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# Shifting NPM agendas and management accountants' occupational identities

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## Abstract

**Purpose** – The purpose of this paper is to illustrate how the occupational identity of management accountants working in the public sector is influenced by a change in management accounting and control systems as well as the underlying management agenda.

**Design/methodology/approach** – From interviews with management accountants and their associates in five public hospitals, the paper illustrates how a change in new public management (NPM)-related managerial agendas interacts with how the management accountants perceive their professional roles.

**Findings** – It is argued that the focus of the NPM agenda in Finnish public health care has shifted from a "down grid agenda", emphasising private sector accounting and control methods, to a "down group agenda" that emphasises accountability, visibility and comparability. This change in agendas has materialised in the implementation of the diagnosis-related groups (DRG) system, and the resultant abandoning of activity-based costing (ABC) systems. Health care management accountants who rely on private sector ideals for constructing their occupational identity may resist the implementation of DRG if they interpret it as a shift in managerial discourse.

**Originality/value** – The paper links two different and sometimes contradictory agendas within the NPM framework with the occupational identity of management accountants. The observed reaction to the shifting agendas has implications for understanding why some accounting systems carry more appeal than others.

**Keywords** Public sector organizations, General management, Work measurement, Accountants

**Paper type** Research paper

## 1. Introduction

The nature of modern organisational control invites employees to develop occupational roles congruent with managerial discourses (Alvesson and Willmott, 2002). These roles, however, are rarely pervasive and are influenced by both the individual's sensemaking of the organisation and the perceptions of others, the image. Furthermore, Dutton and Dukerich (1991) conclude that image, the perception of others, is often tied to identity, that is, how an organisation's members perceive their organisation and their roles in it. Gioia and Thomas (1996) argue that it may be unlikely for a change in image to be sustained without at least some associated change in identity.

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In organisations, the occupational identity of management accountants is associated both with accountant's role image and (perceived) role change. One example of the interconnectedness between occupational roles and role images is the bean counter stereotype. In essence, being a bean counter means focusing on recording, data inputting and reporting tasks instead of decision-making related tasks (Bougen, 1994; Friedman and Lyne, 2001). Furthermore, Friedman and Lyne (1997) suggest that a change in management accounting techniques has the potential for changing the role (and possibly the role image) of management accountants. This can take place through new techniques such as activity-based costing (ABC) working to soften the bean counter image of management accountants, but also by having another profession to fill the gap formed by a new technique. For instance, according to Granlund and Lukka (1997, 1998), the organisational role of management accountants has expanded; they differentiate between the roles of historian, watchdog, adviser/consultant and change agent/member of the management team. In addition, Granlund and Lukka (1997) argue that in industrial organisations the last two non-traditional roles, adviser/consultant and the change agent have become increasingly common as management accountants have been established as controllers. The concept of controllership is thus distinguished from the traditional core of the management accounting function of the historian and the watchdog i.e. the bean counter stereotype. Of course, utilising such a vague concept as the bean counter can be difficult and misleading. Vaivio and Kokko (2006) identify three uses for the bean counter concept: a theoretical abstraction, a stereotype grounded in the popular consciousness, and a normative construct serving commercialised agendas such as management consulting. In addition, as they found little evidence of bean counter roles in today's industry, the question of such actual occupational roles remains an empirical one. However, there is a strong argument for the existence of such external role images that have the potential to influence how a group of professionals is viewed within the organisation, and hence, how the profession reacts to changing management agendas.

*Health care reforms and professional control*

New public management (NPM), a term originally coined by Hood (1991, 1995), is an evolving phenomenon that has taken various, often contradictory paths in different countries (Humphrey *et al.*, 2005; Groot and Budding, 2008). Major themes in NPM research include restructuring government agencies so as to involve decentralised, professionally managed decision making and putting more emphasis on accountability and the measurability of outputs. This often involves incentivisation i.e. moving from a professional public service ethos to cash-based incentives and performance measurement. Such management reforms invariably involve the adoption of new, private sector oriented management controls such as accrual accounts, full costing of products and services, devolved budgeting systems and financial performance indicators (Olson *et al.* 1998; Humphrey *et al.* 2005; Groot and Budding, 2004) The adoption of such accounting controls implies a movement "down grid and down group" (Dunleavy and Hood, 1994) that may explain some of the internal inconsistencies of the NPM-related management agendas. The influences of such agendas have been particularly marked for professional groups (Ackroyd *et al.*, 2004; Lapsley, 2008).

In the field of health care, Chua (1994) characterised this change as that shifting public and political attention from access to health care to its costs, with the real outcomes remaining a "matter of faith". Naturally, as costs move centre stage, a need for their centralised calculation arises. Such a need for product cost calculations is initially extra-organisational, but becomes necessary for tying together differing interests in the organisation (Chua, 1995). In a similar fashion, Preston *et al.* (1997) study how the political agenda associated with diagnosis-related groups (DRGs) shifted from cost reimbursement to cost containment, instituting a commercialised mode of thinking in health care management. Likewise, Covaleski *et al.* (1993) argue that the reform of the health care sector was as much to conform to social and ideological shifts, as it was to improve efficiency and effectiveness. Relating to this, Abernethy *et al.* (2007) review two broadly defined methodological positions in health care accounting research: the positivist behavioural/organisational perspective and the critical/sociological perspective. While the former discusses accounting as a source of relevant information for decision-making and control, the latter examines more diverse explanations for the enactment, development and operation of accounting and control systems within health care organisations. While this study is aligned with the latter perspective, it is important to realise that integration of the two themes is to some extent possible. While efficiency imperatives are real enough, they cannot be disentangled from the historical, institutional and socio-political context (Abernethy *et al.*, 2007)

Shifting political and managerial agendas have implications for the role of professional control in health care organisations. Possible role conflict may emerge if health care professionals confront control systems designed to restrict their autonomy (Abernethy and Stoelwinder, 1995). However, Comerford and Abernathy (1999) argue that professional and administrative roles can be integrated, and professional role need not always be sacrificed to maintain professional norms. Studies outside the field of health care suggest that competition between different professional groups over the ownership of a management accounting system may have implications for management control (Burns and Baldvinsdottir, 2005; Ezzmel and Burns, 2005).

