1. Introduction

The field of quality of healthcare services is dealing with increasing pressures for improved quality, building pressure towards the supply side (Al-Borie & Sheikh Damanhour, 2013). Prior literature establishes that quality of services can be perceived as a crucial sustainable competitive advantage (Zarei et al., 2011) and providing high-quality service can lead to cost savings and improved organisational performance (Kazemi & Fanudi, 2009). In addition, previous research concludes that quality is typically related to the available infrastructure, contemporary technology, and equipment and activities performed by staff (Ferreira & Marques, 2021). However, several studies focusing on measuring the quality of healthcare services have revealed many challenges (Parand et al., 2014). Thus, it is important to become familiar with relevant service quality dimensions and define actionable variables for potential improvements (Tripathi & Siddiqui, 2018). Our article aims to promote the development of relevant quality indicators of services in the healthcare sector (Klemenc-Ketiš et al., 2017) and to offer insight into the topic of knowledge management in the healthcare sector (Han & Pashouwers, 2018).

Little research has considered the impact of various organisational factors such as knowledge transfer, hierarchical organisational structure, and trust on the quality of healthcare services. In addition, there is a growing need for continuous progress in quality issues as it informs interested stakeholders about potential challenges and provides suggestions on how to solve them (Parand et al., 2014). Therefore, existing theory might be difficult to apply in healthcare settings. In essence, knowledge management can be understood as a function of different organisational factors (Mahmoudsalehi et al., 2012). Within the scope of our research, our article focuses on improving our understanding of knowledge transfer facilitation, which is important for the advancement of today’s knowledge-intensive world of work (Cross Walker, 2020). Moreover, we aim to reduce the knowledge transfer gaps that are currently present in healthcare organisations (McLoughlin et al., 2020). In a similar vein, we aim to strengthen previous research efforts to validate the negative impact of excessive hierarchy, formalisation and centralisation on knowledge management activities (Mahmoudsalehi et al., 2012) and on the quality of healthcare services. Previous research similarly suggests an encouraging contribution of trust on knowledge management (Tan & Md., 2013) and its subsequent impact on the services provided by healthcare institutions (Fatima et al., 2018). In our article, we focus on the healthcare services providers’ outlook as it includes a particular emphasis on knowledge of personnel that are implementing services in practice (Lee, 2017), where we believe the role of knowledge management and organisational factors can be integral.

The purpose of this article is to add to state-of-the-art research, by theoretically proposing and...
empirically testing the exploration of organisational factors that influence knowledge management activities into the healthcare sector environment as part of efforts to effectively redesign services (Ferlie et al., 2017). We explore the relationship between knowledge transfer and quality of healthcare services and hierarchical organisational structure and quality of healthcare services. Additionally, we analysed the potential moderating effect of trust on the aforementioned relationships. We tested our developed hypotheses in healthcare institutions in Montenegro with a quantitative analysis of the collected data. As data for all our variables were obtained in a one-time single survey, we acknowledge that common method bias might be a methodological issue. With our research, we aim to contribute towards building a cohesive body of literature regarding the quality of healthcare services and knowledge management in the context of public sector organisations (Al Ahabi et al., 2019) that is currently limited and fragmented (Klemenci-Ketiš et al., 2017; Oluikpe, 2012). In agreement with our overarching theory of the knowledge-based view of the organisation (Grant, 1996; Hislop et al., 2018; Kogut & Zander, 2003), which emphasises the paramount role of knowledge in organisations, our research assumed the relationship between knowledge management and organisational factors as one of the primary sources influencing the quality of services in healthcare institutions. Another goal of our research was to further clarify the link between the organisational factors that influence knowledge management and organisational performance (Inkinen, 2016). We intend to provide further empirical support to the conflict between knowledge-based approaches and bureaucratic approaches (Grant, 1996), including hierarchical organisational structure.

