Accounting and the everyday life of the medical professional: A review of a case study

Abstract
This paper seeks to shed light on whether the calculative practices of management accounting have seeped into the everyday lives of doctors and nurses in the context of a large university hospital in Ireland. The paper seeks to develop the existing body of work on the hybridisation of the medical and the financial expertise by extending our theoretical apparatus for understanding how and why differing degrees of hybridisation occur within the same profession but across different national and organizational contexts. Drawing upon the literature on governmentality and recent debates in the sociology of professions, the study finds the occurrence of a different degree of hybridisation than previously found in other countries. The paper concludes that a complex set of factors help us to understand these national and organisational differences. In addition to previous explanations of variations in the position of management accounting within the pedagogic settings across the countries and variations in public policy and the ways in which the professions define, differentiate and organise themselves, this paper argues that there is a more complex set of factors explaining these national variations. Factors such as the influence of the state over the medical profession, the prevailing blend of three distinct methods of organising and controlling medical work; professionalism, bureaucracy and consumerism, alongside a shift towards the emergence of a collaborative interdependent profession offer further explanations.

Keywords
Governmentality, hybridisation, management accounting practice, professionalism, professional enclosures.
1.0 Introduction

The last three decades have seen attempts by many Governments to make medicine and medical professionals calculable. Government and managerial reforms have sought to involve clinicians in the financial management of their specialties and of the hospitals in which they work. Kurunmaki (2004) demonstrated a willing adoption of management accounting practices by doctors in the Finnish context, whereby they acquired financial expertise over time, resulting in a hybridisation of medical expertise. However, in contrast, the evidence from the UK (Kurunmaki, 2004; Kurunmaki & Miller, 2008) has revealed a resistance by doctors to engage in resource management. Kurunmaki & Miller (2008) suggest that this is characterised by a persistent concern with the aspiration of curing amongst the medical professionals alongside an impermeability to financial expertise but could also reflect an element of self interest. Despite similar concerns of scarce resources and health care reforms, the hybridisation of medical–financial expertises cannot be presumed. This hybridisation appears to vary across specific national and organisational contexts. Miller, Kurunmaki & O’Leary (2008, p.955) suggest that these variances are possibly due to variation in public policy and variation in the ways in which the professional bodies define, differentiate and organise themselves. Kurunmaki, Lapsley & Miller (2011) argue that much work needs to be done to understand more fully the ways in which management accounting is mobilised in a variety of organisational and national settings and to explore further the conditions under which hybridisation of the calculative expertise of accounting takes place. This paper seeks to extend the body of work carried out by Kurunmaki and Miller on the medical–financial hybrid by extending our theoretical apparatus for understanding how and why differing degrees
of hybridisation occur within the same profession but across different national and organizational contexts. This study seeks to shed light on whether the calculative practices and language of accountancy have seeped into everyday medical life by analysing the emergence of a new management accounting practice, in the form of clinical budgeting, within a large university teaching hospital. The paper is also a response to Abbott’s (1988) call for professions to be studied in the context of interprofessional relations (i.e. accounting and medicine). In order to further understand the encounters between the medical profession and the accounting profession, the study draws upon two bodies of knowledge: the literature on the sociology of professions and the literature on governmentality.

The empirical focus of the paper is to understand why the clinical budgeting system was introduced and how this management control practice links the larger political culture with the everyday life of medical professionals. The medical profession is noted for its entrenched autonomy, collegial community and ideology of service alongside a mode of self governance and control. This is a distinct method of organising and controlling work as compared to consumer control or managerial control. In this context the encounters between medics, as professionals of life and death (Abbott 1988, p.325) and accountants, as professionals of loss and profit, will be explored across time within a changing political, economic and social environment and a changing internal managerial environment.

This is a longitudinal study of one case site, carried out over two phases, firstly where a real time study was performed from 1994 to 2000 which traced the design and implementation of the new management accounting practice. In the second phase of
the study the site was revisited nine years later in 2009 to establish whether and to what extent the new clinical budgeting system had become embedded in the organization. The longitudinal nature of the study permitted the messy reality of the implementation of the clinical budgeting system to be revealed over time. The study seeks to explore whether there is a link between the programmatic discourse of the provision of efficient health care and the actions of individuals (doctors, nurses and managers) in their everyday lives.

McKinlay & Pezet (2009) and O’Malley argue that by focusing on the programmatic level of analysis, studies of governmentality ignore how individuals, groups and organisations are affected by the new calculative practices. In drawing on governmentality studies (Foucault, 1991; Rose & Miller, 1992; Miller & Rose 2008) to analyse the emergence of new management accounting practices, Kurunmaki & Miller (2010) argue that it is necessary to consider three distinct and interrelated levels of analysis: the programmatic or policy level of analysis, the practices and processes to which such discourses are linked and the professionals who are required to adopt such practices and processes. This paper employs this three tier level of analysis, by firstly analysing the cascade of Government initiatives that gave rise to the new management accounting practice at the organizational level, secondly describing and analysing the process of implementation of the clinical budgeting system and thirdly attempting to understand the impact of such practices on the medical professionals. Figure 1 is a diagrammatic representation of these levels of analysis. The paper is also responding to recent calls to widen the analysis of management accounting research by examining the relationship between management control and the political and institutional contexts in which those controls exist
In addition Vollmer (2009) calls for management accounting research to examine the social within the economic by exchanging ideas between sociology and economics.

Health care and its professionals have come under increasing pressures for enhanced accountability, cost reduction, rationalised services and quality improvements from external and internal agents (Freddi & Bjorkman, 1989). These pressures have derived from the rise of a combination of managerial control (Weber, 1978) and consumer control (Smith, 1976). Adler, Kwon & Heckscher (2008) suggest that market and hierarchical pressures have been mounting which could threaten the traditional professional values of autonomy by demands for collaboration in a new bureaucratic environment. They suggest that many doctors complain about the corporatization and bureaucratization of their profession. However, Adler et al (2008) propose that the rise of the principles of hierarchy and of the market does not necessarily mean the demise of professional community. Instead they argue that the changing environment in which medical professionals are working has stimulated the emergence of a new form of professional organization, characterised by a move toward a more collaborative form of organizing. This is described as ‘collaborative interdependence’ (Adler et al, 2008, p.368, Gittell, Fairfield, Bierbaum, Head, Jackson, Kelly, Laskin, Lipson, Siliski, Thornhill & Zuckerman, 2000) where doctors are required to collaborate with other clinicians such as the nursing professionals, the allied health professionals and the medical scientists in order to improve cost effectiveness, quality of service and patient safety. Previously these health professionals often worked in separate departments with little overlap on a daily basis.
The following section of the paper summarises the theories from the two literatures that will be used to analyse the case study findings; the sociology of professions and the studies on governmentality. The next section describes the environment in which the hospital was functioning across the two decades from 1991 to 2009 and the cascade of policy initiatives and instruments of governmentality that gave rise to the new management accounting practice at the hospital level. The research method is presented, followed by the case findings. The case findings are analysed using the three tier level of analysis; the programmatic level of analysis, the management accounting practice that is linked to the ambitions of Government and the doctors and nurses who are required to adopt such management accounting practices. The next section of the paper is a discussion of the case analyses as to how and why degrees of hybridisation of the medical-financial expertise occur. The paper concludes with a discussion of the broader implications of the case analysis for the financial management of health care.

2.0 Professionalism

Professionalism is analysed by Freidson (2001) as one of three logically distinct methods of organising and controlling the division of labour, the other two being the logic of the free market (consumerism) and the logic of bureaucracy (managerialism). He argues that the ‘ideology of professionalism is concerned with justifying the privileged position of the institutions of an occupation in a political economy as well as the authority and status of its members’ (Freidson, 2001, p.106). Adler, Kwon & Kecksher (2008) likewise propose three organizing principles; the hierarchy principle which relies on authority as a controlling mechanism, the market principle which relies on price competition as an organizing principle and the community principle
which relies on trust and knowledge growth. Freidson (2001) suggests that to justify the ideology of professionalism it is necessary to counteract the opposing ideologies of consumerism (market control of work) and managerialism (bureaucratic control of work). Freidson (2001) contends that the ideal typical bureaucracy is at odds with the ideal typical professionalism whereby bureaucracy/managerialism aims to reduce discretion as much as possible so as to maximise the predictability and reliability of services or products, however the exercise of discretion is one of the key attributes of a professional. Professionalism challenges managerialism by claiming self-direction and the necessity to apply discretion and judgement in the work performed. The ideal typical consumerism where consumers control the work that people do is likewise intrinsically at variance with professionalism because professions control the supply of professionals to the labour market by limiting membership to the profession through limited admission to the formal education and training programmes, without which one is excluded from membership. The ideal type of professionalism is one where the organized occupation creates the circumstances under which its members are free of the control of those who employ them. In recent decades the rationales of New Public Management such as efficiency and value for money have been driving policy reforms in the health care sector, rationales of bureaucracy and consumerism which according to Freidson’s analyses are intrinsically at odds with the logic of professionalism. Adler et al (2008) however, argue that the increasing adoption of the market and hierarchy principles in the organization of professional work has not diminished the role of the professional community. Instead, they suggest that all three principles are becoming more important and that the principle of community is being transformed over time such that professional community is moving towards a more collaborative form whose main characteristic is one of interdependence. Taking the
medical profession, there is a growing number of hospitals bringing doctors into collaborations with nurses, with the allied health professionals and with other hospital staff to improve cost effectiveness and quality of care. Adler et al (2008, p.367) describe this form of medicine as a collaborative and civic profession, compared with the earlier forms of medicine as a craft guild and more recently as a liberal profession. They propose that the medical profession has evolved through these three different forms over time.

Freidson (2001, p.127) suggests that there are five interdependent elements of the ideal typical professionalism that can be used as a standard by which occupations may be analysed; specialized work grounded in a body of theoretically based, discretionary knowledge and skill and that is awarded special status in the labour force, exclusive jurisdiction in a particular division of labour created and controlled by the occupation, a sheltered position in the labour market that is based on qualifying credentials created by the occupation, a formal training programme which is controlled by the occupation and is associated with higher education and an ideology that asserts a greater commitment to doing excellent work rather than economic gain and is devoted to the quality of the work rather than the economic efficiency of the work. It can be argued that the medical profession is aligned with each of these five elements. Where there is a model of doctors working in both public and private environments simultaneously, where they are operating as employees and as self employed persons the question arises as to whether it is possible for a tendency towards economic gain and economic efficiency to take the place of the higher value of devotion to quality of service.
Adler et al (2008) suggest that professionals possess three attributes; the performance of non-routine tasks that require expertise based on a combination of abstract knowledge and practical apprenticeship, occupational monopoly over the practice jurisdiction and individual autonomy within it alongside legal and ethical responsibility for this practice that is reflected in values of service. Both Freidson (2001) and Adler et al (2008) do highlight that these sets of attributes are more typical of the Anglo-American model of professionalism and that these models may not exist in other national contexts. Professions and their relations with the state may provide some insights to understanding how and why differing degrees of hybridisation of the medical-financial expertise occurs within the same profession but across different national contexts. Such state relations may not be static but rather constantly evolve as the bases of social power alters and as advances in information and knowledge bases occur.