Following this line of thought, it is likely that inter-professional competition over the ownership of new technologies may account for the partial failure to implement new cost accounting practices in hospitals, which form the empirical setting of this study. In health care organisations, one such organisational group that may come to be influenced by accountants' stereotypical or scripted role images is the medical profession, especially due to hybridised and/or polarised roles i.e. increasing amount of the management accounting tasks having been carried out by health care personnel (Kurunmäki, 2004; Kurunmäki *et al.*, 2003; Jacobs, 2005).

While hybridisation studies have mainly concerned the emergence of hybrid medical accountants, little attention has been focused on the other side of the hybridisation phenomenon – the professional roles of accountants working in health care settings. The role of accounting in the management of public hospitals has become increasingly important in hospitals since the managed care systems introducing per-case charges as the main health care funding mechanism (Kurunmäki, 1999). As hospitals looked to private firms for means to cope in this new situation, the new financial rhetoric interpreted per-case reimbursement as "selling products". This new financial representation of a hospital's activities required that cost accounting systems be set up in hospitals.

*Occupational identity*

Sociologists have debated whether individuals have the freedom to pursue autonomous identity projects, and how far identity is the result of ideologies and discourses. For instance, Giddens (1991) argues that while agents take various actions in the social world that affect the structure in which they are embedded, the structure not only limits their choices, but also interacts with agents in dynamic tension. Much of contemporary self-identity, even though characterised by diversifying lifestyle choices, is constructed in the modern workplace (see, e.g. Miller and Rose, 1995), where various professional groups interact. While we concede that there are other, more individual-oriented conceptions of identity and that these can be researched (see, e.g. Haynes, 2008), this study focuses on solely occupational identities in workplaces.

Regarding workplace occupational identity, it has been suggested that the insecurity of modern working life involving constant changes, requires professional workers to develop strong occupational identities in order to survive (Alvesson and Willmott, 2002). Occupational identity is shaped through discursive processes where we explain to others (and to ourselves) what we do, where we succeed and how we wish to develop in the future. Thus, the nature of occupational identity is processual, an emergent quality contained in an organisation's discursive processes. In this study we define occupational identity as pertaining to the attributes that the members of the profession believe and claim to be its character.

Occupational identity and image interact. If a group's members believe their image be negative in the eyes of other groups, this may provide motivation to seek ways of restoring this lost image (Gioia and Thomas, 1996). In fact, the way in which professional groups build their identity around using "state-of-the-art" methods has already proved essential for public sector accounting reforms (Carpenter and Feroz, 2001). This way, managerial discourses can be seen to shape, and to be shaped by, the occupational identity of management accountants in the organisation.

While identity is influenced by institutional contexts and culture (see, for example, Ahrens and Chapman, 2000), occupational identities can also be regulated as a form of management control. Organisations seek to align employees' identities to managerial discourses for management control purposes (see Alvesson and Willmott, 2002). For instance, Skaærbæk and Thorbjørnsen (2007) study how the occupational identity of Danish military officers was gradually split into various "identity profiles" as managerial reforms progressed. In such circumstances, the role of accounting and accounting expertise may signal that certain identity profiles are assessed more favourably than others, and conforming to such profiles can be viewed as a path to career advancement and success. A change in managerial agenda invariably involves identity work (Alvesson and Willmott, 2002).

Thus, identity regulation can be seen as a form of personnel/cultural control that is at the core of management control systems. For instance, Merchant (1998) suggests that when deciding on various control alternatives, managers should start by considering whether personnel/cultural controls are sufficient, and only then consider other forms of control such as output measurement. In the absence of output controls, clan controls are used (Ouchi, 1979). Such controls are based on the belief that organisations are able to create and foster a sense of solidarity and commitment towards organisational goals that has the potential to function effectively as a control mechanism. Much of the debate around NPM practices is focused on replacing other

forms of organisational control with output measurement and quantification (Hood, 1991; Modell, 2004; Johnsen, 2005; Bevan and Hood, 2006; Lapsley, 2008). However, well-organised professional groups remain a characteristic of the public sector, and have the potential to resist management control based on outputs (Lapsley, 2008).

*Purpose of the paper*

The purpose of this study is to illustrate how management accounting professionals' conception of their occupational identity interacts with a change in management accounting and control systems. A change in management control systems is indicative of shifts taking place in managerial agendas within the NPM (Dunleavy and Hood, 1994; Broadbent and Laughlin, 1998). We draw on Alvesson and Willmott's (2002) concept of identity regulation to explore how a management accounting change has influenced health care management accountants' view of their occupational roles and role image. Here, we assume that management accounting professionals are generally expected to live up to the expectations of managers and to adopt and enjoin various managerial discourses in their work. We illustrate a situation where both managerial agendas and occupational identities are changing, and must be recreated by reciprocal discursive practices.

## 2. Research methodology

Our approach is a qualitative field study conducted in Finland's five university hospital districts[1]. The case selection was justified because of hospital sise – university hospitals are larger than others and are thus more likely to employ professional management accountants. In Tables I and II, describing the data, these university hospitals are designated with the letters A-E, so as to avoid pinpointing specific individuals.

| Interviewee no. | Interviewee position | Hospital district | Approximate length of interview (min.) |
|---|---|---|---|
| 1 | Chief of finance | A | 60 |
| 2 | Cost accountant (group interview) | A | 40 |
| 3 | Cost accountant (group interview) | A | |
| 4 | Chief of finance | B | 60 |
| 5 | Accountant (financial planning) | B | 45 |
| 6 | Accountant (budgeting and financial planning) | B | 60 |
| 7 | Chief of finance | C | 60 |
| 8 | Accountant (financial planning) | C | 45 |
| 9 | Chief of administration | C | 50 |
| 10 | Chief of finance | D | 45 |
| 11 | Controller | D | 60 |
| 12 | Accountant (budgeting and costing) | D | 105 |
| 13 | Assistant chief of finance | D | 50 |
| 14 | Chief of finance | E | 45 |
| 15 | Cost accountant | E | 60 |
| 16 | Chief of accounting | E | 50 |
| 17 | Chief of administration | E | 60 |

**Table I.** List of primary interviews

The data for this study can be divided into two parts. The primary data were gathered between 2005 and 2006, and comprise 17 taped and transcribed interviews of professional management accountants, the total length of which is some 14 hours. While the interviews were open in the sense that there were no structured questions, the interviews had two themes. The first interview themes included the management accountants' professional role, their view of their work and its importance, and their relations with other professional groups, while the latter part of the interview concentrated on management accounting change i.e. the adoption of a DRG-based cost accounting and pricing system that was implemented in Finnish specialty health care at the time on a nationwide basis.