2. Literature review

Healthcare is nowadays considered to be a knowledge-driven process with a highly fragmented knowledge base (Meijboom et al., 2004). Knowledge management can offer support for employees in the healthcare sector on how to create, store, transfer and implement knowledge in daily activities (Shahmoradi et al., 2017). In order for healthcare institutions to improve the quality of their services, knowledge management can be used as a tool to transform their knowledge-related activities (Karamitri et al., 2017). As the healthcare system is one of the most complex systems that society has developed, it requires the collaboration and exchange of knowledge between different stakeholders engaging in diverse fields (Orr & Sankaran, 2007). Similarly, Skela-Savić et al. (2017) suggest that practitioners believe quality improvements are in practice achieved in highly complex and adaptive systems.

On the example of primary care, Arvidsson et al. (2019) argue that quality of services and quality development efforts are essential. In the opinion of Klemenci-Ketiš et al. (2017), there is a necessity to develop quality indicators on the basis of a systematic evidence-based approach. Moreover, Ikonen (2020) emphasises that it is important to recognise the knowledge needs of different stakeholders, and also to introduce state-of-the-art knowledge management practices in the environment of healthcare as it could result in a more cost-effective, error-averse and transparent health sector (Guptill, 2005).

Knowledge management can be defined as effective learning processes associated with exploration, exploitation and sharing of human knowledge with the help of appropriate technologies and cultural environments intended to enhance the performance of organisations (Jashapara, 2011). Previous research suggests that knowledge management is a managerial activity involving developing, transferring, storing and implementing knowledge (Hicks et al., 2006). Utilising knowledge management practices offers organisations the potential to achieve competitive advantage and continuous improvement (Colnar et al., 2019; Lojpur et al., 2015) with the final aim of delivering the best possible organisational performance (Shih et al., 2018), which can be understood as the best possible quality of their services.

2.1. Knowledge transfer and quality of healthcare services

Knowledge transfer represents a fundamental part of knowledge management as it enables organisations to transform their knowledge into organisational assets and resources (R. Dawson, 2001). Nowadays, organisations should pay adequate attention to all knowledge management processes, including knowledge transfer in order to enhance their performance (Zaim et al., 2019). Contemporary research on how to improve healthcare regularly includes knowledge transfer and quality improvement (Wensing & Grol, 2019). Knowledge transfer is not solely focused on exploiting existing resources, but it is also exploring the possibilities to make activities more efficient and effective, implying the importance of researching the process of knowledge transfer further within the healthcare environment (Secundo et al., 2019). Similarly, in previous research, knowledge transfer gained attention due to its role in improving organisational performance (Van Den Hooff & De Ridder, 2004), and some studies (i.e., Oyemomi et al., 2016) consider knowledge transfer as a key factor in driving an organisation’s performance. In the opinion of Abma et al. (2017), historically, research conducted in the healthcare environment partially neglected the aspect of
knowledge transfer. Moreover, there are calls to fill the gaps in knowledge transfer within the healthcare system (White et al., 2009). We provide additional empirical research on the relationship between knowledge transfer and organisational performance as these factors have not been explored in the context of the quality of healthcare services as an organisational performance outcome in the Montenegro healthcare setting.

Hypothesis 1: Knowledge transfer is positively related to quality of healthcare services.

2.2. Hierarchical organisational structure and quality of healthcare services

Organisational structure can be defined as the established set of relationships between an organisation’s main components such as its authority and control (Wilson & Rosenfield, 1990). Previous research has established that organisational structure that is related to high levels of formalisation, hierarchy and centralisation has a negative effect on organisational performance (Zheng et al., 2010). In the past, excessive centralisation and bureaucracy have already proved as important barriers to effective quality management in the healthcare environment (Mosadeghrad, 2014). In stark contrast, evidence from the literature suggests that contrary to a hierarchical organisational structure, a flat organisational structure yielded positive results in terms of quality improvements as presented in the healthcare example of Aiken et al. (2002). In addition, interest in the development of quality of healthcare is on a constant rise, where Mainz (2003) suggests that the influence of an organisational structure on the quality of healthcare can be significant. A rigid organisational structure accompanied with excessive levels of hierarchy was also proven as one of the most common obstacles to the successful implementation of knowledge management practices (Chawla & Joshi, 2010). Therefore, we additionally explore the constructs of hierarchical organisational structure and quality of healthcare in the healthcare sector in Montenegro.