Freidson (2001) argues that the ideology of the monopoly of professionalism is grounded in a social enterprise of learning, advancing and practising a body of specialized knowledge and skill. This societal nature of professions, Freidson (2001) argues, can be likened to Weber’s (1946) notion of social closure whereby professionalism is based on a competence through special education, training and continued learning without which one is excluded from being a member. Weber (1978) was of the view that society can be seen as individuals pursuing interests, that this activity generates collectively conscious groups to pursue their own interests. He argues that social groups engage in social closure in the pursuit of their own interests while attempting to exclude others from their group and to usurp the privilege of other groups. Weber (1978, p.342) suggests that the privileged group will aim for a closed
monopoly and ‘its purpose is always the closure of social and economic opportunities to outsiders’. Freidson (2001) argues that the concern of preserving and improving quality of work is achieved by establishing social closures based on training.

Adopting a similar perspective, Kurunmaki & Miller (2010) explore the ways in which professional or ‘expert’ knowledge can give rise to ‘enclosures’. Kurunmaki & Miller (2010, p.3) define ‘enclosures’ as ‘relatively bounded domains or modes of judgement and evaluation within which and through which the authority of a particular group of experts or professionals comes to be associated and concentrated’ (Rose & Miller, 1992; Kurunmaki, 1999, 2004). Kurunmkai & Miller (2010) suggest that such enclosures can play a significant role in hindering inter-organizational cooperation (and the management practices designed to facilitate this cooperation) and are more likely to occur in highly professionalised contexts such as health care and social care. They argue that existing modes of working are likely to be reinforced in such contexts rather than being redesigned as may be intended by policy reforms.

This brings us to explore the role of the state and its policies regarding the logic of professionalism. The ideology of professionalism asserts devotion to the use of disciplined knowledge and skill for the public good (Freidson, 2001). He argues that the creation, maintenance and enforcement of professionalism is dependent on the state as the political authority which has the power to grant professions special status within the economy. Johnson (1995) argues that professions are an integral part of the state and are inseparable from it. Freidson (2001) argues that professionals are autonomous within their own economic sector but not within society because they depend on the state for their empowerment, different types of states impacting to varying degrees on the professions. This line of argument mirrors that of Mac Donald
(1995) regarding the relation between professional groups and the state and how
different types of states with different state structures, political cultures and historical
events demonstrate different relationships between the professions and the state. For
example, doctors employed in hospitals have contracts of employment with the state.
The state has the power to alter the terms of such contracts. A peculiar feature of the
Irish healthcare system is that doctors can engage in treating public patients under
such a contract of employment with the state while simultaneously treating private
patients where they act as self employed persons, either in the same public hospital
site or in a separate private hospital. The introduction of restrictions on the amount of
private work doctors can do in any period is an example of such state intervention and
control over the autonomy and economic privilege enjoyed by doctors. The
imposition of a ‘Clinicians in Management’ initiative and the introduction through
legislation of clinical directors within hospitals are further examples of instruments of
governmentality employed by the state to govern the work of doctors. Similarly the
introduction of clinical pathways as a mechanism to standardise patient treatment, to
control costs and to protect from litigation can be seen as examples of hierarchical and
bureaucratic modes of governing.

Freidson (2001) analyses the evolution of the medical profession over time from the
middle of the 20\textsuperscript{th} century to the start of the 21\textsuperscript{st} century describing what he refers to
as the ‘Golden Age’ and the ‘Post Golden Age’. The Golden Age of medicine refers
to the time when the medical profession was the most highly respected occupation in
the US alongside the Supreme Court Justice, characterised by medical professionals
having complete control over the terms, conditions and content of their work and were
free to follow their own clinical judgement. The rise of private health insurance
companies, employers financing health insurance, investor owner health enterprises for profit hospitals and clinics and increased management by Government agencies, Freidson (2001) argues, have led to changes in the labour status and division of labour within the medical profession. Many physicians have become employees and are in contractual agreements with those who pay for their patients’ services. There is increased control of both the doctor and patient choices due to efforts by insurance companies to restrict coverage and develop objective medical criteria on which to assess claims. Freidson (2001) argues that the ideologies of consumerism and managerialism have come to dominate the discourse on health policy. The professional ideology challenges both of these ideologies in asserting the need for a monopoly in the market place, claiming self direction and the freedom to make judgements in providing patient services. Freidson (2001) suggests that while the medical profession has experienced such changes and challenges to its ideology, medicine still resembles the ideal type of the ‘third logic’ as a method of organising and controlling the social, economic and cultural circumstances of its practice, albeit somewhat diluted than at the start of the 21st century. Such a shift from the ‘Golden Age’ of medicine to the ‘Post Golden Age’ can be observed in both Ireland and England over the last two decades, despite differing cultural and health service contexts.

Such a history of the medical profession draws upon the Foucauldian perspective that a historical analysis is needed to understand the ways in which medical knowledge is reconstituted over time. Foucault’s ideas can be adopted in the study of the medical profession in an alternative manner through the governmentality lens, as an analysis of how the state may govern the profession, how individuals and groups are governed
and how they govern themselves. In addition to studies on the medical profession which have drawn upon Foucault’s analyses (Freidson, 2001; Johnson, 1995; Nettleton, 1992; Arney, 1982; Armstrong, 1982), many studies on accounting have also adopted a Foucauldian perspective in analysing the ideas and instruments of those seeking to reform organisations and individuals through accounting practices and how those accounting practices become mobilised.

2.1 Governmentality

Many studies of accounting, drawing upon Foucauldian analyses, have demonstrated that accounting, as a set of calculative practices, makes visible the activities of organizations and the activities of the individuals within those organizations (e.g. Hopwood, 1987; Miller & O’Leary, 1987, 1990, 1994). Foucault’s (1991) concept of governmentality and panoptic control has been central to these accounting studies. They argue that the calculative practices of accounting enable new ways of acting upon individuals and influencing the actions of those individuals. Miller (1991, 2001) and other authors (e.g. Rose & Miller, 1992; Robson, 1992) were concerned with the distinctive ways in which accounting seeks to act upon the actions of others in relation to the notion of ‘acting at a distance’. This notion formulated in the writings of Latour (1986, 1987) and Callon (1986) addresses how it is possible to act on events, places and people that are unfamiliar and in a different location. The calculative practices of accounting may be looked at in this way as a means whereby those at a centre, having particular information about events and persons distant from them, govern economic activity, social life and individual conduct. Miller (1991, p.738) defined action at a distance as ‘the possibility of a particular point becoming a centre with the capacity to influence other points that are distant, yet without resorting to direct intervention.’
Miller (1992, p.64) argued that ‘as a practice of government, accountancy might best be viewed as a form of what the Greeks called a *techne*, that is to say, a practical rationality governed by a strategic ambition, rather than as a cohesive and more or less coherent body of knowledge.’ It was argued by Rose & Miller (1992) that liberal government is dependent on calculative technologies for ‘governing at a distance’ and to give effect to governmental ambitions. They suggested that the power of government arises from an assemblage of forces by which particular objectives can shape the actions and calculations of others.

Miller (2001, p.380) stresses that management accounting seeks to provide a link between responsibility and calculations and therefore ‘seeks to affect the conduct of individuals in such a way that they act freely, yet in accordance with specified norms’. As such, management accounting does not act directly on individuals but rather acts on the actions of others. The relationship of power in this sense is not one of domination but rather one that attempts to act upon the actions of individuals constituted as agents, capable of choosing from a range of options. Miller (1992, p.66) therefore argued that ‘accounting seeks to bring the actions of ‘free’ individuals into accord with specific objectives by enclosing them within a calculative regime.’ While some calculative technologies can operate as negative checks on the actions of individuals, of greater importance is the discretion and individual decision-making that they may support or require (Miller, 2001). This notion implies that accounting systems seeking to instil responsibility in managers may transform the individual manager into a decision-maker. On this basis Miller went on to explore how accounting, as a technology of government, invents calculating persons (‘calculating selves’) and calculable entities (‘calculable spaces’). Rose & Miller (1992) analysed
the calculative practices of accounting as ‘technologies of government’ and shed light on how the calculative practices of accounting, in making new ways of calculating, seek to make new ways of governing individuals to produce an individual who comes to act as a self-regulating calculating person.

Ahrens & Chapman (2007) support Hopwood & Miller (1994) and Miller & O’Leary (1987, 1990, 1994,) regarding the strategic and programmatic ambitions of accounting, in their analyses of the strategic uses of the calculative practices of accounting within organizations. Ahrens & Chapman (2007) recognise that accounting can be used to discharge formal obligations, communicate with colleagues or pursue informal objectives and that through such uses, they argue that accounting can potentially make significant contributions to the ways in which organisational motivations take shape and the ways in which organisations coordinate intentional action. They suggest that the values, desires, feelings and judgements of the actors surrounding the strategic, commercial, technical and political uses of accounting are relevant to the evolution and eventual acceptance of the calculative practices of accounting. Ahrens & Chapman (2007) have a detailed concern for the activities of agents, analysing the detailed practices through which accounting may be mobilised by organisational members. They focus on the possibilities of management control systems as a resource for action. This practice perspective emphasises the ways in which the actors’ motivations come to be constructed through the daily effort of individuals engaging with each other and with the management control systems. Ahrens & Chapman (2007) analyse the conditions that render accounting operable in specific modes as a structure of intentionality, giving greater prominence to managerial intent. While this paper identifies with the analyses of Ahrens & Chapman
in analysing the everyday activities of individuals, observation of the daily activities of doctors and nurses was not appropriate within the hospital setting.

Miller (2001, p.381) argues that ‘not only can the manager of a global corporation be governed in this manner, but so too can a doctor, a school teacher, or a social worker.’ This paper will explore whether Miller’s argument is reflected in the case of the medical professional within a hospital setting, where the use of accounting information by doctors and nurses in their everyday lives will be examined and whether, after a period of time (nine years), they take hold in the everyday life of a hospital setting.

Figure 1. Insert about here

Recent studies of the dynamics of the encounters between medics and accountants (Kurunmaki and Miller, 2010; Miller, Kurunmaki & O’Leary (2008); Kurunmaki & Miller, 2006) suggest that the development of a medical-financial ‘hybrid’ is dependent on specific national and organisational contexts. Miller et al., (2008, p.943) define a ‘hybrid’ as a new phenomena produced out of two or more elements normally found separately. Hybrids, they propose, include the practices, processes and expertises that make possible lateral flows of information and cooperation across boundaries of groups of organisations, firms and groups of experts or professionals. Kurunmaki, Lapsley & Miller (2011, p.4) suggest that some ideas and practices ‘travel light’ while others do not and argue that we need to understand more fully the ways in which management accounting practices are used by various organisations and national settings within and beyond the state. They argue that we need to further
explore the conditions under which a hybridisation of the calculative practices of accounting can occur. This paper seeks to understand these conditions in the health care context, to extend our theoretical apparatus for understanding how and why degrees of hybridisation of medical-financial expertise occur and the implications of this for the financial management of health care provision.