In addition we interviewed seven other people (five physicians involved in management accounting tasks and two management consultant from the Association of Finnish Local and Regional Authorities) in order to triangulate the interview data (Yin, 1991) and to establish a coherent view of accounting changes taking place in the field of health care. In essence, the chief physicians interviewed were end users of management accounting information. These interviews were used to establish the internal validity of the study by synchronic primary data triangulation, i.e. interviewing various respondents on the same topic (Pauwels and Matthyssens, 2004). Our secondary data containing supplementary archival material consists of memoranda and project plans for cost accounting projects, and documents containing guidelines for management accounting practices. Combining primary and secondary data sources was also important for the triangulation aspect of the study.

In interpreting the interview data, our analysis focused on how the professional management accountants interviewed constructed their professional identities through their talk, and how this identity is created through discursive practices. Thus, the focus of the interviews has been directed at meanings and perceptions of social reality, a view that Silverman (1993) and Alvesson (2003) call romanticism. While part of the secondary data was used to check facts such as the type of calculations the interviewees are actually performing, these "facts" play a relatively minor role in this study, as the vast majority of issues concerning identity, image and occupational roles are socially constructed (Berger and Luckmann, 1967).

The interpretation of the data draws on the identity regulation framework by Alvesson and Willmott (2002). For the purposes of this study we interpret management accountants as identity workers who are enjoined to incorporate the new managerial objectives into narratives of self-identity so that congruence between externally imposed objectives and a view of self can be at least partially achieved. According to

| Interviewee no. | Interviewee position | Hospital district | Approximate length of interview (min.) |
|---|---|---|---|
| 18 | Assistant administrative chief physician | A | 45 |
| 19 | Chief physician | B | 25 |
| 20 | Chief surgeon | C | 65 |
| 21 | Administrative chief physician | D | 35 |
| 22 | Chief physician | E | 30 |
| 23 | Management consultant | | 45 |
| 24 | Management consultant | | 60 |

**Table II.**
List of secondary interviews

Alvesson and Willmott (2002), identity regulation, the discursive practices of that condition the processes of identity formation, and organisational actor's self-identity interact, and identity is "worked" to achieve congruence between the two i.e. identity work.

As a practical (but not trivial) matter, we limit the study of identity to occupation and workplace (Miller and Rose, 1995), but this also allows us to reflect on management accountants' roles. We view roles (and especially professional roles) as characteristically relatively open. Even though scripts such as the "bean counter image" (Bougen, 1994; Vaivio and Kokko, 2006) exist, identities are achieved rather than assigned, and roles are increasingly improvised (Alvesson and Willmott, 2002). Being open and non-scripted, occupational identities are flexible in practice and have a tendency to be internally inconsistent (Ahrens and Chapman, 2000). We also argue that in cases where occupational identity conflicts with image (such as the bean counter image), there is a pressure to accept changes in the working environment (Gioia and Thomas, 1996), and wish explore the nature of this conflict to understand an agent's willingness for change.

Giddens (1991) differentiates between identity as self-awareness and identity as "social", where the latter i.e. the conscious set of self-images, traits and social attributes can be conceptualised as an object of study in social science. Identity can therefore be defined as organised and structured narratives derived from participation in competing discourses. In change situations, identity must be continuously recreated by "identity work" i.e. organisational actors recreating their narratives to suit the new agendas (Alvesson and Willmott, 2002). However, recreating identities in workplaces is not left only to the employee, as identity can be managed, and is increasingly an instrument of management control (Barker, 1993). It has been suggested in the research that in certain circumstances it is possible for control to become part of one's identity (Deetz, 1998).

Managerial agendas such as efficiency are translated into ideal modes of action that are, in turn, translated into discourses and control techniques. Thus, the managerial discourse is a project of rationalisation (Dambrin *et al.* 2007; Hasselblad and Kallinikos, 2000) where techniques such as ABC or DRG can be used to embody the discourse. While organisations seek to align employees' occupational identities with managerial discourses, the process is not unprecedented or effective in increasing employee commitment, involvement or loyalty. For instance, Ezzmel *et al.* (2004) illustrate how ABC was associated with a downsizing management agenda, and how controllers sought to modify this agenda into one that would not come into conflict with the rest of the organisation. Their findings suggest that managerial attempts to introduce new discourses and rationalities were mediated by workers' ability to create discourses where their own interests were defined and articulated. This way, resistance to management accounting change can be seen in the light of threatened occupational identity; the tension between a new managerial discourse and the need to recreate and redefine one's occupational role and role image.

## 3. Two NPM agendas

### *Background*

As a part of the comprehensive state subsidy reform in early 1993, the position of the Finnish municipalities, with regard to health care, changed fairly radically. In the

reformed system, state subsidies for health service operating costs are a lump sum that is paid to the respective municipalities, who then purchase the health care services from the service providers. From an international perspective the reformed Finnish system incorporates many special features, as even the smallest of municipalities are responsible for providing a whole range of medical services. This radical decentralisation offered an option for central government to distance itself from the unpopular cost containment measures necessitated by the economic recession. While the decentralisation is argued to provide incentives for cutting costs, it also leads to continuing conflicts between purchasing municipalities and the service providing hospitals (Häkkinen and Lehto, 2005)[2].

After the state subsidy reform of 1993 the development of public hospital sector management control-related activities took several distinct directions. In many hospital districts, contract-based budgeting was introduced with the intention of generating visibility and aligning the speciality health care providers' sales budgets with the municipalities' purchasing budgets (Hyvönen and Järvinen, 2006). There have been several variations of this practice, however (Punkari and Kaitokari, 2003). Starting from the beginning of the 1990s Helsinki University Hospital (HUCS) had been implementing the DRG system according to international ideals (Lehtonen, 2007). Soon the nation's second largest hospital, Turku University Hospital followed suit, albeit with an implementation that was somewhat more limited.

