ACCOUNTING IN HOSPITAL ORGANISATIONS IN NEW ZEALAND: A QUALITATIVE STUDY IN THE REFORM CONTEXT OF 1984-1994

A thesis presented for the degree of

Ph.D in Management Systems

at Massey University

KEITH DIXON

1994

ABSTRACT

Most general hospitals in New Zealand operate as part of the public sector. Since 1984, that sector has been the subject of radical, government led reforms. The espoused theory of these reforms has been expounded in terms of improving efficiency and effectiveness, and increasing accountability (Boston, Martin, Pallot & Walsh, 1991; G. Scott & Gorringe, 1989). The outward effects of these reforms on the hospital system consist of organisational changes, including the creation of hospital enterprises; changes to the way organisations are financed, including the use of taxes to purchase hospital products delineated according to diagnosis related groups [DRGs]; and changes to their management structures with a policy of *general management* replacing *triumvirate management*.

Inevitably, these official changes have led to social changes to the system in general, and to the situated practice of accounting (Chua, 1988). In this study, an attempt has been made to describe and interpret these changes in the hospital system context, and to shed some light on the way in which accounting has come to be practised within that context. The theoretical posture of the study is a blend of rational, structuralist perspectives, and natural, interactionist ones (Boland & Pondy, 1983; Roberts & Scapens, 1985; Silverman, 1985; Denzin, 1989b). Consistent with this posture, the study strategy of control and design is a version of analytic induction (Denzin, 1989b; Silverman, 1985). The strategy comprised three phases during which a rough notion of accounting in hospital organisations was transformed into a working interpretation; data were gathered and analysed; and a thesis was compiled. The latter comprises thick descriptions and thick interpretations (Denzin, 1989a, 1989b; Patton, 1990) of the hospital system context and the situated practice of accounting; and a theory-in-use (Argyris, 1990; Argyris & Schon, 1974) which provides "explanations in terms of conditions of possibility" (Miller, 1990, p. 329) of what has been occurring in the hospital system, and the role of this situated practice in these occurrences.

Underlying the study methodology was the notion of crafting both the study design and the theory which the study aimed to discover. The data were obtained using methods associated with naturalistic inquiry during time spent in the field. The use of these methods was prompted by a dearth of research published in this area relating to New Zealand, the wide range of perspectives among people participating or interested in the organisations, and the enormity of the changes to the system. The data were

accumulated triangulately (Denzin, 1989b) from among different kinds of participants working on hospital sites (e.g., doctors, charge nurses, other health professionals and hospital staff with managerial responsibilities), from interested parties off-site (e.g, people working in the Department of Health, regional health authorities and organisations outside of the hospital system), and from official documents and published academic literature. The main vehicle used in the field was the *nonschedule standardised interview* (Denzin, 1989b), and inquiries focused, in turn, on practices relating to the budget, cost data reports and the annual report. In addition, interviews of a more general and exploratory nature, and some questionnaires, were used in the preliminary stages of the study.

The picture which emerges from the study comprises four aspects:

(a) a hospital system subjected to macro-level disturbances that have caused a mixture of effects in terms of structures, processes, interactions and outcomes;

(b) an emergence of accounting since the mid-1980s in multiple roles, which are reflective and constitutive of organisational and social practices developing in the system (Ansari & Euske, 1987; Boland & Pondy, 1983; Burchell, Clubb & Hopwood, 1985; Chua, 1995; Kelly & Pratt, 1992; Loft, 1986; Roberts & Scapens, 1985);

(c) qualified success for the situated accounting practice in the role of a political force in converting hospitals to a more effective form of organisation (Mintzberg, 1991); and

(d) accounting practice at a fork in the road ahead, one way leading to its contamination of hospitals by inappropriate forces and forms (Mintzberg, 1991) based on production management; and the other leading to its emergence as an important support in a hospital system founded on a more conjoint organisational configuration (W. R. Scott, 1982) in which professionals and managers apply their craft cooperatively for the joint and several benefit of patients.

These findings have implications which policy makers, health professionals and the public are urged to evaluate.

ACKNOWLEDGEMENTS

I should like to acknowledge the many people who have contributed in various ways to my research and allowed and encouraged me to complete it. Professor Nancy Kinross has played an active part in guiding the study design, helping reflect on the analysis and criticising the thesis as it was being written. Professor Michael Pratt encouraged my original participation in the PhD programme, helped identify the study area and carry out the exploratory work, and provided guidance at a distance during the field experience and thesis phases. Dr Becky Emery also had a hand in the early work. The Health Workforce Development Fund of the Department of Health contributed to the costs of data collection, analysis and reporting. About 120 health workers gave their time to be interviewed or to complete questionnaires, and eight more helped me obtain access to these people. They and their organisations are thanked for confiding their experiences, opinions and feelings. During the writing of this thesis Professor Reg Mathews provided useful comments and encouragement. As it came towards completion, Professor Tony Vitalis made several useful suggestions. Miss Ruth Brodie assisted with the word processing, and Mr Andrew Rowatt helped in overcoming some complications with producing the Figures. Mrs Ann Austin provided editorial comments on the manuscript. I should also like to thank Hegnes, Krista and Harry, our friends, and my colleagues at Massey and elsewhere for their assistance, tolerance and understanding.

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The style of referencing, system of headings and other aspects of style used in this thesis have been guided by the Publication manual of the American Psychological Association (3rd ed.). (1983). Washington, DC: American Psychological Association.

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CHAPTER ONE
PANORAMIC VIEW OF THE STUDY

This chapter starts by outlining the key aspects of the study and its contributions to knowledge. Next, the structure of the thesis is enumerated chapter by chapter. The chapter is completed by further notes on the study's relevance and importance, notes on its limitations, and a comment about the way in which the research was conducted and reported.

Key Aspects and Contributions to Knowledge

This thesis is the culmination of a study of the practice of accounting in hospital organisations in the New Zealand public sector from 1987 to 1994[1] [hereafter "the Study"]. This period was characterised by official and social changes to both the hospital system in general, and to the way in which accounting is practised. This latter "situated practice of accounting" (Chua, 1988) is illuminated in order to render it meaningful and understandable; and a theory-in-use (Argyris, 1990; Argyris & Schon, 1974) is proposed. This theory provides "explanations in terms of conditions of possibility" (Miller, 1990, p. 329) of what has been occurring in the hospital system and the role of this situated practice in these occurrences. Among other things, it is compared and contrasted with the espoused theory under whose guise changes to accounting practice were introduced.

The theoretical posture presented in this thesis is a blend of rational, structuralist perspectives, and natural, interactionist ones (for similar postures, see Boland & Pondy,

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[1] During this period these organisations have been known variously as hospital boards, area health boards and Crown health enterprises.

1983; Roberts & Scapens, 1985;[2] Silverman, 1985[3]). Consistent with this posture, the strategy of control and design reported is a version of analytic induction (Denzin, 1989b; Silverman, 1985). Most of the data were obtained at a micro-organisational level of analysis using methods associated with naturalistic inquiry (Denzin, 1989b) during time spent in the field. Even so, the Study also addresses the industry level, and relations between it and the micro-organisational level. One of the contributions of the Study stems from aspects of the methodology and design being novel in the context of accounting research. These matters are explained in chapters 2 and 3, along with details of data collection, analysis and synthesis.

When the Study began in 1987, research into the nature, role and practice of accounting in New Zealand hospital organisations was conspicuous by its absence, in contrast to a steady stream of published studies from North America, Britain and Australia. Virtually no descriptions were found of the accounting work done either by accounting specialists or others in these organisations, nor about the efficacy of this work. Indeed, there was a dearth of reported research into more general aspects of the administration of these organisations (see Salmond, 1988).

This lack of knowledge of the situation in New Zealand provided the impetus for getting this research under way. Furthermore, during the Study period the health system in New Zealand was caught up in radical, government-led reforms (Boston, Martin, Pallot & Walsh, 1991; James, 1986; Munro, 1994b) which led to fundamental changes in structure and process across the system. These politically charged changes are still in progress at the time of writing, and their meanings from the perspective of people in

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[2] Roberts and Scapens (1985) attribute their "possible synthesis of the different schools which compose contemporary social theory" (p. 444) to Giddens, and use this as a basis for conducting "dialogue across [functionalist and interpretative] paradigms" (p. 444).

[3] Silverman (1985) proposes a theoretical synthesis between structuralist and interactionist perspectives based on the work of Bhaskar. He calls this synthesis *realism*, which name is neither unambiguous nor helpful. For example, the synthesis he proposes is quite distinct from *physical realism*, an idea which Chua (1986) says (accurately) dominates mainstream accounting research ontologically.

hospitals became part of the research problem. This work makes a contribution by providing insights into people's changing perceptions of accounting while working in a discordant environment. These insights attest to the social nature of accounting, rather than the technical-rational one to which most espoused theories are limited, have been captured in the thick descriptions (Denzin, 1989a, 1989b) which comprise chapters 5 through 7, and 9 and 10 of the thesis. Also, the changes affected the way in which the Study was designed and carried out, and this is explained in chapters 2 and 3.