The next section of the paper describes the environment in which the hospital was functioning across the two decades from 1991 to 2009 and the cascade of policy initiatives and instruments of governmentality that gave rise to the new management accounting practice at the hospital level.

3.0 The discourse and programmatic ambitions of Government

This study took place in a large public university hospital in Ireland (named Sanctus University Hospital for the purposes of this study) during a time of significant reform in the health service spanning the two decades at the turn of the twenty first century (1992-2009). These reforms within the health care industry stem from the ‘modernisation’ of the civil public service with the imposition of an emerging ethos of ‘strategic planning’. The concept of accountability is a core principle of the strategic planning process by means of the efficient and effective use of scarce resources. In this respect, the reform agendas during the period under review have brought about policy, legislative, structural and management reforms.

In 1991, a National Case-Mix project was introduced by the Irish Government whereby on discharge from hospital, in-patients in acute care hospitals were required to be classified using Diagnosis Related Groups (DRGs). To this end there was a
wider discourse on Diagnosis Related Groups and case mix measurement (Young, Swinkola & Zo, 1982; Fetter, 1991; Goggin, 1992; Wiley, 1992). The method of classification adopted in Ireland was that developed in the United States. The Government set out to link funding to performance, as budget allocations had heretofore always been based on a historical budget. Ireland observed the Australian case mix measurement system and found that it championed DRG weights and case mix measurement as a measure of hospital efficiency. The Economic and Social Research Institute in Ireland (a non commercial state agency which produces research that contributes to understanding economic and social change and that informs public policymaking in Ireland and throughout the European Union) were also champions of this method of allocating hospital funds. From 1993 a case mix performance related system of measuring efficiency and allocating hospital funds was introduced. In the first year, 5% of the hospital budget allocation was based on this measure of efficiency which increased over time to 10%, 15%, 20%, 30% by 2004 and is currently 50%. The discourse since 1993 has been that the aspiration of Government was to have 100% of hospital funding based on this performance measure. Sixteen years later this has yet to become a reality.

The case mix measurement technique requires that data on hospital activity is gathered from a ‘Hospital Inpatient Enquiry System’ (HIPE) which records the Diagnosis Related Groups. Cost data is extracted from the hospital information system and is allocated to thirteen cost centres, for example, theatre, imaging, drugs etc. This cost data and the activity data are merged to derive a cost per case for each DRG in each hospital nationally. Hospitals are benchmarked against their peers, hospitals being grouped according to size, specialty etc. Those whose costs per DRG
are lower than the national mean within the hospital group gain additional funding, while those with costs higher than the national mean lose funding. The largest gain made by a hospital since the introduction of case mix measurement has been €2.2 million (1% of the hospital budget) while the largest loss of funding was €2.8 million (1.37% of the hospital budget). The largest loss of funding for Sanctus University Hospital was €2.1 million, 1% of the hospital budget. These adjustments would have affected (increased or decreased) the hospitals’ allocation two years subsequently. Some limitations of this measurement technique are that it does not include patients treated on a day case and does not include outpatient activity. Both of these activities have increased in Sanctus University Hospital during recent years so as to improve hospital productivity.

Part of the rhetoric of government was suggested that case mix measurement was a mechanism of controlling health care expenditure\(^1\). However, it also created visibility surrounding hospital activity by measuring and analysing hospital activity at a new, more detailed level than had been the case prior to 1993. Comparisons across hospitals and the link to budget allocation facilitates competition amongst hospitals to be more efficient or more specifically to remove inefficiencies, thereby making them more accountable to Government and to citizens.

The rhetoric and discourse that emerged from 1991 that hospital funding would eventually be 100% linked to peer-group related performance\(^2\) had an effect on

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1. The Report of the Commission on Health Funding, 1989 (Dublin: Stationery Office)
hospital managerial and calculative practices. If funding was to be based on activity, hospital management wanted to know the cost of their activities. Hence, some proactive hospitals developed an interest in activity based costing and clinical budgeting. This interest in activity based costing was enabled by the introduction of annual service plans which was required by law under the Health (Amendment) (No. 3) Act 1996. These plans outlined the services to be delivered by each service provider within their budget during the year. Such service plans estimated the activities of the hospital for the year. Although the goal of proactive hospitals was to achieve a cost per specific patient, the implementation of activity based costing proved very complex with difficulties encountered with the information systems at the individual hospital level, in addition to the significant cost of implementation. Therefore, the process of implementing activity based costing led to changes in the management control practices of the hospital such that a system of clinical budgeting emerged. This brought the managers and the clinical directors together for the first time in managing the hospital clinical activities, alongside the management of the hospital finances.

Following the introduction of the service plans, the government sought to introduce a third major reform, a prescribed hospital management structure that would bring together the expertise of doctors, nurses and a business manager. This led to the national launch in 1998 of a ‘Clinicians in Management Initiative’ by the Department of Health and Children. The programmatic ambition of the initiative was to improve patient care and enhance accountability by closely involving clinicians and other health care professionals in the planning and management of services. This was based on the internationally recognized notion that the most effective use of resources for
the patient could be guaranteed by moving decisions which affect patient care as close as possible to the patient care setting (Heyssel, Gaintner, Kues, Jones & Lipstein, 1984). The model of management structure that was decided upon was that of the Clinical Directorate model. This model was based on the structure developed at the John Hopkins Hospital, Baltimore (Heyssel et al., 1984). The model is characterised by accountability, medical leadership and executive control.

The rhetoric of the model was to engage clinicians in the management process through a combined role as clinician-manager, the use of independent cost centres and devolved budgeting. Within this model, the hospital is divided into clinical directorates reflecting a medical specialty. Each directorate is managed by a triadic structure made up of a clinical director (usually a doctor), a nurse manager and a business manager. Four pilot sites had implemented this model of management in Ireland and were show-cased at the launch of the ‘Clinicians in Management Initiative’ in 1998, in order to represent best practice and encourage hospitals to follow suit. However, it was not mandatory and was not encoded in legislation. The initiative was designed to gradually train staff in hospitals across the country by means of a support agency, the Office of Health Management, a training subset of the Department of Health and Children. Few public hospital sites developed this model of management. Ten years later, in 2009, the Health Service Executive enforced this structure as mandatory in public hospitals. In 2009, Clinical Directors were appointed by the Health Service Executive to manage the hospitals in the way that was envisaged and encouraged in 1998 (eleven years earlier).
While many other reforms (policy, legislative, structural and management) were introduced during the last two decades to govern the Irish health service, the three reforms outlined above (case mix measurement, service planning and clinicians in management initiative) were the key reforms that influenced changes to hospital management control systems. Figure 2 provides a diagrammatic representation of the instruments of governmentality used by the Government to influence the management of the public hospitals.

**Figure 2. Insert about here**

### 4.0 Research Method

This paper was motivated by a desire to understand how and why different degrees of hybridisation of the medical-financial expertise occur in different national contexts and seeks to extend the body of work performed by Kurunmaki (2004), Kurunmaki & Miller (2008) and Miller et al. (2008) by developing the theoretical apparatus to aid our understanding of these differences. This in-depth study explores the ways in which accounting practices are used in the everyday lives of the doctors and nurses in a large university hospital in Ireland, a different context to Finland or England. In order to gain an understanding of the medics’ world, qualitative methods were used. The perceptions of medics and managers in the hospital have been used in conjunction with other qualitative sources to illuminate and interpret the nature and impact of the implementation of a new management control practice labelled ‘clinical budgeting’ within the hospital. The complex nature of accountability for health expenditure necessitates its examination in context in order to illuminate the multi-faceted ways it is experienced and enacted in specific organisational settings.
The case evidence is constructed from forty in-depth interviews conducted at three levels; at the policy level (twelve), at senior management and clinician level (fifteen) and at nursing, junior doctor and middle management level (thirteen). These interviews amounted to a total of sixty seven interview hours. Interviews were held with senior civil servants in the Department of Health and Children, in the Economic and Social Research Institute, the Independent Hospital Consultants Association and within the health insurance companies, all agents external to the hospital boundaries, in order to gain an understanding of the reforms at the programmatic level. Table 1 provides details of the entities and actors interviewed at this level. While the knowledge and perspectives of these individuals informed the case study, the paper draws predominantly on the experience of hospital staff; the medics who were chairs of their clinical divisions and administrative managers.

**Table 1. Insert about here.**

At the hospital level senior management were interviewed about the management practices and processes that were affected by Government policies and programmes. Interviews were carried out at Sanctus University Hospital over two research phases, the first at senior management and senior clinician level while the second phase penetrated further to nursing staff, junior doctors and business managers. Phase I was a six year period from 1994 to 2000 and phase II was a snapshot picture in 2009. At the time of the interviews, Sanctus University Hospital was divided into five clinical divisions with a doctor appointed as ‘chair’ of the clinical division. As it was these doctors who were required to use the new clinical budgeting system and attend monthly meetings surrounding the information produced by this new management
control practice, it was these doctors who were interviewed. Only the ‘chair’ of each clinical division was interviewed during phase I of the study. At that time no other doctors or nurses were presented with or were using the information produced from the new clinical budgeting system. The members of the senior and middle management team were chosen for interview because of their involvement in the creation and operation of the clinical budgeting system. This group of managers included the deputy Chief Executive Officer (subsequently the Chief Executive Officer) the financial controller and the cost accountant. Table 2 details the actors interviewed at phases I and II of the study.

Table 2. Insert about here.

A number of additional evidential sources were also examined, including hospital internal documents (e.g. reports from the clinical budgeting system), the annual reports of the hospital, press releases and publicly available information about the hospital and about the reforms within the health care system across the two decades.

During phase I of the study a series of semi-structured interviews was held with the hospital senior and middle administrative managers and with other agencies. Doctors were also interviewed. All interviewees were sent a broad outline of the issues to be discussed prior to their interview. Interviews were performed until no new data was emerging from the interviews. Each interview was recorded, was between one and two hours duration and was subsequently transcribed by the researchers. Interviews with the managers lasted between one and two hours. Interviews with the doctors lasted one hour to one and a half hours.
The semi-structured interviews were designed to engage in a conversation about recent accountability reforms at the Department of Health and Children level and how those accountability reforms were experienced at the hospital level and why the doctors experienced the new forms of accountability in the manner in which they themselves outlined. The interviewers probed questions about the external and internal pressures driving the new forms of accountability, what the impact of these reforms was for the medics and why they had such an impact.