Hypothesis 2: Hierarchical organisational structure is negatively related to quality of healthcare services.

2.3. Trust and quality of healthcare services

Colquitt and Rodell (2011) define trust as the confident positive expectation of an employee in relation to the behaviours and intentions of an organisation that impact their intentions, motives, and conduct. Holste and Fields (2010) and Chang and Chuang (2011) provide empirical support to the positive relationship between trust and knowledge transfer. Existing literature supports the claim that trust is pivotal in the smooth knowledge transfer between individuals that possess knowledge and knowledge recipients (Ngah et al., 2008). State-of-the-art research by Davenport and Prusak (1998) further validates the positive relationship between trust and knowledge transfer. Ostroff et al. (2003) propose that when discussing trust, researchers should acknowledge that organisational structure influences the emergence of trust within an organisation. In the opinion of Ambrose and Schminke (2003) the levels of trust are typically higher in an organisation with an organisational structure with fewer layers of hierarchy, formalisation and centralisation.

Today, every manager should pay attention to building trust in their organisation due to its impact on improving organisational performance (Brown et al., 2014; Ozyilmaz et al., 2018). Moreover, Tekingündüz et al. (2017) state that low levels of trust in healthcare organisations can negatively impact the level of healthcare services quality. Additionally, there have been claims in recent literature that there are not enough studies that focus on trust and quality of healthcare services (Sari et al., 2020). In our research, we include trust as a moderating mechanism. Among contemporary researchers in the field of management and organisation, exploring moderation effects has gained in importance (J. F. Dawson, 2014; Fassott et al., 2016).

Hypothesis 3: Trust moderates the positive relationship between knowledge transfer and quality of healthcare services.

Understanding the moderating effects of trust on the relationship between hierarchical organisational structure and quality of healthcare services requires additional research.

Hypothesis 4: Trust moderates the negative relationship between organisational structure and quality of healthcare services.

We present our conceptual model in Figure 1.

3. Empirical research

3.1. Sample and data collection procedure

To obtain primary data from respondents we used an adapted questionnaire. Our research was conducted on a sample of 45 Montenegrin healthcare institutions, of which 32 were publicly owned and 13 were privately owned. To further triangulate our research findings, we collected data from the members of the Medical Doctor’s Union that were from another 16 different healthcare institutions. In total, 151 questionnaires were filled out by respondents.
To gain insight from as many different stakeholders as possible, we collected data from 45 board members, 45 medical doctors, 45 medical technicians, and 16 members of Medical Doctors’ Union. To elaborate on our sample, 60.3% of the respondents were women, while 39.7% were men. The largest share of our respondents (37.5%) belongs to the age cohort from 50 to 59 years old. The second-largest share of our respondents (24.3%) belongs to the age cohort from 30 to 39 years old. The vast majority of our respondents (82.4%) had successfully acquired at least an university degree. Moreover, the vast majority of our respondents (94.7%) had been working in the healthcare sector for more than 5 years and the vast majority of our respondents (93.3%) had been working in their current organisation for more than 5 years.

We collected data from employees from public and private health care institutions utilising a combination of convenience and snowball (non-random) sampling. Although random sampling is considered as the gold standard of sampling strategies due to its unbiasedness and the possibility to evaluate the reliability (accuracy) of the resulting estimates (Banerjee & Chaudhury, 2010; Tiwari & Chilwal, 2014), researchers are often faced with a trade-off between the desire for randomisation and pragmatic considerations when choosing their sample. Random sampling is not always possible nor feasible in practice, due to potential constraints in time, resources and costs. Therefore, researchers in the healthcare field often use a convenience or purposive sampling (Van Hoeven et al., 2015). In addition, existing studies support the claim that such purposive strategies can lead to representative samples (i.e., Raaijmakers et al., 2008; Toppl et al., 2004).