In keeping with the *rapprochement* between the micro-organisational and industry levels of analysis (Chua & Degeling, 1993; Silverman, 1985), a second useful aspect of the Study is the induction of a map of the changing hospital system context. This map has been dubbed the *function and values framework* after the way it was induced as explained in chapter 4. It illustrates the marked contrast in emphasis between health professionals at the individual level who have a micro-orientation associated with dealing with each patient; and the central authorities and hospital organisation managers who have a macro-orientation associated with resource allocation (Ackroyd, Hughes & Soothill, 1989; W. R. Scott, 1982). This contrast is a main feature in the descriptions, interpretations and theory-in-use that comprise this thesis.

The map provided a basis for focusing the Study, including organising the thick descriptions mentioned above. In turn, these descriptions were used to induce thick interpretations (Denzin, 1989a, 1989b) of the hospital organisation context within which accounting is practised (see chapter 8), and of the situated practice (Chua, 1988) of accounting among people working in hospital organisations (see chapter 11). These aspects of the Study are useful in that for both policy makers and participants in the system they can provide illumination and promote understanding of what has "occurred in a problematic situation" (Denzin, 1989a, p. 144). Also they "permit reasonable 'extrapolation'" (Cronbach et al., cited in Patton, 1990, p. 489) about past events and the prospects for the future.

The researcher has attempted one such extrapolation and, as a result of this inductive process, has constructed a theory-in-use (Argyris, 1990; Argyris & Schon, 1974) which

provides an explanation of "how . . . accounting has become implicated in the functioning" (Burchell, Clubb, Hopwood, Hughes & Nahapiet, 1980, p. 23) of all levels of the hospital organisation system since 1987, and an opportunity for speculating about its future. This theory is presented in chapter 12. It may be referred to as a theory-in-use because: first, it comprises "universal relationships that are grounded in forms of situated practice" (Chua, 1988, p. 73); and second, it governs the actions of the people working in, or involved with, the organisations being studied.

One of the most pertinent things about the theory-in-use is that it can be compared and contrasted with the espoused theory (Argyris & Schon, 1974, Patton, 1990) of accounting, to which hospital organisations and the system in general give their official allegiance, and which has been prominent in justifications of the health reforms (e.g., see Caygill, 1988; Health and Disability Services Act of 1993; Hospital and Related Services Taskforce, 1988; McCulloch & Ball, 1992; National Interim Provider Board 1992; Public Finance Act of 1989; G. Scott & Gorringe, 1989; G. Scott, Bushnell & Sallee, 1990; Treasury, 1990; Upton, 1991). One useful outcome of this kind of comparison is that it can inform, corroborate and add to knowledge about roles of accounting (Ansari & Euske, 1987; Burchell et al., 1980; Boland & Pondy, 1983; Kelly & Pratt, 1992; Miller & O'Leary, 1987). Similarly, the extent can be gauged to which, in the context of the changes to the hospital system in New Zealand and probably of the changes to the entire New Zealand public sector, "the consequences of accounting do not necessarily have a close and automatic relationship with the aims in the name of which it is introduced and changed" (Hopwood, 1984, p. 185, also quoted in Ansari & Euske, 1987, p. 550). These matters are also examined in chapter 12.

Organisation of the Thesis

The thesis is in four parts addressing the grand design (chapters 1 to 3), a mapping of the hospital system context (chapters 4 to 8), the situated practice of accounting (chapters 9 to 11), and the theory-in-use being proposed (chapter 12). An outline of each of the 12 chapters follows, showing how the various aspects of the Study outlined above are developed in the thesis.

Chapter 1

This chapter starts by outlining the key aspects of the Study and its contributions to knowledge. Next, the structure of the thesis is enumerated chapter by chapter. The chapter is completed by further notes on the Study's relevance and importance, notes on its limitations, and a comment about the way in which the research was conducted and reported.

Chapter 2

This chapter is used to explain matters of methodology, design and purpose. It starts with some brief comments about the Study vis-à-vis traditional accounting research methodology. The next part is a report on how the theoretical posture, and the design and control strategy, evolved; and how this process was intertwined with events in the Study setting. Also incorporated is an articulation of the purpose and aims of the Study. Next, matters of methodology, method, sophisticated rigour, validity and reliability are discussed. These encompass an enumeration of matters which should be made public as part of a research study; namely, the researcher's personal values and the basic assumptions underlying the Study.

Chapter 3

This chapter sets out the events in the Study design and control strategy. Details are given of episodes of data collection and analysis, and how these were used to formulate consecutively two rough notions, a working interpretation, and a theory-in-use of accounting in hospital organisations. Included in the chapter are statements of the rough notions and working interpretation that were derived.

Chapter 4

This chapter arises out of the need to focus the analysis of the qualitative data generated in the Study. It comprises a review of the literature from which the idea for a framework of the hospital system was derived. The framework is based on the contrasting functions and values of people participating in the system, and the organisational forces at work there. Incorporated at the end of the chapter are cast lists of the 34 people interviewed at three hospital sites, and of the 14 people interviewed at off-site locations. These lists show where each interviewee fits into the framework, and helps clarify the wealth of quotational data presented in subsequent chapters.

Chapter 5

In this chapter within-case analyses are used to elaborate the operating core and support service elements of the functions and values framework of the hospital system.

Chapter 6

In this chapter within-case analyses are used to elaborate the elements at the institution level of the functions and values framework of the hospital system.

Chapter 7

This chapter elaborates on the central authority level and on the way changes promulgated centrally have affected hospital organisations. It also contains some perspectives from people in the community.

Chapter 8

This chapter presents a thick interpretation which takes the reader to the heart of the processes and interactions thickly described in chapters 5 to 7. The interpretation illuminates and promotes understanding of the hospital organisation and hospital system context of accounting. This is done by examining each element in the functions and values framework and the relationships between these elements.

Chapter 9

The chapter provides a thick description of the situated practice of accounting in hospitals in 1992-93, focusing on the budget cycle, and the budget setting phase of that cycle among responsibility centre managers, and service managers and their support staff. This phase is covered in linear fashion from the start of budget preparation until a budget is formally approved, which usually happens part way through the financial year.

Chapter 10

The chapter provides a thick description of the situated practice of accounting in hospitals in 1992-93, with particular emphasis on monitoring spending, control and answerability among responsibility and service managers and their support staff. In the course of this description, other accounting processes are implicated, including internal charging, output reporting, case mix costing and annual reporting. The thick description proceeds chronologically from the start of the financial year until after it has been completed.

Chapter 11

This chapter presents a thick interpretation which takes the reader to the heart of the accounting processes and interactions thickly described in the two previous chapters. The interpretation illuminates and promotes understanding of the situated practice of accounting among doctors, other health professionals, and service managers and their support staff.

Chapter 12

In this chapter a theory-in-use of accounting in hospitals in New Zealand is articulated. This theory attempts to explain what has occurred and to speculate about prospects for the future. It takes the form of a series of propositions which are set out chronologically and oscillate between the macro-industrial and the micro-organisational levels of analysis. The official sources in which the espoused theory of accounting in hospitals is portrayed are alluded to, and some comparisons and contrasts are made between the theory-in-use and the espoused theory. The remainder of the chapter contains reflections on aspects of the Study, including the methodology that was used, future research topics, and the researcher's personal journey.

Relevance of the Study

The question of relevance is the subject of a paper by Thomas and Tymon (1982). Writing in relation to *organisational sciences*, they aligned their survey with other contemporary criticisms of the narrow functionalist perspective, including people such as Pondy, Kilmann, Mitroff, Morgan and Smircich, some of whose work is cited later in the thesis. In particular, they were concerned about "conventional [functionalist] notions of methodological and scientific rigor" (p. 345) directing "energy away from the relevance or usefulness of research and in many cases has encouraged research that is of questionable practical utility" (p. 346). They go on to refer to five properties which enhance the relevance of a piece of research, and these are used here to discuss the relevance of the Study.

In the matter of *descriptive* and *goal relevance*, there seems to be an assumption among policy makers in government (e.g., Treasury, 1990; Caygill, 1988) and people of like mind (e.g., Hospital and Related Taskforce, 1988; New Zealand Society of Accountants [NZSA], 1987) of a causal relationship between utilising accounting and improving the performance of hospital organisations. These policy makers and other people also seem

to assume that accounting is capable of manipulation in ways that can alter the behaviour of hospital organisations and the results they achieve. By contrast, empirical studies in other countries have shed some doubt on the accuracy, appropriateness, acceptability and efficacy of these two assumptions. These circumstances made it worth investigating the situation in New Zealand.