The researchers returned to the field site nine years after the implementation of the clinical budgeting system to obtain a perspective of the management control system and how it operated and to explore whether it had become devolved during the intervening years. In this phase, interviews were held with senior management, middle management, doctors who were chairs of clinical divisions, doctors who were not chairs of clinical divisions, nurses and business managers. The objective of this phase of the study was to explore the role of the new management control system within the hospital by analysing how the management control system was used in the daily lives of the key actors in the hospital, being doctors and nurses. The questions were aimed at eliciting a basic role description from the interviewees along with a basic description of the clinical budgeting system from their individual perspective. Questions were then asked about the information from the clinical budgeting system that they might draw upon on a day to day basis, hospital changes stimulated by the clinical budgeting system since 2000, whether they had experienced a change in the language being used in the hospital to one of a language of ‘costs’ or ‘costliness’, the nature of the relationships between medics and managers in the hospital, in addition to
their perspectives on the ambitions of management and the ambitions of medics for the clinical budgeting system. Once again, all interviewees were sent a broad outline of the issues to be discussed prior to their interview. Interviews were performed until no new data was emerging from the interviews. Each interview was recorded (except for two interviewees who did not want the interview to be recorded) and transcribed by the researchers. Interviews were between one hour and one and a half hours.

Detailed notes were also taken throughout each interview. Analysis of such notes with senior and middle management allowed the researchers to identify issues for further probing during subsequent interviews.

The analysis of the interview data involved three processes: data reduction, data display and conclusion drawing/verification (O’Dwyer, 2004). The first analysis of the transcripts and interview notes identified a number of themes from each interview. These were compared across the interviews and grouped into overarching themes. Further readings of the transcripts and field notes and their analyses revealed that there were subthemes within each overarching theme. The data analysis was overlapping and iterative (Ahrens & Dent, 1998; Atkinson & Shaffir, 1998; Baxter & Chua, 1998; Ahrens & Chapman, 2006). A coding scheme was developed in order to aid identification of the themes for each interview. A comparison across the interview data enabled patterns and explanations to be identified. Findings that did not fit with the emerging patterns identified in this process of analysis were highlighted for subsequent discussion as the research continued. The data analysis reveals the calculative accounting practices and processes which are linked to the policies and
programmes enforced by Government. It also reveals the perspective of the medical professionals who are required to adopt such calculative practices and processes.

5.0 The Case Findings

The longitudinal study from 1994 to 2000 (phase I) is analysed as to the events and programmes that gave rise to the new management accounting practices and provides evidence of some of the effects of such new calculative practices within the hospital. The revisit to the case site in 2009 (phase II) is then analysed which explores whether over time the calculative practices of accounting have percolated to the everyday lives of doctors and nurses.

Phase I: Longitudinal Study 1994 - 2000

The case study findings reveal that there were both external and internal stimuli for the emergence of new accounting technologies. There was also a variety of consequences within the hospital of the new management accounting practices; social life within the hospital was affected whereby relationships amongst different professional groups were affected as were relationships within some professional groups. There was also an effect on the actions/behaviours of individual medics.

The key actors during this phase identified five key influences as stimulating the emergence of the new management accounting practices. These were analysed as the introduction by Government of case mix measurement, an anticipated change in the approach to hospital funding, new accountability legislation requiring the preparation of service plans, a discourse surrounding the clinical directorate model of management and the model of patient care in Sanctus University Hospital. Each of
these influences occurred over the time period 1994 to 2000, each advancing the case for new management accounting practices.

5.1 Phase I: Case Analysis

A programmatic analysis of the new management accounting practice

Over time, the researchers attempted to document and make sense of the instruments of governmentality imposed by the Department of Health and Children and how such instruments were used to govern the economic and social life of the hospital and of the individual actors in the hospital site. Interviews with management and with the clinicians revealed a variety of effects of Government reforms on the hospital. Both groups of actors talked about the opening of a new dialogue between senior management and some doctors who were chairs of clinical divisions. In addition cost savings and some process improvements were sought by some of these doctors. However, there were also some sceptics amongst the group of doctors interviewed in that some viewed the new clinical budgeting process as an attempt to shift the burden of accountability and responsibility from and by management to the medical profession. Some doctors interpreted the clinical budgeting process as a divisive instrument within the medical profession, whereby medical staff could now see each other’s activity levels and funding requirements, leading to potential conflict and more overt competition amongst professionals to secure resources. Such greater visibility of doctors’ activity levels and funding requirements, alongside potential conflict amongst the peer group of doctors in competing for resources suggests that the various instruments of governmentality imposed by Government on the hospital acted upon the economic activity, the social life and the individual conduct of some medical professionals.
Phase I is analysed in terms of the mechanisms of governmentality employed by Government in governing at a distance, making visible the activities taking place within the hospital and the rendering of doctors as governable and calculable persons. These are discussed in turn in this section.

5.1.1 Mechanisms of Governmentality

Rose and Miller (1992) suggest that liberal government is dependent on calculative technologies for ‘governing at a distance’ and to give effect to governmental ambitions. McKinlay & Pezet (2009) argue that governmentality involves the management of populations and that the very notion of population implies action at a distance. The imperative of managing from a distance became more acute during the 1990s, when the objective of the Irish Government was to contain costs as health expenditure was growing rapidly. The Government used three key instruments to achieve this ambition of cost containment, first the use of case mix measurement linked to hospital funding on a national budget neutral basis created competition for funds across hospitals. Second, the introduction of service plans, where planned activity levels were matched to estimated expenditure. Third, the promotion of the clinical directorate model of management through the Clinicians in Management Initiative. These three instruments of governmentality, case mix measurement, service planning and the clinicians in management initiative appeared to shape the actions of the hospital by focusing management attention on DRG coding practices, the design and implementation of a clinical budgeting process and attempts to engage doctors in the budgeting process by means of a monthly dialogue. The Government, from a distance, also appeared to have an influence on the calculations made by hospital
management through the design of a new clinical budgeting process and by the attention devoted to case mix measurement and DRG coding in order for the hospital to maximise funding.

5.1.2 Making visible the activities of the hospital

Hopwood (1987) and Miller & O’Leary (1987, 1990, 1994) have demonstrated that accounting, as a set of calculative practices, makes visible the activities of organizations and the activities of the individuals within those organizations. They argue that the calculative practices of accounting enable new ways of acting upon individuals and influencing the actions of those individuals. Case mix measurement, as a calculative practice, enabled government to see for the first time the numbers and types of DRG categories treated by each hospital, including the complexity of those cases and also enabled the government to compare the case workload across hospitals in the State. Case mix measurement along with anticipated changes to the funding mechanism and the introduction of service planning together stimulated the hospital to seek to make changes to its management accounting practices with the attempt to introduce activity based costing so as to achieve patient level costing and to design and implement a new clinical budgeting process. In this way Government acted upon the hospital ‘at a distance’ so that the hospital management acted freely in making these changes to its management control system. The hospital altered its management monthly reporting from a departmental basis to a clinical divisional basis. An ambition of management was to engage the doctors in the management of their activities and related economic consequences.
Dialogue between clinicians and management was stimulated by the requirement to prepare a service plan for 1999 (in accordance with the Health (Amendment) (No. 3) Act 1996). Clinicians and management met to prepare this plan of activity for the year for each clinical division (divided into categories of in-patients and day care patients). At the first such meeting no reference was made to the financial aspects of the plan. It was at the second meeting that the financial budget was matched to the service plan. At subsequent meetings trends in activity were observed, discussed and explained by the clinicians. The analyses of activity variances (explained by the clinicians) were linked to the financial variances (explained by management). Medical issues highlighted by these analyses often led to further meetings between clinicians to solve critical medical problems. The management accountant described the commencement of this new dialogue and how both management and clinicians began to understand each others’ worlds.

It was purely activity information, no financial information. We did the financials in the background. It certainly got the discussion going… So it gave us something to talk about because we now had a budget that we could link to activity and so the trends in activity were quite clear when you looked at the budget, which is something that we didn’t have before. (MA)

As witnessed by the management accountant, there is a sense that the new management control practices had an effect on the individual conduct of some medical professionals.

And they [the doctors] also asked a lot of questions. ‘And why is that? Why have I overspent on that?’… So the debate would be a very very good debate. They would talk about why their activity was up, the issues surrounding the fact that their activity was down… And so really the main benefit is that from the clinician’s point of view we were hearing the problems that they were experiencing and they were hearing the
financial trends that go with those problems… It meant that because they were armed
with this information they could take it away to another forum or committee. (MA)  
Management contends that this new dialogue between management and clinicians
resulted in the clinicians seeking new information about their activities. The clinicians
began to request information about the mix of patients they had treated (which
enabled the doctors to gauge if they were reducing waiting lists or creating waiting
lists), their bed day usage, the laboratory tests and x-rays ordered. They also
demanded that existing activity information systems (from the Hospital In-Patient
Enquiry System) be linked to the new accounting system, so that they could establish
what procedures were being performed, as well as the number of procedures. In
addition, as explained by the management accountant, this provided an opportunity to
examine the complexity of cases and options in their treatment.

We have now got to the stage where I think the clinicians are looking for more
information, in terms of activity. They would like to know what these cases are.
What types of cases? They want to look at complexity levels, particularly for service
planning… The consultants are beginning to look for more information, more
relevant to the day to day work that they do… So they are asking all the right
questions. (MA)

This newly created clinical awareness suggests that clinical budgeting may have
empowered some clinicians to question and to discipline themselves, by engaging in
a new form of decision making. This new clinical awareness, which developed from
clinical budgeting, and the resultant changing environment of shared responsibility is
summarized by the costing specialist of the hospital.

I suppose the main effect is that it has created a dialogue or discussion with the
doctors that wasn’t there before. You will find that you will get stopped in the

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3 Interviewees are denoted throughout the phase I narrative by the letter MA for management accountant, S for senior managers and DC for doctors who are chairs of clinical divisions.
This changing environment and the emerging dialogue between clinicians and management were also reported by the clinicians. The chair of radiology reported that simply having the opportunity to explain activities has engendered a sympathetic and constructive environment.

It is extremely difficult running a hospital as compared to a factory I think. But it has made us look at ourselves and we have made great savings on things like contrast buying, direct negotiations. (DC)

The perception among clinicians that the new accounting practices have provoked them to question and examine the economic consequences of their decisions and practices suggests that some doctors may be transformed into calculating selves. The data presented also indicates that the new calculative practices act as a surveillance technique, which has created a new visibility surrounding the actions of the clinical divisions. The question remains however, to what extent this has permeated through the organisation, to the doctors and nurses treating individual patients?

However this perception of the new clinical budgeting process must be viewed alongside an opposing perspective of some other doctors, who claim that it has created a potential for conflict amongst themselves for internal scarce resources and a new scrutiny of each other’s activities. A chair of a clinical division illustrated this new environment.