However, in some hospitals the DRG system was adopted as a reimbursement mechanism with no direct links to cost accounting or budgeting systems. These generally smaller hospitals simply divided their costs by equivalent units based on HUCS prices, and used the figures so derived for invoicing the municipalities for their services. Naturally, such systems were criticised for inaccuracy, and some hospitals developed other methods of cost calculation, such as ABC, for internal purposes (Hupli *et al.*, 2006).

In fact, this ABC system had been implemented in hospitals since the mid-1990s, when several Finnish hospitals began to look for cost accounting solutions from the private sector. At the time, ABC systems were being developed enthusiastically in manufacturing industries, and the system quickly spread to the hospital sector via the media, academics and the consulting industry (Järvinen, 2006). One interviewee reflected this as follows:

> It was back in 1993 when we had the state subsidy reform in Finland, we began to put prices on our products. By nature I am not always enthusiastic about all new fashions, but at the time we had a chief of finance who got all excited about activity-based costing, he had heard about it in some seminars I guess, and he wanted us to try it here [...] he bought the software [...] so we implemented activity-based costing in order to price our products accurately and easily (Interview no. 10, chief of finance, Hospital District D).

Thus we deduce that NPM practices in Finnish health care had taken two distinct, although in places congruent paths; the private sector-driven path that looked to private sector management tools such as ABC, BSC, process modelling, etc. for inspiration and involved the extensive use of management consultants, and the public-sector driven path that involved establishing quasi-markets, comparable outputs and increased visibility, and involved governmental organisations such as the Association of Finnish Local and Regional Authorities and the Centre of Social and Welfare Research. These developments are consistent with Dunleavy and Hood's

(1994) concept of NPM's "down grid" agenda and "down group" agenda. The former entails de-emphasising differences between the private and the public sector while the latter includes a shift from emphasising processes to emphasising outcome requirements, output measurement and accountability (see also Broadbent and Laughlin, 1998). These two agendas and their characteristics are illustrated in Figure 1.

Thus, the shift from down group agenda to down grid agenda entails a shift away from private-sector modelled modernity (Arnaboldi and Lapsley, 2003; Järvinen, 2006) and the idea that accounting systems should be aligned with strategy and structure (see, e.g. Abernethy and Lillis, 2005) to what Llewellyn and Northcott (2005) describe as a shift from market to metrics under the umbrella of "modernising". In cost accounting systems, this implied a shift from ABC to costing diagnosis-related groups.

*ABC in hospitals: the down group agenda*

What we have interpreted for the purposes of this study as the down group agenda i.e. "lessening or removing differences between public and private sector" (Hood, 1995) is hospitals looking to a private industrial sector for suitable management accounting solutions. In the field of management accounting, examples of such a transfer of accounting tools include performance measurement systems (Brignall and Modell, 2000; Johnsen, 2005), balanced scorecards (Aidemark, 2001; Funck, 2007), process modelling (McNulty and Ferlie, 2004) and ABC (Arnaboldi and Lapsley, 2003; Järvinen, 2006). While the ABC phenomenon originated in the particular managerial environment of the USA in the late 1970s and early 1980s, and reflected a productionist response to this new environment, the specifics of its origin were soon obscured by its extension to other countries and other industries and public services (Jones and Dugdale, 2002). One implication of such a response was the reframing of hospitals as multi-product firms (Chua, 1994) and the notion that hospitals' management accounting systems should be aligned with strategic choices and structure (Abernethy and Lillis, 2001).

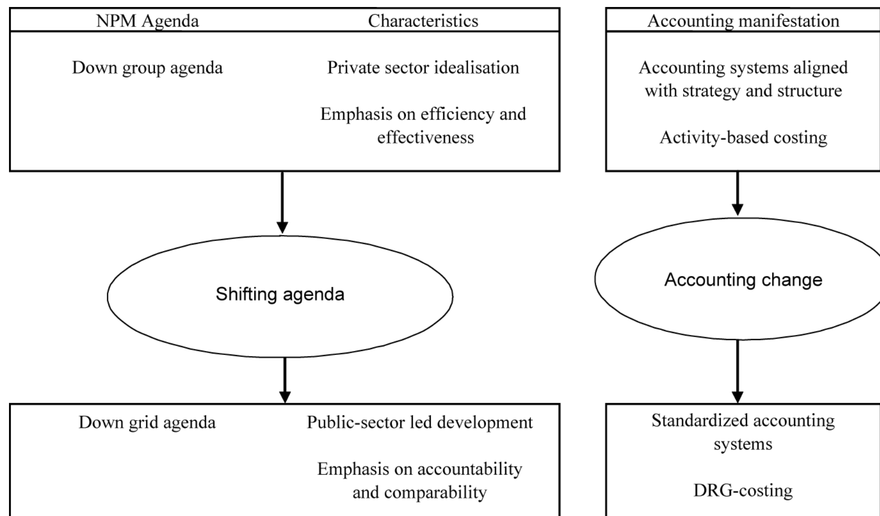


**Figure 1.**
Two NPM agendas and their accounting manifestations

In Finnish hospitals the origins of ABC seem to lie in the historical conjunction of introducing accounting systems in hospitals while simultaneously cutting administrative resources during the severe economic depression of the mid-1990s (Järvinen, 2006). However, motivations for adoptions were found to range from a more or less genuine desire to improve the efficiency of processes and accuracy of pricing to the legitimation of service prices under external pressure. His results support Arnaboldi and Lapsley (2003, 2004), who see the adoption of ABC as a legitimating exercise, as organisations seek to portray themselves as modern. They illustrate a situation where none of the interviewees were able to justify the choice of a particular costing technology, whose selection seems to be more related to the presence of a "champion" in the organisation and management's desire to use "modern" techniques than to a real appraisal of the techniques benefits and its costs.