The Study also exhibits the other three properties mentioned by Thomas and Tymon (1982). First, the Study possesses *operational validity* in that the methods used in the Study, and therefore the research findings, are defensible as valid, reliable and capable of being understood and applied to the organisations affected. Second, the research conclusions are *nonobvious*; and thirdly, the research is *timely*, given the controversy prompted by the changes to the official order of hospital organisations implemented in 1989 and in 1993. Indeed, the Study should inform the debate about the appropriateness of the model introduced in 1993, and about other aspects of the changes.

Importance of the Research

The Study is important in both its macro- and micro-aspects. The macro-aspects derive from the size and scope of the activities of hospital organisations, and their social and economic significance. Among the many components of their services, they provide almost 20,000 beds in approximately 50 general hospitals, 20 maternity hospitals, and a mixture of 60 other hospitals providing geriatric, psychiatric and other special care (Department of Health, 1991a). In economic terms, health expenditure accounts for around 7% of New Zealand's gross domestic product. According to the Ministry of Health (1993a), "just under 80% of the total direct expenditure on health services" (p. 2) was being met from the public purse in 1993-94, and Parliament was appropriating about $5.2bn per year to finance health, including accident treatment funding. Of this, $4.65bn was in Vote Health, and about 85% of this Parliamentary appropriation was going to regional health authorities "to purchase personal health and disability support services" (p. 22).

Significant as it is, the GDP statistic probably understates the extent to which the state health service pervades the life of every family in every community from the cradle to

the grave, and of every workforce in every organisation. Thus, at the micro-level individuals and their families, friends and neighbours depend on the relationships they enter into with health professionals within and outside the hospital and related services system of care. There are also some grounds for arguing that many communities in New Zealand, particularly those in rural areas, retain some of their identity by having a hospital, along with their school and their post office. Despite the desire on the part of government over many years to "rationalise" the hospital system and to close "uneconomic" hospitals (Department of Health, 1969; "A Health Service," 1975; National Interim Provider Board, 1992; Upton, 1991) most still remain as a symbol of these communities, even if services associated with them are being removed[4].

Limitations of the Study

There are undoubtedly many limitations to a study like the present one, conducted by one person in a relatively short time. However, only two will be mentioned. First, the Study has been carried out by a researcher who has approached it from the perspective of the academic discipline of accountancy which, like any other, has an image or set of constructs that are "used to shape and understand the reality being investigated" (S. W. Davis, Menon & Morgan, 1982, p. 307). That is not to say that he has allowed himself to be dictated to by that discipline's traditional myopic view of research as limited to a range of quantitative techniques (Tomkins & Groves, 1983), nor to its traditional view of accounting as serving only rational purposes in a reflective capacity (Ansari & Euske, 1987; Boland & Pondy, 1983; Burchell, Clubb & Hopwood, 1985; Chua, 1995; Kelly & Pratt, 1992; Loft, 1986; Roberts & Scapens, 1985). Indeed, the methodology and design chosen were bold in terms of most contemporary studies (see chapter 2). Nevertheless, studies from a medical, nursing or similar professional perspective would undoubtedly have been different; as indeed would studies from an economic, political or sociological perspective.

Second, in order to restrict the size of the project, organisations representative of the private sector providing secondary care were not included in the Study. That is not to

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[4] For example, see Bell (1994) about Dannevirke hospital.

say that a study of the situated practice of accounting in the private sector would not be worthwhile. While private sector organisations have not been subjected directly to the reforms imposed on the public sector by government, undoubtedly they have been affected by the wash generated by the reforms. The situation whereby private sector activity and public sector activity in the secondary healthcare industry in New Zealand have complemented rather than competed with each other may well change as the 1993 reforms gain momentum and the competition sought by government (Upton, 1991) becomes a reality. The possibility of services and hospital organisations being privatised looms large in many people's minds.

Contrast Between Doing the Study and the Way it is Reported

In this thesis the researchers's experiences are presented in a relatively ordered, coherent manner, starting with the thinking process and proceeding to the doing process. It is important, however, to note that as in most research the reality was one of muddling through, incrementalism and political process (Pettigrew, 1985). The criteria of unstructured design, and design evolving along with field observations, are regarded as "a unique and significant feature of field research" (Ferreira & Merchant, 1992, p. 5). Thus, according to Guba and Lincoln (1983):

> the naturalist, entering the field without *a priori* theory or hypotheses (mostly), is literally unable to specify a design (except in the broadest process sense) in advance. Instead, he or she anticipates that the design will emerge as the inquiry proceeds, with each day's work being heavily dependent on what has gone before. (p. 325)

CHAPTER TWO
METHODOLOGY AND DESIGN STRATEGY

This chapter is used to explain matters of methodology, design and purpose. It starts with some brief comments about the Study vis-à-vis traditional accounting research methodology. The next part is a report on how the theoretical posture, and the design and control strategy, evolved; and how this process was intertwined with events in the Study setting. Also incorporated is an articulation of the purpose and aims of the Study. Next, matters of methodology, method, sophisticated rigour, validity and reliability are discussed. These encompass an enumeration of matters which should be made public as part of a research study; namely, the researcher's personal values and the basic assumptions underlying the Study.

Introduction

The primary purpose of this chapter is to inform readers about strategic aspects of the Study so they may evaluate its reliability and validity from their particular perspectives. This is important for two reasons both of which are related to what was signalled in chapter 1 about the Study entailing:

(a) naturalistic inquiry and qualitative methods;

(b) a design and control strategy of analytic induction; and,

(c) a theoretical synthesis or triangulation (Denzin, 1989b) between rational, structuralist perspectives, and natural, interactionist ones.

The first reason is a general commitment to what Denzin (1989b) refers to as *sophisticated rigour*, which requires researchers who use empirical, interpretive schemes to make these schemes as public as possible (see also Ferreira & Merchant, 1992; McKinnon, 1988; Patton, 1990; and pp. 31, 35 of this thesis). This matter is addressed in the section after next through to the end of chapter 3. The second reason stems from the state of accounting research, and in particular because the choices which were made were bold in terms of the traditions of research in that discipline.

Accounting Research Methodology

Little more than a decade ago it was said that: "The academic accounting fraternity seems to be locked into a myopic view of what research is. It often seems to consider alternative quantitative techniques as the equivalent of the available range of research styles" (Tomkins & Groves, 1983, p. 361). Since then the study of accounting has branched out, but as recently as 1992 Broadbent noted that the majority of accounting and organisational research falls in the functionalist paradigm (see also Burrell & Morgan, 1979; Hopper & Powell, 1985; Laughlin & Lowe, 1990). Nevertheless, there is a growing number of management accounting studies in particular which might be classed as interpretive or based on what Denzin (1989b) labels *naturalistic inquiry* (e.g., a number of such studies are reviewed or referred to by Broadbent & Guthrie, 1992; Chua, 1986, 1988; Covaleski & Dirsmith, 1990; Ferreira & Merchant, 1992; Roslender, 1990). But this growth has been due more to expansion in accounting research than to any shift in methodological emphasis, and interpretive studies still make up only a tiny proportion of the research into accounting published to date.

The present circumstances make for what could be called a *paucity trap*, in that researchers who might be inclined to employ naturalistic inquiry are hampered in two ways. First, they lack exposure to and expertise in this form of inquiry, and have few colleagues to turn to for guidance. Second, consumers and critics of their research lack familiarity with naturalistic inquiry, and so are inclined to question the reliability and validity of studies based on them (McKinnon, 1988). Indeed, there are many critics who take a pro-functional and anti-interpretive position. Naturally, this provokes a contrary response from some of the people who have a pro-interpretive position, and the resulting polarity (Laughlin, 1992) further hampers researchers who try to break out of the paucity trap (for a discussion about similar problems in sociology in the 1960s and 1970s, see Silverman, 1985). Thus, despite the volume and variety of material that has appeared in recent years, this researcher feels a need to justify his methodology and design strategy explicitly in order to gain acceptance for the Study findings among scholars of the accounting discipline. The rest of the chapter attends to this matter incidentally to its main aim, which is to make various matters as public as possible, in keeping with the notion of sophisticated rigour referred to above.

The Emergence During the Study of Methodology, Purposes and Aims

As is implicit in naturalistic inquiry, the Study design emerged as the research proceeded, with each episode depending on previous episodes (Guba & Lincoln, 1983). In retrospect, the general approach has been eclectic, in that the methodological concepts and procedures applied are traditionally associated with various theoretical perspectives. In fact, ideas were selected if they fitted the purpose (Patton, 1990), but the researcher attempted to avoid theoretical inconsistencies and other traps (Chua, 1988; also, see pp. 27-28 of this thesis).