One of the problems about all of this is that it does mean that medical staff are looking at each other’s activities in a far more critical fashion, and the potential for conflict is much higher, which is not necessarily a good thing. And there is certainly an element of the administration getting ‘off the hook’ … (DC)
This clinicians’ interpretation is that the new calculative practices are rendering visible their actions and thereby making them more susceptible to control by one another and by the hospital management. At the end of phase I of the study, it was evident that some chairs of the clinical divisions were actively engaged in the clinical budgeting process while other doctors were sceptical of the intentions of management by their introduction of the new management accounting practice. However, it was impossible to determine whether the clinical budgeting had been devolved down to the ward level as only the chairs of the clinical divisions were receiving the monthly management reports and attending the monthly meetings with management. It suggests that the notion of accounting making visible the actions of individual actors had taken place to some extent yet only at the clinical divisional level. This paper seeks to question how, and to what extent, the language and tools of accounting have diffused and permeated into everyday practices. There is a sense that some doctors began to pursue cost savings and process improvements. One chair of a clinical division reported savings made as a result of introducing computerized radiography, negotiating the contract for consumables used in the department and renegotiating the contracts for capital equipment.

So there were certain glaring problems, if you like, when I started. In that we were paying an awful lot of money for film, contrast and also for our contracts for servicing. So basically what I have done is concentrated on those 3 areas, so we really negotiated the contracts for the contrast and saved money, we have persuaded management that we should go along the lines of computerized radiography… The other thing is we are renegotiating the contracts for our equipment... because that money is going to be ploughed back into the department. Now if I thought that money was going into a general pool I would say, ‘ah, heck! (DC)
This suggests that the medics expect their departments/divisions to be rewarded for any process improvements and consequential savings made. This developing clinical awareness of the economic consequences of decisions is exemplified by the fact that the majority of clinicians interviewed, observed that clinical budgeting could provide useful data to enable them to manage their divisions.

Clinicians view the new calculative practices as providing data for medical planning purposes. It is intimated that this would constitute a change in work practices. This was also identified by the management accountant.

It is a change in culture. You are changing the culture because you are asking all of the heads of Departments what is it that happens?… It is a new set of information that nobody has ever required before. It is an additional function that people have to carry out. (MA)

Miller (2001) stresses that management accounting seeks to provide a link between responsibility and calculations and therefore ‘seeks to affect the conduct of individuals in such a way that they act freely, yet in accordance with specified norms’. The fact that some doctors are seeking cost savings and process improvements, incentivised by retaining those savings to spend as they decide, would suggest that they are as Miller (2001) suggests, acting freely, yet within specified norms. The evidence from the case site suggests that the practical rationale of a variety of Government programmes to control health expenditure, may be viewed as instruments of governmentality which acted at a distance to influence the economic activity and social life of the hospital whilst also shaping the actions of some members of the medical profession.
5.1.3 Constructing governable persons? Constructing calculable persons?

The impact of the new clinical budgeting process such that a new dialogue has been created between management and doctors, resulting in the doctors asking new questions about their medical activities, some doctors seeking cost savings in their clinical divisions alongside process improvements, would indicate that some doctors have become calculating persons, making decisions freely with the new information available. The problematic issue is that the new management accounting practice has not invented ‘calculating doctors’ across the hospital as a whole, it has remained at the chair of the clinical divisional level and does not prevail across all such chairs. At the end of phase I of the study, there was a sense of a changing role of the clinician, whereby the doctor’s role was transforming into a hybrid one, as a doctor and as a manager, but only at the clinical divisional level. However, it was too early in the process of implementation to conclude on this changing role. It was anticipated that revisiting the site some years later would reveal whether this new role will have developed.

Figure 3. Insert about here

5.2 Phase II Case Analysis: 2009

The same site was revisited nine years later, in 2009, to explore whether the new management accounting practices had become embedded in the organizational life of the hospital, through devolved clinical budgeting. The revisit was also intended to determine whether all categories of clinicians, doctors and nurses were using the information from the clinical budgeting system in managing their everyday lives at
the ward level such that they could be rendered calculable and governable persons. This revisit and follow up of the case site is a unique aspect of this study.

This section summarises some differences in the site between the years 2000 and 2009. Phase II of the field study is then analysed under three headings; case mix measurement and the everyday life of the hospital, the everyday lives of nurses and clinical budgeting information and the everyday lives of doctors and clinical budgeting information.

5.2.1 Has accounting seeped into the everyday lives of doctors and nurses (2000 and 2009)?

At the end of the longitudinal study 1994 to 2000, the view of management was that the clinical budgeting system was operational. The flow of information and dialogue that emerged by 2000 is illustrated in Figure 3, alongside a comparison of the process that was operational during the revisit to the case site in 2009. At the end of Phase I, a simple flow of management accounting information went from the financial controller to the heads of the clinical divisions and was brought for discussion alongside clinical matters to the forum of the monthly divisional meetings. At that time no sanctions existed for budget overruns. Where expenditure was below budget, the only reward was that the division was enabled to purchase necessary capital equipment for their division.

Between the two research field visits 2000 and 2009, a new corporate governance structure was introduced on 1 January 2002, which altered the governance of the hospital from being a voluntary agency managed by a charitable religious order to
being a company limited by guarantee with a share capital and managed by a board of directors comprising seven non-executive directors and five executive directors. The day to day management of the hospital was now managed by an executive management committee comprised of senior management staff, both clinical and non-clinical. This change in governance, the withdrawal of the religious management and the introduction of a stronger managerial component of the board of directors and executive management committee may be expected to affect the financial management and accountability of doctors and nurses at the ward level. On revisiting Sanctus University Hospital in 2009 it was possible to access additional voices including nursing staff, doctors who were not chairs of clinical divisions, and business managers. This revisit found that the clinical budgeting system remained at the clinical divisional level, activity based costing had not been implemented nor had patient level costing. It was also revealed that nurses at ward level were not using any information from the clinical budgeting system nor were doctors below the level of the chair of the clinical divisions, during the course of their daily lives. It was evident that the clinical budgeting process did not permeate to the operational level within the hospital. Until the year 2009, there were few sanctions for exceeding budget and no rewards for staying within budget. It appeared that patient care was unaffected by the clinical budgeting system except in a financial crisis where beds may be closed and services cut.

Discussions with all groups of staff across the hospital revealed that only in extreme circumstances has patient care been affected by budgetary matters. The CEO mentioned that six years had passed since it was necessary to reduce services by closing hospital beds and wards. In discussing sanctions for budget overruns and
rewards for under spending, in the past the only sanction has been to close beds or wards. This was supported by all actors interviewed, from management to nurses to doctors.

The CEO summarised the sanctions that were now operational in 2009, which go beyond closing hospital beds and relate more to the daily activities in that financial restrictions are placed on the cost of overtime, of locums, of agency costs and on the purchase of equipment. A consultant doctor confirmed the CEO’s perspective that any savings achieved by one division will be used to supplement the overspending of another division. This is different from the experience observed in Phase I of the study where divisions were allowed to keep any savings made. The new governance of the hospital, now a company limited by guarantee with a stronger managerial component at board and management committee level rather than a charitable entity, may have affected this practice. This has removed any incentive for chairs of divisions to pursue cost savings. The overall sense is that until the year 2009 there were few incentives for clinical divisions to come within budget. However, since 2009 as hospital management seek to come within budget for the hospital as a unit, any savings in one area are used to supplement overspending in another division. In addition there is greater visibility surrounding the activities of the doctors and nurses within the hospital such that financial restrictions exist where none existed previously, on the cost of overtime, locums, agency costs and equipment purchases. In this way, it may be viewed that Government acting at a distance, affecting the actions of hospital management and clinicians, has impacted on the economic activities at the hospital level. In spite of such restrictions on economic activities, best attempts are made by each professional group to ensure that patient care is unaffected by budgetary matters.
However, this is not always feasible as services may need to be limited and staff numbers may need to be reduced, both measures inevitably may have an impact on patient care.

The flow of information and dialogue was perceived by management in 2009 to be more sophisticated than was the case in 2000. For the two largest clinical divisions, a new category of staff, a business manager, had been appointed to act as an interface between the finance office and the chairs of the clinical divisions and with the directors of nursing. Similar to Dent’s (1991) case study of the railways, there are now business managers when none existed before. In addition, a new nurse manager role was created, where an assistant director of nursing (referred to as ‘service nurse managers’ amongst the hospital staff) was appointed for each clinical division, being the point of contact with the business manager. When the roles of the clinical directors, the assistant directors of nursing and the business managers are considered in aggregate there is a far stronger managerial component to these clinical roles than in 2000 which is a significant change from ‘pure’ clinical practice and thus to the everyday life of the hospital at these senior levels. During the revisit, it was found however that for most divisions, the use of the management accounting information did not permeate beyond the chair of the clinical division or the service nurse managers, as junior doctors and ward nurse managers were not in receipt of the monthly management accounting information and therefore were not using this information in their everyday lives. An ambition for the management control system, expressed by management, indicates a third phase of implementation beginning in 2009/2010 of educating junior doctors and nurse ward managers, through a formal education programme, to engage with the clinical budgeting system in their day to day
activities. The penetration of an accounting consciousness appears more limited than the earlier study of Kurunmaki (2004) in Finland but is also different from the experience in the UK (Kurunmaki & Miller, 2008; Kurunmaki, Miller & O’Leary 2008). An analysis of these national variations is necessary to try to understand how and why such different degrees of hybridisation are occurring within the medical profession.

A number of themes emerged from the interviews which are presented as an empirical analysis of Phase II of the case study. These themes are presented in the following section of the paper under the three headings; case mix measurement and the everyday life of the hospital, the everyday lives of nurses and clinical budgeting information and the everyday lives of doctors and clinical budgeting information. A discussion of the role of accounting within the world of medicine is then presented.

5.2.2 Case Mix Measurement and the Everyday Life of the Hospital

The initial importance of case mix measurement faded over time during Phase I of the study (between 1994 and 2000) due to a lack of progress in its implementation by Government and stagnation of the proportion of funding allocated on this basis. However, during Phase II, the early part of the 21st century, following the largest loss of funding experienced by Sanctus University Hospital amounting to €2.1 million (1% of the total hospital budget) and following its expanded role in funding allocation to 50% of the hospital budget for inpatients and day cases, case mix measurement regained its importance as a management accounting practice. Regarding management’s ambition of achieving patient level costing during the 1990s, in 2009 the CEO explained that there was no incentive to produce patient level costs for
funding purposes, the main factor affecting the budget allocation was now case mix measurement. Therefore managing the case mix of the hospital and staying within budget were of utmost importance from a management control perspective and was where management focused their attention.

