.

Methodology: Dahlia, Nurkholis, Abdul Ghofar, Yeney Widya Prihatiningtias.

Project administration: Dahlia.

Resources: Dahlia.

Software: Dahlia.

Supervision: Nurkholis, Abdul Ghofar, Yeney Widya Prihatiningtias.

Validation: Dahlia, Nurkholis, Abdul Ghofar, Yeney Widya Prihatiningtias.

Visualization: Dahlia, Abdul Ghofar, Yeney Widya Prihatiningtias.

Writing – original draft: Dahlia.

Writing – review & editing: Dahlia, Nurkholis, Abdul Ghofar, Yeney Widya Prihatiningtias.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study were collected through questionnaires. These data are available from the corresponding author upon reasonable request via email: dahlia@student.ub.ac.id or dahlia@unsulbar.ac.id

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