Data for all four of our model variables were obtained from individual respondents in a single one-time survey. Consequently, common method bias might potentially impact some of the proposed relationships in our conceptual model. To explore the presence of common method bias, we applied the simple Harman’s single-factor bias test (Harman, 1976). Our first factor accounted for 56.7% of the overall variance. As this result is slightly above the recommended threshold (50.0%) suggested by Podsakoff et al. (2006), we acknowledge that common method bias might be an issue.

### 3.2. Measures

To explore individual constructs in our research, we opted for measurement instruments that satisfy predetermined criteria: (1) they are commonly cited in research articles that are published in relevant scientific journals; (2) they have been used in the most recent research; and (3) they are well-established and have been frequently used and/or developed by key authors of the researched topics. In the scope of this research, we applied the 5-point Likert scale ranging from 1 (I strongly disagree) to 5 (I completely agree) to assess the respondent’s agreement about what level of knowledge transfer, hierarchical organisational structure, trust, and quality of healthcare services were present in their healthcare organisation.

#### 3.2.1. Knowledge transfer

We used the eight item scale (α = .93) that Downes (2014) adapted from multiple resources and utilised to measure knowledge transfer. The questionnaire consists of statements such as: “In my organisation key experts are readily identified and contacted.”

#### 3.2.2. Hierarchical organisational structure

We used the three-item scale (α = .80) that Downes (2014) constructed from multiple resources in order to measure organisational structure. The questionnaire includes items such as: “In my organisation, organisational structure impedes the sharing of knowledge.”
3.2.3. Trust
We utilised the three-item scale (α = .83) that Downes (2014) developed from various references to measure trust. The questionnaire consists of statements such as: “In my organisation there is a lack of trust in people because they misuse knowledge or claim credit.”

3.2.4. Quality of healthcare services
We utilised the five-item scale (α = .85) that Downes (2014) adapted from various resources to measure the quality of healthcare. Items included in the questionnaire are, for example: “In my organisation, we are delivering a higher quality service to our users.”

3.2.5. Control variables
We included two control variables: age and highest level of education. Inclusion or exclusion of control variables can have significant consequences on research conclusions (Bernerh & Aguinis, 2016). Demographic characteristics, including age and highest level of education may have an influence on the overall levels of knowledge management-related activities (Srivastava et al., 2006). Both control variables were utilised in similar previous research (Abbas et al., 2020; Le & Lei, 2017). Our questionnaire consists of 21 items and six constructs (see Table 1).

3.3. Research methods
To analyse our primary data and to explore the suggested interaction effects we performed a series of hierarchical linear regressions in SPSS 25.0. To check whether our conceptual model adequately fits our data, we conducted a confirmatory factor analysis (hereinafter: CFA), using the lavaan version 0.6–5 (Rosseel, 2012) of the programming environment R – version 3.6.2 (R Core Team, 2018). We explored the convergent validity of all items by exploring standardised factor loadings. The goal was to determine if our items were statistically significant and above the recommended .50 threshold (Hair et al., 1998). The results of our CFA analysis displayed that all the standardised factor loadings for three out of four constructs were statistically significant and above the .50 threshold. Two items that were initially intended to measure hierarchical organisational structure did not fulfill the aforementioned criteria. The standardised factor loadings for knowledge transfer were within the range from .71 to .91, for hierarchical organisational structure from .61 to .97, for trust from .71 to .86 and for quality of healthcare service from .52 to .92. In our final model, 19 items were used.

Composite reliability index (hereinafter: CRI) and average variance extracted (hereinafter: AVE) were included to further test the composite (construct) reliability (Fornell & Larcker, 1981). In evaluating our results, we pursued the recommended values of Diamantopoulos and Siguaw (2000) for CRI1 (.60) and AVE2 (.40). Our proposed constructs are within the proposed CRI and AVE cut-off values. To evaluate our model fit, we explored several fit indices that are recommended by researchers (i.e., Škerlavaj et al., 2010). Our expected four-factor solution displayed the following results: CFI = .97; chi-square: 187.731; RMSEA = .05; and df = 135. All evaluated fit indices display a good fit with our data and are well within the recommended threshold values.