The Contextual Relevance of the Method and Methodology

Getting Started

Making tactical choices that fitted the purpose was done from the outset of the Study in 1987. At this time, reported research into the nature, role and practice of accounting in New Zealand hospital organisations, and into more general aspects of the administration of these organisations, was conspicuous by its absence. This initial problem of a lack of local research was addressed primarily by visiting hospital organisations and talking with people involved in them. These early visits to the field marked the point of departure into the use of qualitative inquiry (Patton, 1990). Employing similar theoretical and methodological ideas throughout the Study, as reported later in this chapter and the next, stemmed partly from the usefulness of these early encounters.

Qualitative Methods for Data Collection

During the course of the Study there were many more incidents which reinforced the view that qualitative methods, which generated data at a micro-organisational level of analysis, were relevant to studying hospital organisations in New Zealand. Among other things, it could be inferred from these incidents that:

(a) Various groups of people involved in these organisations seemed to perceive the world in disparate ways;

(b) The languages of these groups had insufficient commonality to enable the formulation of questions which would have had the same meaning for different people; and

(c) The organisations were in an obvious state of traumatic change (Denzin, 1989b, and Patton, 1990, were particularly useful in drawing out these points).

Attaining a Theoretical Posture

Paralleling the emergence of this view on methods and data, the view was also reached that the broad ontological assumptions of the interpretive paradigm had a significant place in the Study. However, it was felt that going too far in the direction of interpretive frameworks would be just as spurious as taking an extreme functionalist position. This view stemmed from the beliefs which the researcher brought with him into the Study (see pp. 39-40 below), and the data which were gathered in the field (e.g., what participants said about "the government", "the health system", "the hospital", "the ward"), from official sources and from secondary sources. These data reinforced his view that the ontological assumptions of the pluralism area of the functionalist paradigm were also relevant. In particular, this second set of assumptions was essential to being able to address: the macro-level of analysis as well as the micro-level; relations between the two; and, issues to do with "survival, the prevention of system breakdown and negative entropy" (Hopper & Powell, 1985, p. 445). Thus, as signalled earlier, the theoretical posture presented in this thesis is a blend of rational, structuralist perspectives, and natural, interactionist ones. In this perspective it is assumed that, "The social world is no more reducible to members' meanings than it is reducible to purely objective structures" (Silverman, 1985, p. 47).

This perspective is similar to ones adopted by other accounting researchers. These include Boland and Pondy (1983), who argue that emphasising the polarities of natural and rational system theories in a research design "fails to appreciate the interaction of the natural and rational aspects of organizing and the dialectic quality of the lived experience in organizations" (p. 225); and Roberts and Scapens (1985), who point out that "mutual exclusivity of paradigms holds out the unwelcome promise of a social

science that is forever internally divided" (p. 444). A more complete articulation of the basic assumptions which characterise the theoretical posture of the Study is given later in the chapter (see pp. 40-44 below).

Strategy of Design and Control

In keeping with the theoretical posture, the strategy of design and control is a version of analytic induction (Denzin, 1989b; Silverman, 1985; see pp. 34-35 of this thesis). This strategy was crafted in the manner that a potter might craft clay (Mintzberg, 1987). The strategy involved four steps and has something in common with versions of analytic induction outlined by Denzin relating to biographical and visual methods. These steps are enumerated in Exhibit 2.1, in which they have been further synthesised into three phases. How this crafting ensued is related next. As well as providing some initial assurance about the reliability and validity of the Study (see discussion on pp. 31-36), this should give the reader some idea about events in the Study setting.

An Elaboration of the Interplay Between the Study Design and its Setting

The crafting of the Study design and control strategy was contingent on characteristics of the setting, including practical difficulties in obtaining access to organisations and people. Major changes were occurring to the "official order" of hospital organisations; and naturally, these entailed extraordinary changes to their "social order [which] is composed of the patterns of relationships, meanings and interpretations as constructed and made sense of by the interacting individuals" (Preston, 1986, p. 525, also cited in Chua, 1988, p. 68). Note that, while Chua subsequently criticises the validity of the distinction between "official" and "social" orders (p. 70), she does so in a way that suggests that the former is socially constituted by people in authority from whom *espoused theory* (Argyris, 1990; Argyris & Schon, 1974; Patton, 1990) also tends to originate.

James (1986) traced the undercurrent of the political, economic and social changes in New Zealand back to the early 1970s, but they were not implemented in earnest until after Prime Minister Sir Robert Muldoon was defeated in the 1984 general election.

Exhibit 2.1. Steps in the analytic induction control and design strategy of the study.

CONCEPTUAL PHASE

Step 1: The researcher creates and formulates a rough notion of accounting in hospital organisations in New Zealand from:

(a) legislation, official documents relating to the industry, government and the public sector, and official documents from hospital organisations;

(b) academic and professional literature relating directly or indirectly to healthcare and hospital organisations, and to accounting for healthcare and hospitals; and

(c) people with whom the researcher has had informal discussions including commissioners, managers, accountants, doctors, nurses and other health professionals.

Step 2: The researcher formulates a working interpretation of accounting in hospital organisations in New Zealand and decides when decisive events and experiences occur that reflect what is to be described and interpreted. Noteworthy is that this step and Step 1, while comprising the conceptual phase of the study, have been treated as a field experience (Patton, 1990).

SUBSTANTIVE FIELD EXPERIENCE PHASE

Step 3: Three sets of processes, procedures, activities and documents (viz., budgets, cost data and annual reports) are examined in the light of this interpretation. Interview data about these are triangulated by source and perspective to establish contradictions, irregularities and discontinuities. Each set is treated in the same way, and a progressive refinement of the interpretation occurs by successive analysis and synthesis of the field data until all the events and experiences encountered have been explained.

THESIS PHASE

Step 4: At this point, the researcher has arrived at a theory; that is, a set of descriptive and operational concepts that form a conceptual scheme bound together by a set of propositions that best depicts the phenomenon of accounting in hospital organisations in New Zealand. He then makes a claim for having produced the said theory and a thesis is then presented in its natural sequence. Among the items addressed in the thesis are questions of sophisticated rigour, the significance of the theory, including how it compares and contrasts with prior and/or espoused theory, and avenues for further development of the theory.

After that, they affected the entire economy, including the public sector. Munro (1994b) gives a brief synopsis of events from 1984 to 1994; and Boston et al. (1991) discuss the way in which these changes affected the underlying ethos, process and structure of the public sector, of which the health service is a part. As already indicated (see pp. 13-14), one of the reasons for using methods associated with naturalistic inquiry was that the social order of the Study setting was changing rapidly (Denzin, 1989b).

The initial "conceptual" phase of the Study design and control strategy, comprising two steps (see Exhibit 2.1), was commenced in 1987. At its close in 1991 a coherent research problem had been formulated. After that, and in particular from August 1992 to February 1993, empirical data were collected in a "substantive field experience" phase. This second phase was in between two official order changes to hospital organisations, which occurred in late 1989 and July 1993 and which were steeped in controversy, as is evident later in the thesis. Before the first change, a myriad of services, facilities and organisations (viz., *regional offices of the Department of Health*, *hospital boards* and *area health boards*) had evolved under such legislation as the Social Security Act of 1938, the Hospitals Act of 1957, and the Area Health Boards Act of 1983.

Under the first change these services and facilities were reconstituted within 14 organisations which assumed the title of *area health boards* (Caygill, 1988). In describing this first change, the Minister of the day was quoted as saying, "We need to concentrate more resources on health and less on sickness, which in the past has often been the focus of the health system" (Clark quoted in 'Minister Emphasises Need,' 1989, p. 27). This was a main premise for establishing area health organisations in place of institutionally oriented hospital board organisations, and the passing of enabling legislation in the early 1980s (Area Health Boards Act of 1983). According to Clark (1989), the primary objectives of area health boards were:

(a) to promote, protect and conserve the public health and to provide health services within their region;

(b) to ensure effective co-ordination of the planning, provision and evaluation of health services between the public, private and voluntary sectors within their area; and

(c) to establish and maintain an appropriate balance in the provision and use of resources between health protection, health promotion, health education and treatment services.

In the second change, which followed a change of government, many of the same services and facilities were reconstituted as 23 organisations which became known as *Crown health enterprises* (Upton, 1991). Another central feature of this 1993 change was the creation of four regional health authorities which were set up as purchasers of primary and secondary health services on behalf of the residents of their regions. Meanwhile, the Crown health enterprises were espoused as providers of services from which the regional health authorities could make purchases.

These two official order changes were accompanied by intense, traumatic and controversial changes to the social order of hospital organisations. These occurred throughout the Study period and are still in progress at the time of writing. The meanings of these changes from the perspective of people in hospitals are part of the research issue. Thus, people's perceptions about the changes are used to illuminate the nature and impact of the restructuring in the chapters containing thick description (chapters 5-7, 9 and 10) and thick interpretation (chapters 8 and 11).

It was at about the time that the second change was implemented that the second phase of the Study gave way to a "thesis" phase, of which this document is the outcome. This third phase was completed in September 1994, and additional data which arose during this phase relating to events taking place in the Study setting were incorporated into the analysis (e.g., see pp. 253, 395, 397).