*DRGs: the down grid agenda*

The down grid agenda involves increasing the visibility and accountability of public sector actions, "shifting the emphasis from process accountability towards a greater element of accountability in terms of results" (Hood, 1995). Such a managerial agenda emphasises formal measurable standards and measures of performance and success, and greater emphasis on output controls. We interpret that the implementation of DRG-based reimbursement, cost accounting and budgeting systems falls into this category, as standardisation, comparability and visibility seem to be the recurrent themes in the recent health care accounting reforms. Llewellyn and Northcott (2005) argue that in health care, hospital cost benchmarking has political appeal that partly results from the fact that, at least in the European context, competition between hospitals for customers is seldom a relevant issue. Their findings suggest that, when coupled with the financing system, this type of cost benchmarking seems to be promoting "averageness", where actual practices as well as costs begin to converge. In a more decentralised setting, Grafton and Lillis (2005) found reactions to public policy agenda differ in different hospital networks. According to them, giving decentralised autonomy in how to implement a policy reform can have a profound effect in reaching the goals of the policymakers.

In 2005, the Association of Finnish Local and Regional Authorities made a decision to support a project aimed at implementing DRG across the entire speciality health care, which was named the National DRG Standardization Project (SATU). The long-term policy goal, to which the project was to contribute, was that all the nation's hospitals would (and should) have the same output measures, and the same methods to calculate the costs for these outputs. This would enable benchmarking, cost efficiency and increasing competition in the health care (quasi-) market (Talvinko, 2005). From the outset it was quite clear that the Centre for Social and Welfare Policy (STAKES) was a staunch supporter of DRG standardisation, as its health economists had been collecting cost data from all Finnish hospitals since 1999, and transferring that cost data into DRG format for purposes of benchmarking and analysis. This cost data was published in a series of statistical reports labelled "productivity of hospitals in Finland" (Linna, 1999; Junnila, 2004).

As the National DRG Standardization Project commenced, two main motivations were cited for establishing the standardisation project, but both were related to the great variation inherent in hospital prices. Firstly, the output measures differed from

one hospital to another, and DRG was a proposed solution to this. Standardisation of hospital output measures was thus on the agenda. Second, even in hospitals that had adopted DRG, there were inexplicable variations in calculated full cost prices. Thus, visibility and accountability had to be increased. One interviewee described the situation as follows:

> And if we look at the reports on hospital pricing, the same product in different hospitals has a different price, and the variation is huge. This means that we have to find out [. . .] where the prices are coming from, how they are calculated. And we know that the rule is, or at least it is supposed to be, that hospital prices are full cost prices. And still we have this huge variation, so I would like to know where this is coming from (Interview no. 23, management consultant, Association of Finnish Local and Regional Authorities).

## 4. Shifting NPM agendas and occupational identities

This section is organised as follows: first the changing (from down group to down grid) NMP agenda and discourse in the form of the National DRG Standardization Project is described. Second, we discuss how the change in the managerial agenda has changed management control, and the implications of this for management accountants' occupational identity and image. Third, we discuss the implications of identity work for resistance to management accounting change.

### *Changing managerial discourses: the case of hospital cost accounting*

As the hospitals that were not using DRG at all or were not using it for management accounting purposes joined the National DRG Standardization Project, the managerial discourse also began to change. As the implementation projects were being initiated, new agendas such as comparability, visibility, recording and classification emerged. It seems that DRG was more than anything associated with efficiency through comparability, i.e. the idea that being able to compare hospitals would create the pressure that would increase efficiency. That pressure would, somehow, originate at least partly from the outside. One interviewee commented on this as follows:

> My understanding is that the DRG is being implemented because of the desire to compare activities and make different hospitals comparable [...] I can imagine that if it can be demonstrated that some of our activities are inefficient in comparison to other hospitals, we will be obliged to take a close look at it [...] the motivation of this is the fear that our limited resources will be wasted on inefficient activities, the resources must be used efficiently, and no one will want to stand out negatively (Interview no. 4, chief of finance, Hospital District B).

Thus, as reported by Llewellyn and Northcott (2005), benchmarking-oriented cost information was seen to promote "averageness". It seems that what was important in the comparability of cost information was that purchasers, not hospitals, would be able to compare the full cost prices. In this way, DRG represents a change of control structure that has an external focus on improving efficiency. That is, efficiency is improved not only by hospitals themselves focusing on operations that seem more expensive than in other hospitals, but also by vigilant purchasers who will either direct attention at too costly services, or purchase them from outside if possible:

> [. . .] the problem is that the purchasers have no comparable product prices, like what this procedure costs in hospital A and hospital B. Different hospitals have different product definitions, and they calculate their costs in different ways [. . .] and it requires quite a lot of

knowledge from the purchasers to be able to make sense of any of this (Interview no. 17, chief of administration, Hospital District E).

According to this line of thought, the heterogeneous nature of costing and pricing was considered a problem. This did not mean, however, that service costs were not calculated, nor did it mean that product cost calculations were in some way incomplete. On the contrary, in many hospitals where DRG had not been previously used, the prevailing method for calculating the costs of health care services was ABC. In fact, ABC had been widely advocated by both consultants and academics, and was widely seen as the "cutting edge" in management accounting and control systems. Even in 2006, the academic research report by Hupli *et al.* (2006) can be viewed to clearly advocate ABC, viewing DRG-based costs as grossly inaccurate and unsuitable for decision-making. Thus it seems that ABC was related to another kind of efficiency discourse that was oriented to production i.e. the idea that modelling processes within the organisation and calculating the costs of the processes would create pressures that would cause organisational actors to improve efficiency. These efficiency pressures would be internal and based on economic rationalism. For instance, widely-cited recommendations by a group of academics to hospital managers stated:

DRG-based information is enough for prospective payment invoicing, but not for managing the clinics. Activity-based costing provides better information for management purposes, but is hindered by the amount of work that is required, and the lack of management accountants (Hupli *et al.*, 2006).

Some interviewees found the two competing discourses confusing. One interviewee attributed this to the different consultants used:

[...] the reason why our policies have been so different [with respect to management accounting] is that we have employed different management consultants, and different consultants have different methods (Interview no. 19, chief physician).

Some interviewees who were strongly in favour of using ABC for cost calculations sought to integrate the existing ABC models with the new DRG system, especially on the wards, and called this integrated model "clinical management accounting". This system, while proclaiming that it is DRG-based, seemed to exhibit many features of ABC. A technical paper written by a clinical manager and a management consultant in Hospital District B states:

Average length of stay has shortened so much that clinical management accounting must measure it in hours, not in bed-days. Many hospitals are today assigning patients to certain activities on the wards, and recording nursing, overseeing and rehabilitation hours per activity [...] according to the cause and effect principle.