4. Results
Results from Table 2 suggest that respondents on average evaluate knowledge transfer (3.89) the best, which is followed by quality of healthcare services (3.80). Hierarchical organisational structure (2.21) and trust (2.04) on average received a significantly lower evaluation. Correlation coefficients between our measured variables are moderately negative, with ranges between −.40 and −.59 and weakly or strongly positive, with ranges between .17 and .65 (Akoglu, 2018). There was a significant and positive correlation between the quality of healthcare services and knowledge transfer (.65; p < 0.01). The quality of healthcare services had a significant and negative correlation with

Table 1. Montenegro healthcare questionnaire (adapted from Downes, 2014).

| Construct                              | Number of Items | Cronbach alpha (α) |
|----------------------------------------|-----------------|--------------------|
| Knowledge Transfer                     | 8               | .93                |
| Hierarchical organisational Structure  | 3               | .80                |
| Trust                                 | 3               | .83                |
| Quality of Healthcare Services         | 5               | .85                |
| CV1 – Age                              | 1               | /                  |
| CV2 – Highest Level of Education       | 1               | /                  |

Legend: CV = Control Variable

Table 2. Mean Values, Standard Deviations, and Coefficient Correlations (n = 151).

| Variable                              | Mean | SD    | 1     | 2     | 3     | 4     | 5     | 6     |
|---------------------------------------|------|-------|-------|-------|-------|-------|-------|-------|
| 1. Age                                | 48.82| 10.76 |       |       |       |       |       |       |
| 2. Highest Level of Education         | 4.72 | .64   | −.60  |       |       |       |       |       |
| 3. Knowledge Transfer                 | 3.89 | .94   | .01   | .01   | .93   |       |       |       |
| 4. Hierarchical organisational Structure | 2.21 | .92   | −.06  | −.10  | −.59**| .80   |       |       |
| 5. Trust                              | 2.04 | .79   | 0.17* | −.05  | −.40**| .62** | .83   |       |
| 6. Quality of Healthcare              | 3.80 | .80   | −.01  | −.11  | 0.65**| −.51**| −.43**| .85   |

Reliability indicators (Cronbach’s alphas) are on the diagonal in the parentheses. **p < 0.01 and *p < 0.05
Legend: SD = Standard Deviation, p = significance
hierarchical organisational structure (−.51; p < 0.01) and trust (−.43; p < 0.01). Trust showed a significant positive correlation with the control variable of age (.17; p < 0.05) and with hierarchical organisational structure (.62; p < 0.01). In addition, trust had a significant and negative correlation with knowledge transfer (−.40; p < 0.01). There was also a significant and negative correlation between hierarchical organisational structure and knowledge transfer (−.59; p < 0.01).

We explored the direct relationship between knowledge transfer and quality of healthcare services. Additionally, we tested the proposed direct and negative relationships between hierarchical organisational structure and quality of healthcare services. We included trust as a moderating mechanism between the relationship of knowledge transfer and quality of healthcare services. We also aimed to establish whether trust acts as a potential moderating mechanism in the relationship between hierarchical organisational structure and quality of healthcare services.

In our first regression model, we included knowledge transfer and two control variables. In our second regression model, we selected hierarchical organisational structure and two control variables. In our third model, we tested our proposed two-way interaction effect (knowledge transfer × trust). To conclude our series of hierarchical linear regressions, we included in our fourth model our second two-way interaction effect (hierarchical organisational structure × trust). The results of all models are presented in Table 3.4

In model 1, we found a significant and positive relationship between knowledge transfer (β = .56; exact p = .000) and quality of healthcare services. Therefore, the hypothesis H1 is supported. In model 2, we found a significant and negative relationship between hierarchical organisational structure (β = −.41; exact p = .000) and quality of healthcare services. Therefore, we confirm the hypothesis H2.

Models 3 and 4, which included trust as a moderator, showed considerable added value in comparison with direct effect models.