Interlink Between Issues in the Setting and the Study Aims

The range of services, funding arrangements, organisational structures and administrative processes of the whole public sector health system were affected by both of the official

order changes referred to above (Caygill, 1988; Upton, 1991). First, the evidence suggests that area health boards, and later Crown health enterprises (and regional health authorities), were a product of what Hood (cited in Boston, 1991; see also Hood, 1995) has described as the New Public Management approach to, in this case, the healthcare dilemma of the aggregate demand for public sector health services outstripping the supply of scarce resources.

This growth in demand for healthcare services has been attributed to changes in the demographics of the client base, increases in the technological capabilities of healthcare disciplines to deliver care, and an increase in the number of conditions that are regarded as *medical problems* and, therefore, within the purview of hospital organisations (P. Davis, 1981). Meanwhile, virtually the only source of revenue for public hospital organisations has been state funding. This has been constricted since the mid-1980s (Department of Health, 1989b) due to a combination of economic necessity and ideological zest. The people who emerged as central policy makers after the fall of Muldoon carried out a far reaching but speedy evaluation of public and economic policy. The basic convictions which emerged from this evaluation were that:

(a) government was spending too much money, and thereby gathering too much tax and borrowing too much;

(b) there was too much state involvement in the life of New Zealanders;

(c) government was not managed in a businesslike way; and

(d) something had to be done about all of the above, and quickly.

Links between these pressing issues of public finance and, *inter alia*, the pervasion of *a managerial approach* (Boston, 1991) into the public healthcare system, can be traced through a collection of articles, legislation and official documentation which relate to the public sector and health reforms. These are associated with both the Treasury (see for example, McCulloch & Ball, 1992; Public Finance Act of 1989; G. Scott & Gorringe, 1989; G. Scott, Bushnell & Sallee, 1990; Treasury, 1990); and the Office of the Minister of Health and the Department of Health (see for example, Caygill, 1988; Health and Disability Services Act of 1993; Hospital and Related Services Taskforce, 1988; National Interim Provider Board, 1992; Upton, 1991). These documents articulate

the espoused theory of control of the new generation of hospital organisations according to people in positions of central authority. They show that many of the elements of this espoused theory are linked to "managerial functional disciplines, of which accounting is one" (Argyris, 1990, p. 503). For example, terms such as *efficiency, effectiveness, value for money, cost-effectiveness,* and *accountability* are frequently associated with the intended *outcomes* and *outputs* of the activities of hospital organisations. Budget processes are described as a means of allocating resources between organisational subdivisions, and budgets and ledger systems are put forward as a means of controlling the use of resources in total and within these subdivisions.

In enunciating the first official order changes, Caygill (1988) emphasised the need for people in the hospital organisations to be more informed about the costs of both existing and planned activities. It was expected that these organisations would be characterised by accounting for the purpose of "the provision of 'relevant information for decision making', with the achievement of a 'rational allocation of resources' and with the maintenance of institutional 'accountability' and 'stewardship'" (Burchell et al., 1980, p. 10). Furthermore, the new area health boards were issued with a financial reporting proforma to be used in order to provide annual estimates, and monthly, six monthly and annual reports and statements of accounts to the central authorities (Minister of Health, 1990). This proforma incorporated public sector professional accounting concepts and standards stipulated in NZSA (1987). It was also to be used in publishing the annual report for general public consumption.

Two inferences can be drawn from the above. The first is that accounting can play a dichotomous role. This is consistent with the espoused theory that accounting has to do with "regulation to achieve order and equilibrium within an essentially managerial approach to organisational effectiveness" (Hopper & Powell, 1985, p. 442). Perceived from this essentially unitary perspective, accounting information is used to make rational decisions in order that organisations perform efficiently and effectively, and to engender accountability between an organisation and its stakeholders (NZSA, 1987). The second is that accounting is not "necessarily limited to those practices and institutions of a professionalized elite known as 'Accountants'" (Arrington & Francis, 1993, p. 107).

Thus, there were several aspects which emerged in formulating the Study problem which symbolised how the role of accounting was being elevated in hospital organisations, and these were in addition to the way accountants were being augmented (see also Bates, 1991; Dixon, 1989, 1992; Lawrence & Dumble, 1991; Tuson & Van Peursem, 1994).

Occurrences like those described above were not unique to New Zealand. Similar changes in hospital management were happening in Australia (Abernethy & Stoelwinder, 1990), Great Britain (Bourn & Ezzamel, 1986a; Flynn, 1992), Sweden (Coombs, 1987) and USA (Young & Saltman, 1985; Austin, 1989). These writers, along with others besides, have discovered evidence which shows that these changes are proving problematic. This evidence lends support to arguments such as those of Argyris (1990) about defensive reasoning in the face of implementing accounting, and of Mintzberg (1989, 1991) about formal management control being inappropriate in professional organisations. Meanwhile in New Zealand, little is known about what has been emerging. Hence, the primary purposes of the Study are:

(I) TO ILLUMINATE THE PRACTICE OF ACCOUNTING IN HOSPITAL ORGANISATIONS IN NEW ZEALAND IN ORDER TO RENDER IT "MEANINGFUL AND UNDERSTANDABLE" (DENZIN, 1989A); AND,

(II) "TO PERMIT REASONABLE 'EXTRAPOLATION'" (CRONBACH ET AL., CITED IN PATTON, 1990, P. 489) ABOUT WHAT IS OCCURRING.

The means chosen to achieve these broad purposes entailed the use of both thick description and thick interpretation (Denzin, 1989a, 1989b) in which "the meanings and experiences that have occurred in a problematic situation" are captured and "the reader [is taken] to the heart of the experience being studied" (Denzin, 1989a, p. 144). Having started to implement these means in the thesis phase of the Study, it was possible to articulate some more precise aims for the Study in terms of what the interpretation was about, and what the theory addressed. These aims are:

(I) TO DISCOVER THE SITUATED PRACTICE (CHUA, 1988) OF ACCOUNTING AMONG PEOPLE WORKING IN HOSPITAL ORGANISATIONS IN NEW ZEALAND; AND THENCE

(II) TO INDUCE A THEORY-IN-USE (ARGYRIS, 1990; ARGYRIS & SCHON, 1974) WHICH ILLUMINATES "HOW . . . ACCOUNTING HAS BECOME IMPLICATED IN THE FUNCTIONING" (BURCHELL ET AL., 1980, P. 23) OF THESE ORGANISATIONS, AND WHICH, *INTER ALIA*, CAN BE COMPARED AND CONTRASTED WITH THE ESPOUSED THEORY IN WHOSE NAME THE SITUATED PRACTICE IS BEING DEVELOPED.

The term *theory-in-use*, was elucidated earlier in the thesis (see pp. 1, 3-4). At this point it is useful to explain three other key terms used above. These are *situated practice*, *thick description*, and *thick interpretation*.

Situated Practice

Although she did not set out a neat definition of the situated practice of accounting, Chua (1988) makes several references to the concept which indicate that it refers to accounting as it is constructed and accomplished in organisations. She deduced that it relates to "the situational nature of interaction" and starts "from the question of how the participants in some event find its character and sustain it" (p. 65). Also, that it pertains to "the situated nature of accounting meaning and roles" (p. 67) from the actors' points of view. Furthermore, she infers that thick description and thick interpretation of situated practice offer an account of what is happening, as opposed to what should happen. Such an account captures more accurately the lived experiences of people, and helps "develop an understanding of the way that accounting information . . . also shapes organisational reality" (Roberts & Scapens, 1985, p. 455, also cited in Ansari & Euske, 1987, p. 550).

Thick Description

In attributing the word *description* to research, aspersions of inadequate analysis and explanation are often implied (Silverman, 1985). The term *thick description*, however, means something else which is, in itself, explanatory. According to Denzin (1989a) such a description:

> does more than record what a person is doing. It goes beyond mere fact and surface appearances. It presents detail, context, emotion, and the webs of social

> relationships that join persons to one another. Thick description evokes emotionality and self-feelings. It inserts history into experience. It establishes the significance of an experience, or the sequence of events, for the person or persons in question. In thick description, the voices, feelings, actions, and meanings of interacting individuals are heard. (p. 83, also quoted in Patton, 1990, p. 430)

As to going about compiling thick descriptions, Chua (1988), Denzin (1989b) and Patton (1990) all distinguish between causal questions, and *how* type ones. They argue that in the main, thick description should be compiled from qualitative data in the form of answers to *how* type questions obtained from the people being studied, and that answers to causal questions (i.e., those of the *why* variety) should be treated with far greater caution in compiling such descriptions (this matter is revisited on p. 26 of this thesis). Thus, in compiling the thick descriptions of situated practice which feature in the Study the basic question addressed is:

> HOW IS ACCOUNTING PRACTISED AMONG PEOPLE WORKING IN, OR INVOLVED WITH, HOSPITAL ORGANISATIONS IN NEW ZEALAND?