*Management accountants' expressions of role and identity: pre-SATU project*

The interviewees were also asked about their education, work experience, and how they perceived their roles in the organisation. It seems that the occupation began to develop only in the mid 1990s, in the wake of the state subsidy reform and the emergence of the first cost accounting systems. At first, the role of management accounting was not always clear, and the job descriptions were quite vague. One management accountant remembered how he began his job in the early 1990s:

> [before the current job] I was an accounting instructor at a commercial school [. . .] my first days at the hospital were quite a shock [. . .] The chief physician was not quite sure what a management accountant was supposed to do, so I was given an office and told just to do something (Interview no. 6, management accountant, budgeting and planning, Hospital District B).

At first, the job descriptions were unclear, and the heads of the clinics might be unsure what kind of tasks management accountants were supposed to accomplish. Normally, the job of the management accountant was to assist the heads of the clinics in pricing, budgeting and *ad hoc* calculations. At the same time medical practitioners were quickly becoming hybridised i.e. assuming management accounting tasks (Kurunmäki, 1999, 2004). For instance, the management accountant mentioned before continued with a retrospective account of his first year as the first management accountant in the hospital's history:

> [. . .] he (the chief physician) never said it aloud, but after I had worked with him for a year, doing the product cost calculations, I realised that he did not understand the concepts of depreciation and overhead cost allocation at all, and I took some time to explain this to him [. . .] After that, I realised that I should not let medical practitioners influence the accounting system too much (Interview no. 6, management accountant, budgeting and planning, Hospital District B).

The latter quote embodies how the newly established management accounting function sought to legitimate its existence and establish boundaries between physicians who had been involved in cost accounting and pricing activities i.e. hybrid accountants (see, e.g. Kurunmäki, 1999; Kurunmäki *et al.*, 2003; Jacobs, 2005).

There seemed to be many variations as to on how management accounting tasks were actually organised. Typically, the heads of the clinics (who were medical doctors) would prepare their clinic's budget assisted by the accountants. The full cost calculations were mostly teamwork requiring the input of different professionals, who would respect one another:

> Cost accounting in our hospital is organised so that at the finance office we have prepared the preliminary calculations, and after that, chief physicians and head nurses have to be in it quite intensively, I mean we cannot know how many minutes of surgery and preparation it typically takes to operate on an ulcer, and this may vary from one year to another, we need professionals to give us this information (Interview no 16, chief of accounting, Hospital District E).

In product and service pricing, arguments concerning competition were presented in several directions. One key idea in establishing comparable prices is the creation of the quasi-market; the idea that municipalities would be able to purchase health care products where the prices were lowest. Such ideas have been evinced in the creation of purchaser-provider models (Siverbo, 2004) managed care systems (Hyvönen and Järvinen, 2006).

However, in order for the prices to be fully comparable, prices would have to be strictly full cost, which, if interpreted strictly, would potentially eliminate all strategic considerations in product and service pricing. Likewise, there could have been no systematic cross-subsidisation between various clinics, which had been a quite common practice (Järvinen, 2006). The interviewees considered that this debate was partly a result of differing opinions on the nature of the public sector; while the

interviewees argued that the National DRG Standardization Project emphasised the non-profit nature of health care organisations in a legalistic way emphasising accountability i.e. that a strict full cost principle should be applied (down grid agenda), others were of the opinion that more freedom would allow for efficient operations, increasing the value-for-money from a tax-payer perspective (down group agenda). One management accountant commented on this:

> [. . .] it is probably because I have a background in business, I am strongly in favour of our hospital carrying its own risk concerning the accuracy of our prices, so that if we calculate our prices wrongly and sell services too cheap, it is our problem and we will suffer from it. So I think that no one from the outside has the right to come and tell us how we should be doing our cost accounting (Interview no. 11, controller, Hospital District D).

Since the hospitals were operationally different, some of the management accountants interviewed did not believe that benchmarking and comparisons would produce credible results, especially in circumstances where there were competitive bids, where DRG was seen as problematic due to its aggregate nature – the municipalities wanted to know exactly what they were purchasing:

> [. . .] a major problem with DRG is that our activities should be similar in order for the cost comparisons to be relevant. For instance, there are so many different types of surgical procedures with different cost structures that it doesn't work. And especially in competitive bidding, where the purchasers will ask us to quote prices in two or three classes [within a single DRG group] anyway (Interview no. 4, chief of finance, Hospital District B).

If the management accountants regarded DRG as insufficient and too aggregate for use in competitive bidding, there was another side of the argument, too. Some interviewees contested the idea of the quasi-market as a source for efficiency, and regarded it as a monopoly instead:

> If we all were to have our services defined in exactly the same way, we would, in essence, create a market monopoly [...] benchmarking of DRG costs by an outside party would suffice for political control, we don't need our actual calculations to be similar across all hospitals (Interview no. 1, chief of finance, Hospital District A).

Thus, the interviewee, who was, incidentally, in charge of DRG implementation, expressed a fear that if all hospitals were to use the same product categorisations and calculate their costs in the same way, the result might as well be the decrease of competition in the long run.

*Post-implementation expressions of role and identity*

The DRG discourse was closely related to comparability. According to a document issued by the Centre of Social and Welfare Research (STAKES):

> Having comparable information between hospitals is one of the central ways of evaluating and developing speciality health care in the future [. . .] our data allow comparisons from the viewpoint of municipalities, financiers, hospitals and other service providers.

The uniqueness of one's own organisation and how it differed from what was considered an "average" way of doing things was a source of resistance amongst the interviewees. There may have been fears that the benchmarking and price

comparisons would create pressures to change organisational structures. One interviewee commented on pressure to standardise as follows:

> It makes absolutely no sense that in every place we should begin to organise our activities in the same way in different organisations. If we here find it necessary for the intensive supervision unit to be part of the Respiratory surgery ward, and other hospitals find it not necessary but have these patients in the intensive care unit instead, or do something else, you can never have the same cost structures (Interview no. 10, chief of finance, Hospital District D).