The results of model 3 showed a significant and positive relationship between the two-way interaction of knowledge transfer and trust on the quality of healthcare (β = .21; exact p = .005). We provide empirical support for the hypothesis H3. In addition, our model 4 displayed a significant and negative relationship between the two-way interaction of hierarchical organisational structure and trust on the quality of healthcare (β = −.26; exact p = .003). Thus, our results provide empirical support for hypothesis H4; however, the interaction term is negative. The analysis of the simple slope for H3 suggests it is significant (exact p = .000). We show the interaction between knowledge transfer and trust as they influence the quality of healthcare in Figure 2.

Figure 2 illustrates that the highest levels of quality of healthcare services are achieved when the level of trust is high. Moreover, the influence of knowledge transfer is also important as in cases of both low and high levels of trust, higher levels of knowledge transfer then lead to better quality of healthcare services. In the example of high knowledge transfer, the best quality of healthcare services is also associated with high trust; however, the difference to the example of low trust is marginal. In the example of low knowledge transfer, low trust contributes to better quality of healthcare services, which emphasises the necessity of additional research.

Our analysis of the simple slope for H4 suggests it is significant (exact p = .000). We present the interaction between hierarchical organisational structure and trust as they influence the quality of healthcare services in Figure 3.

The highest levels of quality of healthcare services are achieved when the levels of trust are high. In addition, the influence of organisational structure is also important as higher levels of organisational structure that can be connected with extensive bureaucracity, unnecessary formalisation, and excessive centralisation negatively impact the overall quality of healthcare services both in the example of low and high levels of trust. In the case of low levels of hierarchical organisational structure, high trust contributes to better quality

| Table 3. Hierarchical regression analysis predicting the quality of healthcare services – Models 1–4. |
| Variables | Model 1 | Model 2 | Model 3 | Model 4 |
| --- | --- | --- | --- | --- |
| | b | s.e. | t | b | s.e. | t | b | s.e. | t | b | s.e. | t |
| Age | 0.00 | 0.01 | 0.09 | 0.00 | 0.01 | 0.01 | 0.00 | 0.01 | 0.15 | 0.00 | 0.01 | 0.08 |
| Highest Level of Education | −0.16 | 0.08 | −0.13 | −1.95* | −21 | 0.10 | −2.16 | −2.24* | −1.14 | −0.08 | −11 | −1.74 | −16 | 0.09 | −13 | −1.74 |
| C_KNOT | 0.48 | 0.06 | 0.56 | 7.84** | 0.43 | 0.06 | 0.51 | 6.93** | −0.30 | 0.09 | −34 | −3.53** |
| C_ORGSTR | −0.36 | 0.09 | −0.41 | −4.20** | 0.08 | 0.15 | −0.23 | −0.23 | −0.09 | −10 | −1.07 | −0.10 | −11 | −1.07 |
| C_TRUST | −0.21 | 0.07 | −0.22 | −2.87* | −0.41 | 0.10 | −0.18 | −1.80 | −0.15 | −0.15 | 0.23 | 1.07 |
| C_KNOTC_TRUST | −0.11 | 0.06 | −0.21 | −2.89* | 0.17 | 0.06 | 0.21 | 2.89* |
| C_ORGSTRxC_TRUST | −0.18 | 0.06 | −0.26 | −3.06** |
| R² | 0.469 | 0.303 | 0.503 | 0.353 |
| F(df) | 27.14(123) | 13.39(123) | 24.68(122) | 13.31(122) |
| ΔR² | 0.469 | 0.303 | 0.034 | 0.050 |

*p < 0.05

**p < 0.01
of healthcare services in practice. When the organisational structure is highly hierarchical, the quality of healthcare services is in practice higher in the case of low trust, which requires additional research.

5. Discussion and conclusions

The findings of the study showed that knowledge transfer can be interpreted as a significant factor for the quality of healthcare services. Therefore, it is necessary to continuously review our knowledge and acquire new expertise in order to gain competitive edge and have better quality of services, which requires adequate knowledge transfer. Our study indicates that a hierarchical – strictly centralised organisational structure is in negative correlation with the quality of healthcare services. The application of a hierarchical – strictly centralised organisational structure in a complex system such as healthcare has only limited effects (Radević & Haćek, 2019).