To be honest, things have changed quite considerably from my vision of the patient based costing and specialty based costing in the late 1990s and early 2000s, because circumstances have changed quite a lot. There is no incentive and there is no appetite for it [patient based costing] at the moment. It is at the back of everybody’s head and it is aspirational and it is where we would like to be, but in the scheme of things it is a long way away… It would always have been nice to do but managing your budget is the most important thing and protecting your case mix base. (S)

The CEO explained that due to this loss in funding of €2.1 million in one year, management had focused on developing the record keeping of clinical activity for case mix measurement purposes, this being the most important factor to influence the allocation of funds. The director of finance stated that the loss of funding focused the mind of management on the hospital’s case mix and on the coding of hospital activity. Furthermore the imposition of a new Consultant’s Contract by the Minister for Health and Children (in 2009) has introduced restrictions on the amount of private work a doctor employed in the public sector can perform. This restriction is computed by reference to complexity of workload and is therefore linked to the case mix measurement system. Some problematic issues surrounding case mix were identified leading to inequity of allocation of funding across different hospitals. For example, blood tests performed in some hospitals are recorded as part of the activity and workload whereas in Sanctus University Hospital such tests are not included in

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4 Interviewees are denoted throughout the phase II narrative by the letter S for senior managers, MA for management accountant, DC for doctors who are chairs of clinical divisions, DNC for doctors who are not chairs of clinical divisions, SNM for senior nurse manager, NM for nurse manager and BM for Business Manager.
activity recordings. In addition, work performed on a day case basis in non-specified
day care settings are excluded from case mix in Sanctus University Hospital, while in
other hospitals day case activity is included where they have specified day care beds.
There was a sense that despite working more efficiently, this work was not recorded
in case mix and therefore ultimately gave rise to an inequitable allocation of funding
across hospitals.

The role of case mix in managing the hospital finances and activities was highlighted
by the CEO.

The good thing about it is, it’s hard to understand for the lay person, you would want
a PhD in advanced mathematics to sort out case mix, it is very difficult to explain it
to the board, their eyes just glaze over. It has become so sophisticated now that we
are in a position to promote what is going to benefit the hospital financially and close
up the loops on the areas that will damage the hospital… Some hospitals wouldn’t
have the same level of concentration, they just let it happen. You can’t just let case
mix happen, you have to manage it. (S)

The CEO also highlighted the dysfunctional effect of the funding mechanism and the
lack of incentives to treat increasing numbers of patients. He explained that improving
the length of stay and moving patients out of the acute hospital setting costs the
hospital more than keeping the patient for longer.

There is no rationale under the Irish healthcare system. Normally the more efficient
you are the less costly it is, for all. But the more efficient you are in our service, the
more costly you become, because of the fixed budgeting system where there is a
disincentive to be efficient. The longer you leave a patient in a bed the less costly
that patient becomes. There is no financial incentive to move the patient on, because
the next patient becomes more costly, for the first 3-4 days. (S)

The notion of keeping a patient in an acute hospital bed, rather than moving the
patient to an alternative facility, and treating additional patients so as to keep costs
down and stay within budget, is all the more dysfunctional when waiting lists are growing nationally, as a consequence of which patients are being sent abroad for medical treatment. It is evident from the data collected that case mix measurement is only of importance to the senior management of the hospital and it has not filtered down to non-consultant hospital doctors, junior doctors or nursing staff at ward level. This is despite the fact that the daily clinical activity and complexity of workload, performed at the operational level within the hospital, are the key factors that influence the amount of funding received by the hospital.

Since 2000, there is now a greater emphasis on medical recording in order not to lose funding. Stronger bonds are being built between two texts, between the patient’s medical record and the profit and loss account of the hospital. In addition admittance and discharge policies have been fundamentally influenced over time. While such decisions are made at the senior management level within the hospital, such changes are bound to affect, in some way, the everyday work of doctors and nurses at the ward level. It appears therefore that the programmatic ambitions of Government through the calculative practice of case mix measurement is acting at a distance and is impacting on the daily life of the hospital while not resorting to direct intervention.

5.2.3 The Everyday Lives of Nurses and Clinical Budgeting Information

The different voices across the hospital have similar perceptions of nurses’ use of clinical budgeting information suggesting that such information is not used at the ward level. Education and training about hospital budgets for nursing staff was a common theme throughout the interviews. The director of nursing, assistant directors
of nursing and the CEO recognise this as a training need. The director of nursing highlighted this to be the case, especially in Ireland.

From a nursing perspective, we always feel we need more education about budgeting. That would have been reflected in different ways. Training in other countries, the Clinical Nurse Managers i.e. the front line manager, would have the training in budgeting from an early stage, but that is not the case in Ireland… They [nurses] would be aware of the budget, some would be more aware than others, but responsibility rests with the Service Nurse Manager. So it has filtered down to that extent. (SNM)

An explanation of the devolution of clinical budgeting to the level of the service nurse manager in each clinical division was revealed during the interviews, in that some service nurse managers do not pass on the budgetary information to their ward managers. However, senior management were of the understanding that this was already taking place. The director of finance explained that this is a recent revelation to senior management and outlined how they plan to address the matter.

It [accounting information] does permeate in certain cases but not all. We’ve only just discovered that, we [senior management] thought it went to every ward manager, some of the service nurse managers weren’t passing it on. They didn’t let their nurse managers have the information. So it has gone back to the business managers. If he doesn’t have some of the information, we will be sending information directly to the nurse managers, because our view is everybody should be getting that information. (S)

This suggests that the hierarchy and power struggles within the nursing profession may be a factor contributing to this lack of devolution. While senior management believe nurse ward managers should be managing their ward at every level, if they are not provided with relevant management information, it is impossible for them to manage the ward other than at the patient level. This dilemma and lack of communication is highlighted by the CEO’s opinion on the role of the ward manager,
when viewed in light of the fact that many ward managers do not receive the clinical budgetary information.

Nurses are very underdeveloped in terms of management and management training. We have Clinical Nurse Managers level II. Their rather limited view on life is that they manage the patients on their wards and that is it and they don’t manage the ward… (S)

An assistant director of nursing explained that when the clinical budgeting system was first implemented it had no impact on her daily work but has now become relevant on being promoted to assistant director of nursing and a clinical nurse manager level II. She outlined the budgetary process from her perspective and her view on the devolution of accounting information:

Every week we meet with the business manager, the two Assistant Directors of Nursing for Surgery, the Chair of the division of surgery and the business manager and apart from other things, we discuss the finances… Every month then we would get information on how we are doing, what each theatre is spending, whether we overspent, what we overspent on… Speaking for myself, although I expect them [nurse ward managers] to be accountable and maybe I am tripping myself up, I do not give them a budget, well I can’t really because this is the surgery budget, it stays with me. (NM)

However, this assistant director of nursing has an expectation that her staff should be conscious of costs which appears to be at variance with keeping the budgetary information to herself.

In addition to the lack of permeation of management accounting information beyond the assistant director of nursing level to the ward managers, there is a sense that the organisational intent and the individual intent are not aligned. It suggests a hierarchical approach to management as opposed to a collegial or collaborative
approach. It also suggests an attitude amongst the assistant directors of nursing that knowledge equals power, suggesting that the prevailing organising principle is that of the hierarchy principle which relies on authority as a controlling mechanism (Adler et al., 2008).

5.2.4 The Everyday Lives of Doctors and Clinical Budgeting Information

Interviews were carried out with the chairs of the clinical divisions, with consultant doctors who were not chairs of divisions and with junior doctors. As with the nursing profession, the data collected revealed that doctors (other than the chairs of a clinical division) pay little or no attention to the clinical budgeting information. The doctors stated that they never use the clinical budgeting information, that it is used only at senior management level, that many consultant doctors do not attend their monthly divisional meetings where the budgetary information is discussed as ‘it seemed pointless’. The professor of their specialty attends the monthly divisional meetings and reports back to the monthly departmental meetings, should any relevant financial matters arise. Even at the departmental meetings, it was revealed that financial issues are rarely discussed, except in the context of nurse appointments and equipment replacement or purchase. When asked about using the clinical budgetary information one consultant doctor stated:

Absolutely not, only on a crises basis, not monthly or weekly or daily…We have a divisional budget, and beyond that, are crisis managed. (DNC)

Furthermore the consultant doctors outlined that they have never received information of their own activity levels.

I have never had an output of my activity levels, inpatients, outpatients or a year on year comparison. I am now receiving information regarding my public / private mix only because of the new Consultants’ Contract. (DNC)
A consultant who had been employed in another public hospital revealed a different experience across the two hospitals, one where no information of activity is received and the other where 2-3 year plans of activity are made.

The director of finance explained the role of the doctors from a senior management perspective:

The chairmen of the divisions as we call them, they are all advocates for the rest of the clinicians in that division… Advocates for changes, as opposed to being the one looking over, ‘Well how many surgeries did you perform this week and are you utilising the theatre properly?’ (S)

In terms of daily interaction with hospital finances, the director of finance explained the process of expenditure approval.

They [doctors] ring for financial approval. They know they have to come through myself, to get locums in, if there was somebody out sick or on maternity leave and things like that. They ring here looking for financial approval to order a PET or whatever and then an order is raised in patient services. Basically it’s our way of monitoring what is being requested…(S)

This was confirmed by the consultant doctors who highlighted that ‘any locum service and overtime now has to be approved by the director of finance of the hospital.’ When asked whether the doctors use the monthly management accounting data, the director of finance suggested that they do not.

I wouldn’t think so, I’d say for a lot of them it’s only if there’s an issue raised in a certain area… These people are paid as managers, you know what I mean? You are expecting them to manage. The next option is to take away all responsibility as a devolved budget and manage it centrally, which is not what we wanted to do (we were nearly tempted last year to do it a few times, given that the situation was going so bad) but that’s taking a huge step back. If we do that we are going away from the devolved budgets. And so, I suppose, what we do is we reinforce it, we have the
director of nursing reinforcing it, we have the chairman of the division reinforcing it.

(S)

Regarding doctors engaging in the clinical budgeting system, the CEO confirmed the practice as told by the doctors and the director of finance, that it is only the chairs of the clinical divisions who engage in any way with the clinical budgeting system.

The doctors are worse [than the nurses]. You see the consultants are on board now, and they see the need [for clinical budgeting], but the junior doctors are a law unto themselves. Whatever limited management training there is for nurses, there is none for junior doctors…! (S)

In terms of doctors’ interaction with hospital finances when a new technique or equipment comes onto the market, an assistant director of nursing suggested that a need for a greater understanding of the realities of the world of management and a greater collaboration is necessary between doctors and the business managers.