Overall, the management accountants interviewed seemed to believe that their relative position had improved over time; that they were no longer regarded as office workers doing unimportant jobs. The management accountants were frequently part of the administrative department. However, in some hospitals the interviewees had recently begun to compare themselves to the business controlling function of private firms. A common view among the interviewees was that they wished to rid themselves of the administrative image, burdened with conceptions of bureaucracy and paperwork in stagnant offices. Instead, they modelled themselves on the business world. This was unequivocally stated by a controller, who, perhaps unsurprisingly, had a strong background in the business controlling function of a private sector firm:

> [. . .] my lack [of public sector] work experience is a kind of weakness, but also a strength. I used to work in a company listed on the stock exchange, in various controllership positions, really nothing to do with the public sector [. . .] My work now includes the entire field of management accounting [. . .] what we are doing is the business support of our clinics (Interview no. 11, controller, Hospital District B).

Implementing the DRG system also occasioned new requirements for administrative staff, and new people were being recruited both in information processing and in management accounting. While this administrative burden was a cause of extensive criticism, it was also seen as a chance to increase the size and improve the quality of hospital's accounting staff, increasing the profession's importance. Hospitals were not, however, always viewed as very attractive workplaces in the accounting profession, as it seemed that hospital management accountants could be viewed more as "bean counters" than many others:

> They [the IT department] just hired a new guy, he has an MSc in business economics. Yes, we are also recruiting new people, they all have to have a business education, an accounting education. We have been able to find good recruits, especially at the moment when on the job market they seem to have difficulties finding work elsewhere (Interview no. 10, chief of finance, Hospital District D).

As to the question of how the new work caused by the DRG would be divided between management accountants and medical practitioners, one interviewee replied:

> Will the doctors take care of DRG-based accounting? Certainly not. They simply don't have the time for that. What they have to do is to put down the diagnoses, that is already a lot of work. And then [after the calculations are complete] they have to make use of the new cost information in decision making (Interview no. 16, chief of accounting, Hospital District E).

However, even if the DRG caused new work for both medical practitioners and management accountants, the process was considered integrative. After the DRG system was introduced, one interviewee stated that discussion and communication

between management accountants and medical practitioners had increased significantly:

> I was surprised by the fact that [. . .] the last time when I was reviewing our cost-based prices with our doctors, we had a debate and as a result were able to form a kind of common view on things, so we all thought we have something to contribute to this issue (Interview no. 14, chief of finance, Hospital District E).

The view that collaboration had increased after the DRG implementation was also shared by the chief physicians interviewed, who were both involved in management accounting tasks themselves, and often in a managerial position. One chief physician commented:

> Our accountant, he comes here [to the interviewee's office] regularly and we look at the figures together. We just did the sales budget; it went easily. And he has always found the time for me, and I think this is the best way to do it. If I were to do it myself, it would take me several days, but he does it in a few hours [. . .] he's great (Interview no. 19, chief physician, Hospital District B).

In addition, the he was eager to divest himself from the rest of the management accounting work:

> [. . .] what I have wondered, since the finance department keeps asking us all kinds of information, now that they have these new systems, why don't they do all the calculating themselves. I mean I should not be digging my files for a piece of information that the accountants could probably access themselves (Interview no. 19, chief physician, Hospital District B).

Another medical practitioner who was heavily involved in accounting work also believed that management accountants should take more responsibility for costing in the DRG environment:

> If you want to hear a medical practitioner's opinion, I think that when something is halfway done, it is of no use [. . .] so with a great probability, we would benefit if the accounting function were organised on a more professional basis [. . .] the cost calculations we do here are in some way useful, of course, but for the end user, and that's what I am, the benefit decreases considerably when the quality of accounting numbers goes down. I mean, we should already by now have had decent cost reports issued for every chief surgeon (Interview no. 20, chief surgeon, Hospital District C).

Abernethy *et al.* (2007) note that even if physicians have acquired new linguistic competence in employing accounting rhetoric in their work, studies such as Abernethy and Chua (1996), Covaleski *et al.* (1993) and Kurunmäki (1999) demonstrate how accounting allocations have shifted power and authority away from health care professionals to administrators and financiers. In this process, the medical profession has introduced accounting into its sphere of activities (Kurunmäki, 2004; Kurunmäki *et al.*, 2003) or become almost full-time administrators (Jacobs, 2005). However, the advance of the down grid agenda has increased the complexity of the accounting system and introduced comparisons that require standardised ways of producing accounting numbers. According to the interviewees, this seems to increase calls for a more professionalised (i.e. accountant-run) management accounting system.

## 5. Discussion and conclusion

The purpose of this paper was to study how a change in the NPM agenda and discourses influenced the occupational identity and roles of management accountants. Our starting point was that the workplace is the principal site for the formation of identity, and that occupational identities react to and interact with management control (Alvesson and Willmott, 2002; Ezzmel *et al.*, 2004; Skaærbæk and Thorbjørnsen, 2007). As managerial agendas and discourses change, identities must be worked out or conflict may ensue.

Management accountants in health care can be regarded as a special case because the boundaries of the professional groups are sometimes fuzzy (Kurunmäki. 1999, 2004; Jacobs, 2005). While some studies such as Abernethy and Stoelwinder (1995) argue that professional conflicts can be controlled by separating the administrative and medical professions, other studies, such as Comerford and Abernathy (1999) and Kurunmäki (2004), advocate integration. In fact, a study by Ahrens and Chapman (2000) found that while management accounting innovations such as ABC and enterprise resource planning systems influenced the occupational roles of management accountants, they did not influence the occupational identity of management accounting much. Thus it is not the new technical tool in itself that requires identity work, but the new managerial agenda behind or associated with that tool.

While identity as such can be an elusive concept, occupational or workplace identity is much less so. Here we have viewed management accountants' occupational identities as accounts constructed in interview situations together with the interviewees (Silverman, 1993). The empirical setting for this study was Finland's National DRG Standardization Project, which has pressured Finnish hospitals to abandon their traditional management accounting systems and adopt a diagnosis-based case-mix accounting system that is uniform across all hospitals. Our primary data came from interviews with management accountants working in Finland's five university hospitals. The date was triangulated so that in each hospital several management accountants were interviewed on the same subjects. In addition, at least one other person per hospital working in close connection with the management accountants was interviewed for the purpose of ensuring the internal validity of the study. After that, the transcribed interviews were compared with the secondary archival data to establish a coherent picture of the management accounting change.