Although a certain degree of control and leadership is necessary, trust, human relationships, and motivation can replace hierarchical relationships (Addicott, 2008). Not only that, but a system built on trust and knowledge transfer will facilitate quicker communication, greater involvement, and motivation of employees and higher quality of services. The findings of this study correspond with previous research by other authors (Claver-Cortés et al., 2007; Cricelli & Grimaldi, 2010; Mintzberg, 1980). Moreover, trust is recognised as a vital factor of success for modern organisations (Adizes, 2018; Koohang et al., 2017; Kuokstis, 2017). In this context, our research highlights the link between trust and knowledge transfer in the function of quality of services. A high level of trust along with a higher level of knowledge transfer ensures the highest level of quality of services. Therefore, knowledge transfer and trust can be referred to as complementary processes, as expressed in the existing literature (Assem & Pabbi, 2016; Boateng & Agyemang, 2016). However, it is interesting that in case of low knowledge transfer, high trust does not mean much. Although such situations are not very common in practice, it is interesting to see that when knowledge transfer is at a low level, a high level of trust can be counterproductive. This occurs because the healthcare services imply a holistic and systemic approach to patients. Therefore, if there is high trust between employees (but knowledge transfer is low), this may result in errors based on routine behaviour.
and assumptions that one of the colleagues had done something that we expected from them.

In a complex profession such as healthcare, it is essential not to stop questioning and seeking new answers in order to provide best services. In cases where trust is low and so is the level of knowledge transfer, doctors will intensify their preventative actions and checks of their own work and work of others through detailed discussions with a patient in order to reduce the risk of treatment error. In this context, knowledge transfer among the entire medical staff is imposed as a “conditio sine qua non” of successful healthcare services. However, this study indicates that trust influences the relationship between hierarchical and strictly centralised organisational structure and the quality of healthcare services.

With our study, we verify theoretical implications found in existing literature that connect the field of knowledge management with healthcare. We explored and gained in-depth knowledge on available theories and defined key success factors of knowledge management applied in healthcare. Results revealed important information related to our proposed hypotheses and provide added value in terms of multiple theoretical implications. Based on empirical data, we support Klemenc-Ketiš et al. (2017), who argue that researchers should continuously focus on exploring possibilities on how to improve the quality of healthcare services as we aim to solve some of the existing challenges in healthcare services (Parand et al., 2014). We also support Ferlie et al. (2017) and their efforts to effectively redesign healthcare services. This, in turn, can enhance the quality of healthcare services and contribute to a broader understanding of the organisational factors that determine their quality. In relation to the common findings regarding knowledge transfer, we support authors who recognise the importance of knowledge transfer on the advancement of today’s knowledge-intensive world of work (Cross Walker, 2020). With our research, we follow contemporary research streams combining knowledge transfer and quality improvements (Wensing & Grol, 2019) and aim to reduce the gap in understanding the importance of knowledge transfer in healthcare organisations (McLoughlin et al., 2020; White et al., 2009) as this was historically neglected in the healthcare environment (Abma et al., 2017). In relation to the negative impact of hierarchical organisational structure, we found that it negatively influences both the quality of services in the healthcare environment (Mosadeghrad, 2014) and knowledge management activities (Mahmoudsalehi et al., 2012). Similar to the findings of Fatima et al. (2018) and Tan and Md. (2013), we show that trust has a positive impact on the quality of services in healthcare organisations and on knowledge management activities. In addition, we fill a gap in research regarding trust and its influence on the quality of healthcare services (Sari et al., 2020) and validate the findings of the positive impact of trust on organisational performance (Brown et al., 2014; Ozyilmaz et al., 2018). The results substantiate a better understanding of knowledge management in the public sector (Al Ahbabi et al., 2019; Oluüke, 2012), where we conducted our research in the context of healthcare organisations. Knowledge management is rarely investigated within the public sector environment, and especially in the healthcare sector. Finally, we are able to provide empirical support to the issues between knowledge-based and bureaucratic approaches (Grant, 1996) and to the broader discussion regarding the knowledge-based view of the organisation (Grant, 1996; Hislop et al., 2018; Kogut & Zander, 2003). These facts exemplify the added value of our research and are a significant contribution to the existing body of scientific literature that explores the impact of knowledge management on healthcare and the quality of healthcare services.