Data collected from each of the professional groups within the hospital indicates that, as with the nursing profession, clinical budgeting has not devolved beyond the most senior clinicians. However, from the business manager’s perspective, budgets are devolved whilst acknowledging that the reality differs significantly across the hospital. All consultants interviewed used the term ‘frustrating’ when talking about clinical budgeting, because they feel they have little or no control over expenditure, e.g. the consultant in Accident and Emergency highlighted that it is a demand led service, that of a total annual budget of €9 million, €8 million comprises salaries. Overall the sense from clinicians is that ‘clinical budgeting is frustrating…’ One consultant indicated that the move to day case procedures ‘is a removal of a source of frustration.’
It appears that, as suggested by Freidson (2001), a clash is occurring between the logic of professionalism and the logic of managerialism within the hospital site. The logic of professionalism is challenging managerialism by claiming self direction and the necessity to apply discretion and judgement in the work performed. There is also a sense that the doctors claim a devotion to the quality of their work as opposed to the economic efficiency. The medical enclosure appears very much entrenched below the level of clinical director. The doctors are indeed affected by the new financial restrictions imposed by having to seek approval for certain types of expenditures and working within those constraints yet the doctors who are not clinical directors are not actively engaged in the clinical budgeting process or the dialogue surrounding their clinical activities within the hospital available budget. While the ideal type of professionalism according to Freidson (2001) is one where the organized occupation creates the circumstances under which its members are free of the control of those who employ them, the new consultant's contract has limited the amount of private work doctors can perform, thereby suggesting an increasing influence of the state on the mix of work doctors perform and the maintenance of the ideal logic of professionalism.

While doctors may have a continued degree of autonomy within their own economic sector, this is not the case within society as they depend on the state for their empowerment. The new hospital management structure and flow of information across the professional groups of the senior management, the business managers, the assistant directors of nursing and the clinical directors does suggest a shift towards the community principle as posited by Adler et al., 2008, where collaboration amongst the health care professionals is emerging, characterised by trust and interdependence.
5.2.5 The role of accounting within the world of medicine

Contrasting views exist amongst staff as to whether medicine can be facilitated by accounting numbers. Although doctors who are not chairs of clinical divisions do not engage with the clinical budgeting system, they can see the relevance of accounting numbers to their world. One consultant doctor (not a chair) referred to his experience in the UK, where each consumable on the ward was labelled with the unit cost of that item and how this simple labelling system influenced the choices made by doctors on the wards, making the doctors self-disciplining persons. Another consultant doctor (also not a chair) could see that accounting numbers could provide patient level costing. In addition, more information to doctors was seen as a role for accounting numbers to enable them to manage their activities. The HIPE system was seen as key to providing this data along with case mix information.

The director of nursing argued that it has become impossible to ignore accounting numbers throughout the hospital but that clinical need will always override budgetary constraints.

It is hard to ignore accounting. People are much more cost aware. If a certain stent is so much cheaper than the stent that is being used here, questions would be asked and an investigation would be done into the clinical reasoning for that. Even though questions would be asked, if there is a clinical reasoning and it is upheld, that will override the budgetary constraints. (SNM)

While other nurse managers agreed with this perception of the usefulness of accounting in a medical environment, some nurse managers were of the view that there was a clash between medicine and accounting. The nurse managers arguing for the relevance of accounting in a medical context argued that in order for a doctor to manage their
activities they need to have this information and that there are no adverse implications for patients in the use of these numbers.

A physician himself has to look to see how many admissions, how many discharges, what are his bed days like, the condition of the patient, acuity. They need to self reflect as well on things like that… (NM)

However, another assistant director of nursing argued that there is a clash between the practices of medicine and accounting. This nurse cited a comparison with a private hospital she had visited whereby a new piece of equipment for hip replacement procedures was on the market, yet the private hospital staff were not authorised to purchase the equipment due to the increased cost and increased cost to the patient. However she argued that in the public setting, this would never arise as the new equipment would be purchased if there was evidence of a better outcome for patients, i.e. a clinical reasoning.

The sense is that accounting has perhaps pierced the surface of the world of medicine but that the majority of medical professionals remain unaffected by hospital budgets except in crisis situations. The recent global economic crisis has brought about a greater awareness of cost and budgetary matters but that in a public setting, the medical case will always take precedence over the economic case. Until 2009, funding was always found from somewhere before the year-end so there was a false sense of security. It is argued that the doctors’ role as patient advocate remains the fundamental basis on which hospital decisions are made. For example, ‘the patient needs it and my responsibility is to cure and that is the bottom line’. An assistant director of nursing argued that ‘having a consultant at the top hasn’t meant many changes’.
6.0 Discussion

This paper seeks to extend the body of work carried out by Kurunmaki (2004) and Kurunmaki & Miller (2008) on the hybridisation of the medical and financial expertises by extending our theoretical apparatus for understanding how and why differing degrees of hybridisation occur within the same profession but across different national and organizational contexts. The study has drawn upon the literature on governmentality and recent debates in the sociology of the professions. The study began during a period of significant reform in the Irish health care service. A combination of the set of reforms at government level had a significant impact on the funding allocated to hospitals which, in turn, stimulated new management accounting practices at the organisational level. The first phase of this study sought to understand why and how the programmatic ambitions of Government had an effect within the hospital, drawing upon the literature on governmentality (Miller and O’Leary, 1990; Miller & Rose, 1990; Hopwood & Miller, 1994; Miller 2001). This study of the conditions under which new accounting practices emerged (Miller and O’Leary, 1990) required a programmatic analysis of events. Phase II of the study sought to explore whether over time the new management accounting practices had become mobilised by organisational members in their daily lives. The analysis of this data draws upon both bodies of knowledge surrounding modes of governing individuals and recent debates in the sociology of the professions in attempting to understand the degree of hybridisation of the medical and financial expertises of doctors and nurses. The two phase approach to understanding the why and how of new management accounting practices addresses some concerns in the literature (Armstrong, 1994; McKinlay & Pezet, 2009) that the governmentality studies in accounting have paid little attention to the operation of accounting practices and to ‘how individuals, groups
and populations absorb, comply and resist’ (McKinlay & Pezet, 2009, p.17) new accounting practices. This required a longitudinal study to be carried out. Across time, the study shifted from a programmatic level of analysis to an everyday level of analysis in order to explore whether the new management control system was used to govern the doctors and nurses and how doctors, nurses, and business managers conduct their everyday tasks with reference to accounting. The findings in Ireland differ from the experiences in both Finland and the UK. In Finland a willing adoption of financial expertise was found amongst medics (Kurunmaki, 2004) whereas in the UK an entrenched resistance to financial expertise has been witnessed (Kurunmaki & Miller, 2008; Kurunmaki et al., 2008). Ireland appears to lie at some point between the Finnish and the UK ends of the spectrum. The paper seeks to understand how and why such differing degrees of hybridisation occur across different national and organizational contexts.

The ambitions of Government in Ireland during the 1990s surrounded cost containment and enhanced accountability of health care providers. In the early part of the decade the Government sought to govern the economic life of hospitals through the use of case mix measurement as an instrument of governmentality. The calculative practices of accounting may be viewed as a means whereby those at a centre, having particular information about events and persons distant from them, may govern economic activity, social life and individual conduct (Hopwood, 1987; Miller & O’Leary 1987, 1990, 1994; Miller, 1991; Rose & Miller, 1992; Robson, 1992). Miller (1991, p.738) defined action at a distance as ‘the possibility of a particular point becoming a centre with the capacity to influence other points that are distant, yet without resorting to direct intervention’. While acting at a distance, case mix
measurement, as an instrument of governmentality, allowed the hospital management to manage their case mix at the local level, enabling them to act freely but within specified norms, so as to maximise their funding allocation.

Phase II of the study provides evidence that, more than a decade later in 2009, case mix measurement remains an important instrument of governmentality. Service planning was subsequently used by Government as a second instrument of governmentality to further govern the economic life of the hospital. It required hospital management to work alongside the clinicians for the first time to plan activity levels and to match those activities with their budgeted cost. In so doing, it brought about a new dialogue between management and medics, thereby governing, from a distance, the social life, in addition to the economic activities within the hospital. The requirement to submit service plans to the Department of Health and Children also stimulated a structural change within the hospital, from reporting on a departmental basis to reporting by clinical division. It was at this time that the five clinical divisions were created with a consultant doctor being appointed to the role of chair of the clinical division. At a later date a further ambition of Government was for doctors to become engaged in the management of their hospitals. They sought to achieve this through the insertion of a general clause in the Consultant’s Contract with Government requiring consultants to engage in the management of their hospitals, in addition to showcasing pilot hospitals which had implemented a clinical directorate model of hospital management (Heyssel et al., 1984). The launch of this showcase was labelled the Clinicians in Management Initiative. This initiative was used as a further instrument of governmentality in seeking to influence the interactions between the social groups of medicine and management at the hospital level. This was not a
mandatory requirement. Hospital management had the freedom to choose whether to introduce such a management structure. Sanctus University Hospital did this freely of its own accord but used the label ‘clinical division’ rather than ‘clinical directorate’. The service planning requirement together with the move to a clinical divisional organisational structure led to a new dialogue between management and the chairs of the clinical divisions.

Ahrens and Chapman (2007) have a detailed concern for the activities of agents, analysing the detailed practices through which accounting may be mobilised by organisational members. They focus on the possibilities of management control systems as a resource for action. The key ambition of management is that doctors and nurses throughout the hospital will take responsibility for the hospital budget and manage that budget. Miller (2001) argues that the main objective of management accounting is to link together responsibility and calculations. He suggests that management accounting focuses on exacting responsibility from individuals rendered calculable and comparable. Freidson (2001) however contends that the logic of such a bureaucratic perspective (managerialism) is at odds with the ideal typical professionalism. The notion that professionalism challenges the fundamentals of managerialism needs to be recognised in the analysis of how and why differing degrees of hybridisation have been observed. Relevant to this is theory of Adler et al. (2008) who propose that the medical profession is moving towards a more collaborative form whose main characteristic is one of interdependence. Perhaps in Ireland this shift has begun whereas it may not have commenced in the UK.
Ahrens and Chapman (2007) suggest that the values, desires, feelings, and judgements of the actors surrounding the strategic, commercial, technical and political uses of accounting are relevant to the evolution and eventual acceptance of the calculative practices of accounting. A number of factors indicate that the values and goals of the three social enclosures are currently not aligned. The fact that budgeting information is not shared by assistant directors of nursing with their clinical nurse managers, the fact that senior doctors in one clinical division do not attend the part of the monthly management meetings where financial matters are discussed and the overriding concern of doctors and nurses with managing at the patient level only, aggregate to facilitate an understanding as to why the clinical budgeting process has not evolved much since Phase I of the study and why there is little evidence of hospital wide acceptance of the management accounting practices by doctors and nurses at ward level. The evidence suggests that the organisational intent and the individual intent of actors are not aligned. As there is limited evidence of a daily effort of individuals engaging with the management control system or engaging with each other about the management control system, it cannot be concluded that the accounting practices have become embedded within the hospital. While this is the intent of management it has not yet been accepted at all levels of the medical profession.