In this study, we employed two agendas within NPM that have been discussed in the literature, namely the down group agenda emphasising private sector orientation, and the down grid agenda emphasising measurable and comparable outputs (Dunleavy and Hood, 1994; Broadbent and Laughlin, 1998). In its variety, NPM has been found to be an extensive phenomenon with a capacity for internal contradictions (Groot and Budding, 2008). We argue that in Finland the adoption of hospital costing systems has been roughly a two-stage process, where methods consistent with NPM's down group agenda have been first taken to use. Since 2003, the emphasis of costing system development has shifted to methods more consistent with the down grid agenda.

Thus, while both the old costing system (ABC) and the new one (DRG) have been associated with NPM-related accountability arrangements, they represent different managerial agendas within the NPM ideology, and have the capacity to contradict one another. Most interviewees seemed to associate ABC with an efficiency discourse

including conceptions of modernity and private sector idealisation (Arnaboldi and Lapsley, 2003, 2004; Järvinen, 2006) with an internal, production-oriented focus (Jones and Dugdale, 2002; Ezzmel *et al.*, 2004). While DRG also seemed to be associated with a commercial mindset (Preston *et al.* 1997; Lehtonen, 2007), the interviewees accredited DRG with more emphasis on benchmarking and comparability.

One key feature of the National DRG Standardization Project was to implement a uniform cost accounting system in hospitals irrespective of local needs or strategy. Interestingly, this suggests that key decision-makers may have disregarded the notion common in accounting literature that strategy, structures and accounting control systems should interact (see, e.g. Abernethy and Lillis, 2001). Instead, strategy was seen by the interviewees as irrelevant and attention was directed to benchmarking strategies (see Llewellyn and Northcott, 2005). The actual costing system implementation, however, was decentralised and left the majority of decision-making power at the local level. Like Grafton and Lillis (2005) we found that reactions to public policy agenda and standardisation differ somewhat, and that decentralised autonomy has the potential to influence how goals of managerial reforms are achieved.

While NPM practices have been reported to have programmatic features concerning the limiting of professional autonomy (Broadbent and Laughlin, 1998), those able to ride on the crest of the wave of new ideas and find legitimation for their actions may stand to gain. Thus, such accountability arrangements influence professions (Kurunmäki, 2004; Jacobs, 2005; Skaærbæk and Thorbjørnsen, 2007) and might, in part, explain why certain organisational groups choose to identify with one managerial agenda more than other (Jary, 2002; Ezzmel *et al.*, 2004). In such circumstances, occupational identities were found to be split in diverse directions. Some of the management accountants interviewed seemed to identify with the down group agenda and emphasised the adoption of management tools that had proved successful in private businesses. These interviewees also made it clear that they were business-school trained and/or had a background in private business.

It seems that the discourse associated with private sector ideals concerning management accountants' roles and business partnership was associated with the criticism of the DRG system and a requirement for unified cost information. The notion that costs should be calculated in the same way across all hospitals seemed to be a limiting and restrictive form of centralised control. Instead, for those emphasising the business controller identity/image it was important for "backward" public services to learn from leading businesses. The idea that all hospitals should have similar systems was condemned by these interviewees as "absurd" (although the activity-based systems did in fact exhibit some similarity). Thus, these management accountants seemed to have embraced the notion that accounting systems should be aligned with strategy and structure in order to improve performance (see, e.g. Abernethy and Lillis, 2001). These interviewees generally rejected the indifferent view according to which, since hospitals were a public service, the exact mechanism by which municipalities should be charged for patient visits was basically an uninteresting issue. Here, the comparison with private sector management accountants also seemed to represent a preferred occupational image (Bougen, 1994; Vaivio and Kokko, 2006), although not necessarily the actual role, of the interviewees (Dutton and Dukerich, 1991).

On the other hand, in hospitals where ABC had not apparently played a major role in cost accounting and pricing, the interviewees seemed to identify more with the down group agenda. A commonly expressed view was that benchmarking costs would eventually result in more standardised procedures and uniform cost behaviour i.e. "averageness" (see Llewellyn and Northcott, 2005). Typically, they expressed concern about efficient health care provision but emphasised the social role of hospitals and the importance of health care to all. However, somewhat paradoxically (but similarly to, e.g. Grafton and Lillis, 2005), the responsibility for the DRGs was left to the local level, resulting in variations in the level of implementation.

In our interpretation we have assumed that members of an occupational group monitor and evaluate the stance taken on the shifting managerial agendas, because this influences others (e.g. the medical profession, the financiers) to make characterisations of it. This way, a dynamic role image, for instance the business controller or a change agent role (Granlund and Lukka, 1998) can be linked to images of modernity (Arnaboldi and Lapsley, 2003, 2004). Interestingly though, those who may have been concerned with the adoption of "modern" cost accounting systems in the past, may be in danger of at least partially losing the legitimacy of their actions when there is a shift in managerial agendas. Such modernity, however, is elusive and prone to continuous change. In fact, studies such as those by Arnaboldi and Lapsley (2003, 2004) and Järvinen (2006) have found little support for rational choice in costing systems and suggest that seeking legitimacy from the financier is the key to understanding many accounting reforms (see also Carpenter and Feroz, 2001).

All in all, we argue that studying the occupational identities of management accountants and their identity work can offer insight as to why certain accounting systems are viewed more acceptable than others, and what consequences the process leading to eventual acceptance has in organisations. We are, however, left with a feeling that the influence of contradictory management agendas on inter-professional competition, professional boundaries, the fear of becoming "bean counters" as a source of occupational identity, and the possibility of "split identities" would warrant further research.

## Notes

1. Finland is divided into 17 hospital districts, of which five are centred around a university's medical faculty.
2. In fact, the cuts in Finnish total health expenditure in the 1990s can be characterised as quite drastic in the OECD context. For instance, in 2000 the health care expenditure per capita was in real terms still lower than at the beginning of the 1990s.

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