Thick Interpretation

Coexisting with the concept of thick description is thick interpretation. According to Denzin (1989a), "thick interpretation gives meaning to the descriptions and interpretations given in the events that have been recorded" (p. 101); and, "it has the objective of constructing an interpretation that is meaningful to the persons studied" (p. 102). For Patton (1990), "interpretation means attaching significance to what was found, offering explanations, drawing conclusions, extrapolating lessons, making inferences, building linkages, attaching meanings, imposing order and dealing with rival explanations" (p. 423). Interpretation is a way for the researcher to share his/her insights with the reader, and must be clearly qualified as such. "The emphasis is on illumination, understanding, and extrapolation rather than causal determination, prediction, and generalisation" (p. 424).

On the relationship between thick description and interpretation, Patton (1990) claims that "description is balanced by analysis and leads into interpretation. An interesting and readable report provides sufficient description to allow the reader to understand the basis of an interpretation, and sufficient interpretation to allow the reader to understand the description" (p. 430). Also Denzin (1989b) points out, "Thick description creates the conditions for thick interpretation, which attempts to take the reader to the essential features of the experience that has been thickly described" (p. 159). Thus, in this Study, the experience described is used to discover:

> THE MEANING AND ROLE OF ACCOUNTING IN THE PATTERNS OF RELATIONSHIPS, MEANINGS AND INTERPRETATIONS AS CONSTRUCTED AND MADE SENSE OF BY THE PEOPLE WORKING IN, OR INVOLVED WITH, HOSPITAL ORGANISATIONS IN NEW ZEALAND.

Reliability and Validity of the Study Methodology

The Study, and in particular step 3 in the control and design strategy (see Exhibit 2.1), rests on the theoretical assumption that the utilisation of interpretive or naturalistic inquiry leading to a thick description and thick interpretation of the context and situated practice of accounting is consistent with inducing a theory-in-use which provides "explanations in terms of conditions of possibility rather than underlying causal or determining influences" (Miller, 1990, p. 329) (see Figure 2.1). For the sake of reliability and validity, it is pertinent to examine this assumption and its implications in terms of research methodology.

Interpretive Frameworks, Eclecticism and Triangulation

According to Morgan (1984), the interpretive paradigm "encourages us to be aware that 'organizational reality' is more often than not a mosaic comprising multiple realities" (p. 314). Also, that "an interpretive view of organizational reality sensitizes organizational members to the importance of understanding organization as a cultural phenomenon rich in contextually based systems of meaning" (p. 314). These ontological underpinnings of the interpretive paradigm contrast with those of the functionalist paradigm in two ways. First, the theory associated with the latter claims to create "a world characterized by certainty" (p. 312); and second, it claims to generate

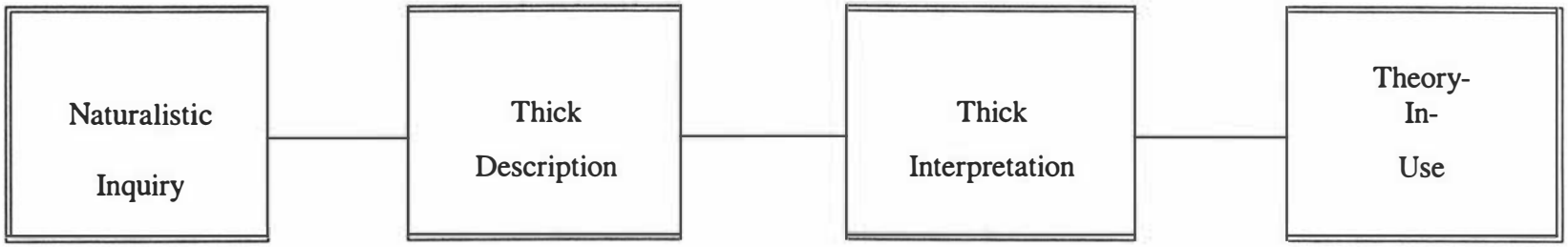

Figure 2.1. Sequence of moving from naturalistic inquiry to theory-in-use.

generalisable knowledge which is valid and reliable and can therefore be used as a basis for organisational action in different situations.

Epistemologically, the interpretive paradigm perceives each person's realisation of the world as unique, but as each person's experience in organisations as in life is shared by others, then "people constantly create their social reality in interaction with others" (Hopper & Powell, 1985, p. 446). In an organisational setting, there is an infinite variety of realisations and shared meanings, and the nature of these realisations and meanings is likely to be dynamic. Deducing these realisations and meanings by normative means is a forlorn task. Thus, one turns to induction, and to interpretive frameworks which focus on *how* type questions, such as: How is a system "socially perceived and organised by people in different organisational contexts? What meanings and significances are generated and emerge?" (Chua, 1988, p. 72). These frameworks emphasise "the essentially subjective nature of the social world and [attempt] to understand it primarily from the frame of reference of those being studied" (Hopper & Powell, 1985, p. 446). The underlying concern of the researcher is to obtain understanding of social interaction, in contrast to the functional researcher who is often seen as endeavouring to find ways of manipulating variables in order to achieve some socially constructed and contextually specific end states labelled by such laudable but hazy terms as *efficiency* or *effectiveness* (for a discussion on the latter, see W. R. Scott, 1977).

Corresponding with the focus of interpretive frameworks on *how* type research questions, qualitative inquiry that obtains answers to *how* type questions from organisational participants can generate data for interpretive studies (Patton, 1990). By using this kind of inquiry and type of question, a researcher can "attempt more accurately to capture the lived experiences of actors being studied" (Chua, 1988, p. 73); and give greater emphasis than functionalist academic research "to the perceptions and explanations of the participants themselves" (Hopper & Powell, 1985, p. 446). The data from qualitative inquiry can be used to derive thick descriptions and thick interpretations of situated practice, from which, among other things, theories-in-use can be constructed (Patton, 1990). These theories offer a richer, less causal explanation of individuals' interactions

at the micro-level; the dynamics of organisational life; and so across to events at the macro-level. They contrast with espoused theories, which are usually revealed by "interviewing . . . managerial staff and administrators, and analyzing official documents" (p. 107).

The notion of espoused theories, and of contrasting them with corresponding theories-in-use, seems to straddle the functionalist and interpretive paradigms. But this position is defensible within the theoretical posture of the thesis. As indicated earlier, this posture is a synthesis or triangulation of the broad ontological assumptions of the functionalist and interpretive perspectives (see pp. 1-2, 14-15). It is consistent with the picture painted by Chua (1988) of interpretive studies in accounting wherein "theoretical and empirical eclecticism . . . . allows researchers freedom to develop or discard key assumptions" (p. 69). She argues that this eclectic modification of strict or pure theoretical perspectives is healthy if it enables the researcher to explore and understand the phenomena being studied.

Another author who has advocated eclecticism in the form of triangulation of theories as well as data, methods and investigators, is Denzin (1989b). He reviews "critical discussions of multiple triangulation" (p. 244) as a research approach, and also argues that researchers employing triangulation are committed to what he calls *sophisticated rigour*, meaning:

> that they are committed to making their empirical, interpretive schemes as public as possible. This requires that they detail in careful fashion the nature of the sampling framework used. It also involves using triangulated, historically situated observations that are interactive, biographical, and, where relevant, gender specific. (p. 234)

On the down side, Chua (1988) points out that eclectic borrowing can lead to theoretical inconsistencies, including attempts to distinguish rational from non-rational (natural) accounts of action, with the intention of replacing the latter with the former on grounds of superiority. However, theoretical consistency does not preclude comparison of different accounts of contextual reality, such as is included in the work of Ansari and

Euske (1987), as long as some master reality is not used to judge other realities. Thus, for example, the notion of contrasting theories-in-use with corresponding espoused theories seems to be a valid exercise if, as Burchell et al. (1980) claim, "espoused theories are very different from theories in use. . . . At best the roles of accounting and the practice of accounting would appear to have a rather equivocal relationship" (p. 11).

According to Chua (1988), borrowing also has other traps for the unwary. These include the confusion of paradigm with research method (see pp. 29-31 of this thesis), and weaknesses in interactionism and/or ethnomethodology such as the validation of theory. These weaknesses stem from the notions that actors cannot be trusted entirely, and that interpretations are intrinsically incomplete and filtered through the second-order concepts of researchers (Van Maanen, 1979). Also, Silverman and Gubrium (1989) and Turner (1989) argue, at a much more fundamental level, that contamination by the values of the researcher (ethnocentrism) is endemic to all research (see also S. W. Davis et al., 1982).