Miller (1994) suggests that the development and spread of a vocabulary of costs and costliness helps to establish as legitimate and self-evident, the importance of knowing and calculating the costs of activities and individuals. The vocabulary of costs can operate as an organizing rationale around which debates can take place regarding costs. He contends that this in turn fuels the call for further calculations. Differing views exist across Sanctus University Hospital Limited as to whether a vocabulary of
costs and costliness has evolved. Senior management believe that some doctors and nurses are very cost aware, especially since 2009. It is difficult to determine whether this is actually an enhanced understanding of hospital costs and budgetary matters due to the passing of time and the embedding of practices, as those practices become more routine or whether it reflects an enhanced financial literacy due to the global economic environment prevailing during 2008 and 2009. Both the finance director and an assistant director of nursing perceive that doctors and nurses are more aware of costs since January 2009. In the past, interviewees explained that additional funding was always obtained before the year end. Therefore, there was no incentive to be cost aware. As highlighted by the director of nursing, ‘if you were living in a land of plenty, there could be a lot of wastage.’

While Kurunmaki (2004) revealed a willing adoption of management accounting techniques by medical professionals in hospitals across Finland during the 1990s, the penetration of accounting consciousness appears more limited in Ireland, despite some fifteen years of numerous new public management reforms. At the end of phase I of this longitudinal study there was a sense that the role of the medical professional in the hospital setting may be changing, that a hybrid role of doctors was emerging with a dual responsibility for patients and for hospital management. However, phase II of the study revealed that nine years later, despite an enhanced managerial component of the role of senior doctors and nurses alongside many changes to the daily life of the hospital, the daily life of doctors and nurses at ward level was unaffected as the clinical budgeting process had only permeated to the level of chair of the clinical divisions and the assistant directors of nursing. This study of accounting in practice and its use in the everyday lives of doctors and nurses has
demonstrated that in this empirical setting, in the national context of Ireland, the clinical budget has not become the hegemony. A problematic dimension of the new accounting practice was that it was interpreted differently within the social group of doctors, some perceived it as a surveillance mechanism and as a mechanism to shift economic responsibility from and by senior management to the doctors, while others perceived it as an empowering mechanism but only where they were incentivised to make savings and pursue efficiencies.

Kurunmaki (2004) noted that in contrast to Finland at this time, medical professionals in the UK were seen to resist the intrusion of accounting practices into their daily lives and remains an aspiration (Kurunmaki & Miller, 2008). Ireland appears to lie along a continuum between the two extremes of Finland and the UK whereby managerial and clinical leaders are working together with a new language and practices which were previously alien to the medical profession. However, the hybridisation of the medical and financial expertises remains limited. Why is this so?

Kurunmaki (2004) suggests that the difference between the Finnish and UK experiences may in part be explained by the position of management accounting within the tradition of business economics as part of a discipline that included marketing and management in contrast to the professional status and perception of accountancy in the UK. Miller et al. (2008) suggest that the variation in the hybridisation of medical and financial expertises experienced in Finland and the UK is possibly due to two factors, variation in public policy and variations in the ways in which professional bodies define, differentiate and organise themselves. This paper proposes that recent debates in the sociology of the professions may assist us to
further understand how and why the variations witnessed across Finland, Ireland and the UK have arisen. This may in part be explained by drawing upon Freidson’s (2001) three distinct methods of organising and controlling the division of labour; professionalism, managerialism and consumerism and the notion that the ideologies of managerialism and consumerism are at odds with the ideology of professionalism. The difference between the three jurisdictions may be accounted for by a different mix of professionalism, managerialism and consumerism at play within the respective healthcare systems and the local sites studies. It appears that professionalism, albeit to a different extent, is stronger in the case of Ireland and the UK with both medicine and accounting being practiced within professional enclosures and that managerialism is a stronger force in Finland where only medicine is practiced as a profession and accountancy constitutes a technique within the disciplines of business economics and management.

The relations between the professions and the state offers a further strand of teasing out the reasons for variations across the three countries studied. Mac Donald (1995) proposes that different types of states have different levels of state penetration in civil society and knowledge based services. He argues that the Anglo-American model lies at one end of a spectrum with very low levels of state penetration while communist societies lie at the opposite end of the spectrum where knowledge based services are provided and regulated entirely by the state. While Ireland and the UK may lie close to the Anglo-American end of the spectrum it appears that Finland lies along the continuum towards the opposite end. This is reflected in the extent to which the respective states have influence and control over the work of doctors. In Finland, the medical labour market is organised at a state level where hospital doctors are
employed by the state and work as civil servants. This contrasts with the case in Ireland and the UK where the medical labour market is organised by the profession and although hospital doctors are employed by the state they have considerable freedom to practice outside of their contractual agreement with the state. Since 2008, in Ireland, a greater extent of administrative control has been exerted on doctors over their freedom on the mix of public and private work they perform. For the first time in the history of medicine in Ireland a restriction has been placed on the amount of private work that hospital doctors can perform alongside their public contract with the state. This may further explain why a different degree of hybridisation has taken place in Ireland than in the UK. Such changes in the labour force status alongside changes in the division of medical labour provide further insights into the variations witnessed. In recent years in Ireland some of the specialised knowledge and skill of doctors has been acquired by nursing staff through the shift from an apprentice type training to a mix of academic qualification and apprenticeship. In addition the evolution of specialist nurses for specific disease types has taken place which has also transferred certain knowledge and skills from doctors to nurses. Adler et al. (2008) argue that this growing collaboration of doctors with nurses, with other medical specialists and the allied health professionals has arisen in response to various external and internal pressures for greater accountability, quality improvement and cost reduction requiring a community network and transdisciplinary working rather than tribalism and siloed departments and processes. They suggest that the ascendancy of the market (consumerism) and hierarchy (managerialism) principles has not diminished the role of community and that a new form of professional community is emerging in the process characterised by collaborative interdependence.
7.0 Conclusion

This paper contributes to the literature on governmentality by addressing some of the criticisms of the body of governmentality studies in accounting in analysing the development of new management accounting practices, in the specific context of a university hospital in Ireland, from both a programmatic and from an everyday perspective. The paper is specific to the Irish context, a context that is, it is argued (e.g. Weetman, 2006; O’Dwyer & Unerman, 2008) relevant across national boundaries as it establishes comparative contexts for similar discourses on health care provision in different national settings. It also highlights the interaction between local and global discourses surrounding health care management.

The study illustrates how the generic ideas of New Public Management are put to work through the instruments of accounting in this special local setting in Ireland. The study found that calculative practices were used by Government acting at a distance to create visibility surrounding the activities of the hospital, thereby making the hospital governable and more accountable to the State. These governmental calculative practices stimulated the development of new management accounting practices at the hospital level. The new management accounting practices brought about some significant changes to the everyday life of the hospital and did make visible some of the actions of doctors and nurses in the hospital. However as engagement with the clinical budgeting process remained only at the senior medical level, the doctors and nurses at the ward level did not become calculable or governable persons. The new dialogue that was created amongst doctors, nurses and managers suggests that the clinical budgeting process did penetrate the medical enclosure to some extent, although not fully. For the time being it appears that the permeation of the new
accounting practice is limited. It was also found that management perceived that education and training in budgetary and management matters was required of both doctors and nurses who operate at the patient level. The education of doctors and nurses at university level in Ireland has, to date, not included modules on finance, accounting or management. A chief physician in a Finnish hospital commented surrounding the acquisition of financial expertise by clinicians (Miller et al., 2008, p.957) ‘...in the training of doctors we have to begin on a completely different scale, teaching doctors various things (such as accounting), not just medicine’. This has implications for the education policies and strategies for university medical schools in both Ireland and the UK.

The paper responds to Kurunmaki, Lapsley & Miller (2011) call for the need to explore further the conditions under which hybridisation of the accounting expertise takes place. Empirically, the paper has shown that the hybridisation of medical professionals, whereby medics acquire management accounting expertise has partially occurred in Ireland which differs from the experiences in both Finland and the UK. In the Finnish setting (Kurunmaki, 2004), this hybridisation took place over time, commencing with the delegation of budgets to clinical units and developing through the costing and pricing of hospital services. In the Irish setting, the most senior doctors and nurses have become engaged in the clinical budgeting process, yet unlike Finland, the medics have not been involved in the costing of services. As hospital budget allocations are not 100% based on activity levels, as patient level costing has not evolved because of a lack of incentive to do so, together with the fact that reimbursement is not based on a DRG or procedure basis, junior medics have not been engaged in such calculative practices. The evidence from the UK (Miller et al.,
2008) suggests a continued reluctance on the part of clinicians to actively engage in the hybridising of medical and financial expertise, where the boundaries between medical and financial expertise remain more strongly defined. Recent debates in the sociology of the professions were drawn upon to further explore why these variations between Finland, Ireland and the UK have arisen.

The complexity of the health care sector and complexity of the nature of the role of health care professionals is reflected in the complexity of factors contributing to these national and organisational differences. Theoretically, this paper argues that a mix of multiple diverse factors accounts for these variations rather than a simple small set of factors. While variations in the position of management accounting within the pedagogic settings across the countries is relevant (Kurunmkai, 2004) along with variations in public policy and the ways in which the professions define, differentiate and organise themselves (Miller et al., 2008) this paper argues that there are additional factors that further explain these variations. Variations in the mix of the three logics of professionalism, managerialism and consumerism at any point in time in addition to relations between the profession and the state and the degree of control the state has over the work of the professions may further account for these national differences. The division of labour within the hospital sites is also a relevant factor and the extent to which a collaborative profession as elaborated by Adler et al. (2008) has emerged. While this collaborative interdependent profession has emerged in Finland and partially in Ireland, it does not appear to have developed in the UK. As highlighted by Kurunmkai et al., (2011) ‘some ideas and practices travel ‘light’, while others may be too heavy to travel easily’. Future research could explore the impact of financial and management education of junior doctors and nurses on the use of
financial expertise in their daily management of their hospital unit. Further research on the characteristics of the collaborative profession may also shed light on the mechanisms whereby the various professional enclosures within a hospital setting may be dissolved.

This partial hybridisation in Ireland and the lack of hybridisation in the UK has implications for all health care actors as the professional enclosures, in such strongly professionalised contexts, may limit the possibilities for information sharing and information exchange. This is particularly startling in light of the Audit Commission (2006) Report in the UK which found that disengagement of senior clinicians from core management processes was a reliable indicator of impending financial trouble in Hospital Trusts. This has implications for policy makers in both Ireland and the UK for the need to develop policies and strategies to ensure mandatory engagement of doctors and nurses in the management of their hospitals.

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Figure Captions

Figure 1.
Programmatic and Everyday Analyses

Figure 2.
Instruments of governmentality to influence the management of Sanctus University Hospital

Figure 3.

Table 1.
Key Actors Interviewed Beyond the Boundaries of the Hospital

Table 2.
Actors interviewed at Sanctus in Phase I and Phase II of the study