The practical contribution of this research can be found in identified opportunities for better organisation of the healthcare system, through improved knowledge management of knowledge transfer, hierarchical organisational structure, and trust. Healthcare services providers and especially their managers must continuously search for opportunities to enhance the understanding of what their patients need or wish in order for them to be able to meet or even exceed their expectations related to quality of healthcare services. The scope and results of the research, in the form of recommendations, can be helpful to managers and decision makers in healthcare systems to create better organisational performance and increase the quality of healthcare services. Specifically, our findings can help healthcare organisation managers to provide concrete suggestions on how to create effective strategies. This study will further promote the necessity for healthcare organisation managers to devote more attention, time and resources towards efforts and activities that are aimed at improving the quality of healthcare services. From a practical point of view, our study also offers empirical evidence regarding the need to monitor and manage the quality of healthcare services, with a particular emphasis on the aspect of employees and their knowledge.

All our conclusions should be taken with a bit of caution derived from the existing limitations of our research. Although we believe that this article’s contribution is significant, some limitations exist. First, limitations are primarily reflected in the lack of objective indicators about the quality of healthcare services, in accordance with applicable rules in Montenegro. Therefore, this research is predominantly based on perception questionnaires and some bias in the respondents’ ratings is possible. The second limitation relates to a common method bias issue. Third, since
the results are based on Montenegrin healthcare system, we believe that similar research should be done in other countries to get a higher degree of generalisation of final findings. Even if the reliability and validity indicators were satisfactory for our research, the application of our results is potentially limited due to the inclusion of only one country. Fourth, a longitudinal study, which would have enhanced the accuracy of our results, was not conducted. Fifth, another limitation is the complexity of the healthcare environment. Healthcare employees are consistently exposed to demanding and complex situations, which might influence their responses. Sixth, within the scope of this research we did not distinguish between public and private healthcare organisations.

Among the avenues for future research, we suggest the following: (1) promote and further develop efforts that focus on measuring the quality of healthcare services in Montenegro; (2) in order to mitigate the problem of common method bias, data should be collected for independent and dependent variables at different points in time. Additionally, we suggest researchers to opt for the mixed-methods research approach to combine qualitative and quantitative research findings; (3) the limitation of only one country included could be reduced by including an international sample; (4) to conduct a longitudinal study that involves repeated observation of our selected variables over a longer period of time; (5) further research with the inclusion of a higher number of respondents; and (6) future research should consider differentiating between different types of healthcare organisations, potentially also in terms of type and size of the examined organisation.

In a nutshell, this study built a conceptual research model that empirically examined the impact of knowledge transfer and hierarchical organisational structure on the quality of healthcare services, along with a special focus on the impact of trust on two observed relationships. Findings showed a significant correlation between the observed constructs. Knowledge transfer causes higher quality of healthcare services, while a strict hierarchical and centralised organisational structure has adverse effects on it. A high level of trust significantly influences the correlation between knowledge transfer and the quality of healthcare services, as well as the relation between the hierarchical organisational structure and the quality of healthcare services. A high degree of trust combined with high knowledge transfer gives the best results, and the positive impact of trust is identified in the case of a more flat organisational structure.

Disclosure of potential conflicts of interest

No potential conflict of interest was reported by the author(s).

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Notes

1. CRI for our four constructs: KT .94, OS .83, Trust .84, and Quality of HS .87.

2. AVE for our four constructs: KT .65, OS .63, Trust .63, and Quality of HS .59.

3. Without modification indices, the results of the model fit were: CFI = .87, chi-square = 414.473, RMSEA = .11, and df = 146.

4. Additional analysis revealed that with only control variables in Model 1, the R² is .013, which is significantly lower than the R² in Model 1 and Model 2 in Table 3. The b values are: age = -.002, highest level of education = -.144; s.e. values are: age = .007, highest level of education = .112; b values are: age = -.021, highest level of education = -.114; t values are: age = -.240, highest level of education = -.1285.
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