On the use of interpretive research in accounting, Chua (1988) argues that despite any difficulties, an interpretive framework appears "to provide new insights into the study of accounting as it is practised in organisations" (p. 72). Other advocates of this position include Ansari and Euske (1987) who claim that measurement and similar weaknesses endemic in interpretive studies "are more than compensated for by the realism of studying an organization . . . first hand" (p. 551). Similarly, in studying accounting in hospitals, Abernethy and Stoelwinder (1990) claim that "traditional research methodologies using questionnaire data gathered at arms length are unlikely to capture the richness of [a public hospital] research environment" (p. 27). This coincides with the claim that an ethnographic approach "allows a fieldworker to use the culture of the setting (the socially acquired and shared knowledge available to the participants or members of the setting) to account for the observed patterns of human activity" (Van Maanen, 1979, p. 539). In effect, the researchers become *humans-as-instrument* preferring "their greater insightfulness, their flexibility, their responsiveness, the holistic emphasis they can provide, their ability to utilize tacit knowledge, and their ability to process and ascribe meaning to data simultaneously with their acquisition" (Guba &

Lincoln, 1983, p. 324). As Patton points out, reliance on the researcher involves the concept that: "The human factor is the great strength and fundamental weakness of qualitative inquiry and analysis" (p. 372). Hence, there is a need to assure the reader about how the researcher designed and conducted the Study (see p. 31 of this thesis).

Field Research and Qualitative Inquiry

A review of some 80 field research studies by Ferreira and Merchant (1992) indicates that paralleling the recent growth in interpretive studies in accounting there has been a greater and more varied use of field research methods. These have been motivated by descriptions of organisational practices, building new theories, or testing hypotheses. However, although these studies favour qualitative data gathering methods in the form of field research, not all of them are inclined to the use of interpretive methodologies. This is not surprising since: "The use of a research method does not bear a one to one relationship with the adoption of a paradigmatic position" (Chua, 1988, p. 72). There is a distinct difference between, say, conducting case studies or using an ethnographic approach in order to collect data, and adopting the research paradigm of interpretive sociology. Much seems to depend on whether a researcher is prepared to limit his or her ontological assumptions to any of those implicit in and consistent with the interpretive paradigm; or conversely, to adopt assumptions either wholly consistent with the functionalist paradigm; or which straddle the two by recognising, say, the interaction between "the natural and rational aspects of organizing and the dialectic quality of the lived experience in organizations" (Boland & Pondy, 1983, p. 225; also quoted on p. 14 above) (see also Guba & Lincoln, 1994).

Several discrete ontological assumptions coinciding with these two paradigms were discussed by Tomkins and Groves (1983). Those associated with the functionalist paradigm appear to coincide to some extent with the world as a simple machine, the world as a complex system, and the world as a complex hologram (Mitroff, 1985) (see also Boland & Pondy, 1983, who distinguish between rational closed system models from rational open system ones, and alongside natural models of similar ilk). These correspond, to some extent, to the subdivisions of the functionalist paradigm enumerated by Hopper and Powell (1985), namely objectivism, social systems theory and pluralism.

The particular significance of this distinction to the Study is that four models (Mintzberg, 1989, 1991; W. R. Scott, 1982; Becher & Kogan, 1980) are used in chapter 4 in order to derive a map of the hospital system context (dubbed a *functions and values framework*). This framework made it easier to understand the relationships occurring among various kinds of people connected with hospital organisations, and thence served as an aid to focusing the Study data. It appears that these four models view the world as a complex hologram, and they also fall into the category of "pluralistic work [which] often uses interpretive methods" (Hopper & Powell, 1985, p. 445). That is to say, many of the data used to induce them were qualitative and field based (for example, see Mintzberg, 1979a), and all appear to have embodied the ethnographic perspective prescription of being "simple, sequential and reflexive: less theory, better facts; more facts, better theory" (Van Maanen, 1979, p. 539).

Ferreira and Merchant (1992) describe the growth in field research in accounting as dramatic and ascribe it at least in part to prominent accounting academicians who have been advocating field research in accounting since the early 1980s. As Chua (1988) implied, it is not obvious that many advocates of this development subscribe to any particular methodological paradigm, or indeed find it important to differentiate between the concepts of methodological paradigms and data collection methods. They merely favour field research methods as a means of obtaining the data they see as being important to the study of accounting. A source of support for this view is Patton (1990) who argues that:

> While these intellectual, philosophical and theoretical traditions[1] have greatly influenced the debate about the value and legitimacy of qualitative inquiry, it is not necessary in my opinion, to swear vows of allegiance to any single epistemological perspective to use qualitative methods. . . .

---

1 Among the traditions in qualitative inquiry referred to were: ethnography, phenomenology, heuristics, ethnomethodology, symbolic interactionism, ecological psychology, systems theory, chaos theory: non-linear dynamics, hermeneutics, and orientational qualitative inquiry (Patton, 1990, pp. 64-91).

> *The methods of qualitative enquiry now stand on their own as reasonable ways to find out what is happening in programs and other human settings.* (pp. 89-90)

This claim lends further support for the validity of carrying eclecticism into the realm of theoretical perspectives in a manner akin to the theoretical posture presented in this thesis.

Validity and Reliability in Fieldwork

The point has been made already about the importance of accounting researchers in particular, and users of qualitative methods in general, being obliged to inform their readers about how they employed these methods. This information is required so that these readers can evaluate the reliability and validity of a study and its findings from their particular perspectives. Of necessity, the process of informing requires researchers to think through, articulate and become aware of the intricacies and complications of their methods. This in itself is important to the validity and reliability of a study according to Van Maanen (1979) in that it allows a researcher to make allowances for potential sources of threats to its validity and reliability, and so enhance its quality.

In similar vein, Patton (1990) argues that one of the standards of basic qualitative research is research rigour, a great deal of which derives from the researcher. This includes that person's values, methodological skills, sensitivity and integrity, and the way that the research activity is carried out. Reporting on the attention paid to these matters assists readers to evaluate a study for validity and reliability. However, as McKinnon (1988) notes, this is something which accounting researchers often seem unable to do, and so they provoke criticism of their particular field studies and of the method type in general. Ferreira and Merchant (1992) also indicate that little disclosure about how a research design evolved with the project means that "the limitations of the selected design remain unknown to the reader of the paper" (p. 19).

Some Prerequisites of Using Qualitative Methods

McKinnon (1988) enumerates four main types of threats to the validity and reliability of field research, namely, researcher-caused effects, researcher bias, data access limitations, and complexities and limitations of the human mind (see also Ferreira & Merchant, 1992). She enumerates a series of strategies and tactics that could be applied systematically and generally, both during the conduct of field studies and as part of the content of field study reports, in order to attend to problems of validity and reliability. The strategies relate to the amount of time the researcher spends in the research setting (see also Van Maanen, 1979), the use of triangulation (see also Denzin, 1989b; Tomkins & Groves, 1983), and the researcher's social behaviour while in the setting. Among the tactics are approaches to interviewing and probing questioning (see also Patton, 1990).

In relation to interviewing, which is the most prevalent method relied on in the Study, Van Maanen (1979) suggests that in order to be able to rely on field data the researcher must appreciate a fundamental distinction between "an informant's first-order conceptions of what is going on in the setting and the researcher's second-order conceptions of what is going on" (p. 540); and, within first-order conceptions, the differences between presentational and operational data. First-order conceptions comprise descriptive properties of the studied scene and "the situationally, historically, and biographically mediated interpretations used by members of the organization to account for a given descriptive property" (p. 540). The field data based on first-order conceptions comprise operational data gleaned by observing and hearing what goes on in the course of operations; and presentational data in the form of "appearances put forth by informants as these (observed) activities are talked about and otherwise symbolically projected within the research setting" (p. 542). Meanwhile, second-order conceptions are the theories or "notions used by the fieldworker to explain the patterning of the first-order data" (p. 541). McKinnon (1988) alludes to these distinctions in discussing note-taking tactics and differentiating between observational notes, theoretical notes and methodological notes. Ultimately, however, it seems that no matter how much care is taken, the results of ethnographic study will have been mediated several times over:

> first, by the fieldworker's own standards of relevance as to what is and what is not worthy of observation; second, by the historically situated questions that are

> put to the people in the setting; third, by the self-reflection demanded of an informant; and fourth, by the intentional and unintentional ways the produced data are misleading. (Van Maanen, 1979, p. 549)

In the last context, Van Maanen (1979) makes the point that like any other data source, informants in the field can provide incorrect data. In particular, he mentions the potential for lies, deceptions, evasions and conjectures coming from informants; and also the potential for the researcher to capitalise on these if they are recognised as false. Informants can mislead deliberately, either by answering questions wrongly, or by not volunteering information which the fieldworker has not asked about. Usually it is things that matter most to informants about which they are inclined to mislead deliberately. In addition, they can mislead about matters in which they themselves are wrong or have been misled, and about matters to which they are too close to be aware of underlying assumptions. In summary:

> misdirection in fieldwork arises from several sources not the least of which is the ethnographer's own lack of sensitivity for the discrepant observation and lack of appreciation for the tacit bases of one's own understanding of the social world. (p. 548)

Silverman (1985) notes these types of concern, not just among interactionists (of whom Van Maanen would be classified as one), but among positivists. However, he suggests that "we need not hear interview responses simply as true or false *reports* on reality. Instead, we can treat such responses as *displays* of perspectives and moral forms" (p. 171). Thus, for example, if interviewees (or the same interviewee at a different juncture in an interview) differ in their account of elapsed time or trends in the quantity of a task being performed, these should be taken at face value rather than checked or adjudicated according to some documentation, official or otherwise (for instances of these types of occurrence in the Study data, see pp. 318, 321-322, 347).

Validity and Reliability in Control, Analysis and Reporting

Problems of validity and reliability also arise with using qualitative data and reporting the results of studies based on such data. In the matter of control and design, Denzin

(1989b) relates that there are three basic strategies which can be employed in order to ameliorate these problems so that causal, interpretive propositions can be formulated. These are *the experimental method*, *multivariate analysis* and *analytic induction*, and he holds that they should be used according to the circumstances of a particular study.

Analytic Induction

The strategy advocated not only by Denzin (1989b), but also by Silverman (1985) and Chua (1988), for tackling the problem of developing and validating generalisations from data obtained from qualitative inquiry is analytic induction. "Analytic induction . . . is a strategy of analysis that directs the investigator to formulate generalizations that apply to all instances of the problem" (Denzin, 1989b, pp. 165-166). However, in their short discussion of this strategy in the context of the history of sociology and anthropology, Vidich and Lyman (1994) draw attention to reservations about the usefulness of analytic induction in formulating generalisations in a manner akin to functionalist theory. But these do not detract from the reliability and validity of using this strategy in circumstances like this Study, in which preliminary observations are formulated into a rough definition of the phenomenon to be explored, which is then refined into a theory-in-use that provides an explanation of the phenomenon in terms of "conditions of possibility" (Miller, 1990, p. 329).

In describing analytic induction Denzin draws parallels between it and experimental design, and points out that it calls for "the investigator to search for empirical instances that negate the causal hypothesis" (p. 166). Furthermore: "This strategy not only forces the careful consideration of all available evidence, both quantitative and qualitative, but also makes necessary the intensive analysis of individual cases and the comparisons of certain crucial cases" (p. 168). Moreover: "another central feature of analytic induction is its reliance on theoretical rather than strict statistical sampling models" (p. 169). And finally: "concepts are used in a sensitizing fashion . . . permit[ting] the investigator to work back and forth between theory and observations, altering where necessary both the theory and the definitions of central concepts" (p. 169). Thus, this form of induction embodies the prescription for organisational research to be sequential and reflexive.

In contrast, the dominant concern of most accounting research rests with the more traditional scientific method perspective of deducing a priori hypotheses and testing these using multivariate analysis. This method of drawing generalisations from most, or even just some, instances of the problem or phenomenon observed has been criticised because of "the temptation to form premature theories upon insufficient data" (Sherlock Holmes in The valley of fear cited by Van Maanen, 1979, p. 539). Meanwhile, it seems that analytic induction is not a strategy which is expressly familiar in accounting research. The only mention of it in the accounting literature consulted in the course of the Study was a passing one by Chua (1988). However, arising from their review, Ferreira and Merchant (1992) mention methods of theory building which appear to have some of the qualities of analytic induction.

Reporting Issues

In the matter of reporting, reference has already been made to some important matters and to particular deficiencies in accounting research reports as discussed by Ferreira and Merchant (1992) and McKinnon (1988). Silverman (1985) has also raised criticisms about reports of field studies in sociology, even though such studies have been common practice in that discipline since at least the 1970s. Citing Mehan, he points to the following grounds for criticism in particular:

> First, conventional field reports tend to have an anecdotal quality. Research reports include a few exemplary instances of the behaviour that the researcher has culled from field notes. Second, these researchers seldom provide their criteria or grounds for including certain instances and not others. As a result, it is difficult to determine the typicality and representativeness of instances and findings generated from them. Third, research reports presented in tabular or summary form do not preserve the materials upon which the analysis was conducted. As the researcher abstracts data from raw materials to produce summarised findings, the original form of the materials is lost. Therefore, it is impossible to entertain alternative interpretations of the same materials. (p. 12)

Some sentiments about the form of this thesis, and in particular the making public of matters such as values, assumptions, procedures and processes, have been expressed

already. It is anticipated that the researcher has attended to these other potential sources of criticisms in the course of the Study, and disclosed this "as fully and truthfully as possible . . . as part of the report of actual findings" (Patton, 1990, p. 372). But throughout this thesis the author has been faced with "the agony of omitting" (Lofland cited in Patton, 1990, p. 429), particularly from the thick descriptions and thick interpretations in chapter 5 to 11. However, as Patton points out, not making these omissions would have detracted from the focus of the Study.

Personal Values

Consistent with the above reference to the efficacy of making certain matters public, Hopper and Powell (1985) argue that accounting researchers should preface pieces of work with an articulation of their personal values. Thus, the author has provided some details about himself and his life environment, his perception of accounting, and his perception of hospital organisations, in the belief that these are indicative of those individual values which have a bearing on the Study.

The researcher grew up in an English working class family during the 1950s and 1960s. Among the memorable characteristics of the two communities in which this family lived were the central role of the (coal)pit, comparative deprivation, and things of a working class political ilk. Towards the end of his school life the researcher began to be active in Labour Party politics. Coinciding with the completion of an economics degree course, of which the most memorable parts were the theory of the firm and encounters with the works of Keynes, Galbraith and Marx, the researcher started a period as a local council politician. He also took a job in accounting and finance with another local council, and so found himself working on both the political and administrative sides of local government. This state of affairs continued until the early 1980s, at which time a combination of personal and career circumstances took him out of both areas and into teaching of public sector accounting in an institution of higher education.

The researcher's new career as a teacher, and later as a researcher, provided opportunities to broaden his knowledge and experience. After three years in England, the researcher went to Papua New Guinea to teach accounting to government employees.

In the last of his three years there he married a woman who is from Kiribati. Since then he has since spent some time intermittently in this atoll republic, and his elder child was born there. His observation of and participation in village life in both of these so-called lesser developed countries have helped shape his values by putting the formality and materialism of Western society into perspective. They have also exposed him to different macro-cultures and to organisational forms and processes. These have shed a different light on the kinds of structures, institutions and organisations he had experienced in Britain and is experiencing in New Zealand. Since arriving in the latter in 1987, a large part of his time has been taken up by the Study and other academic pursuits in connection with working at the University, but he has also been involved in being a family person, a father and becoming settled in New Zealand. To some extent he came to New Zealand with certain expectations about its "Britishness", and although these have been reinforced by such things as language, names of places, political, economic and social institutions, laws, accounting practices and so on, there are quite important differences. One of these of importance to the Study area has been the extensive role of the state in providing "mutual sustenance" and an individual "quest for security" (James, 1986, pp. 12-13) from the earliest days of European settlement. However, as James points out, to see this as "New Zealanders practis[ing] socialism without doctrines" (p. 13) is to think in European terms, and this the researcher has been inclined to do, but less and less so as the Study has unfolded.

The researcher chose to work in the accounting area after leaving full-time education for various reasons. One of them was that he perceived financial people, including the local authority treasurers he encountered from the outset of his politically active period (1970-1980), as having an apparently disproportionate say in policy determination and implementation. The desire to be able to match knowledge with financial specialists, and indeed with political leaders who also tended to derive some of their power from having a grasp of the rudiments of finance, partially explains the irony of choosing to enter a profession whose practitioners in the main seem to have a managerial capitalism (Marris, 1967) frame of reference.

Having since crossed the bridge from profession to academic discipline, the researcher is of the view that though there are undoubtedly other dimensions and uses attached to it, mainstream accounting is entwined in the conventional wisdom of capitalism (Hopwood, 1976; Roberts & Scapens, 1985, also cited in Hopper & Powell, 1985; Tinker, 1985), and that accountants as a profession, generally serve the interests of wealthy people ahead of others in a variety of ways. Moreover, he perceives accounting as espoused as technical and objective but practised as social and subjective. It seems that seldom are its basic assumptions contemplated, or "awkward questions [asked] of [its] relationship to prevailing sectional interests" (Hopper & Powell, 1985, p. 430). In some senses, many of the presently dominant functionalist theories of accounting could probably be described as "reproducing ideology in the guise of science" (p. 450) in order to maintain the status quo.

It is through these awkward questions that the researcher has come to take a particular interest in hospital, educational and similar human service organisations. He perceives these and similar public sector organisations as being more likely than organisations owned and directed by private capitalists to do things which are of benefit to society's underdogs. Even so, he believes that in practice they are geared up to protect or benefit those with wealth as much, if not more than, those without it, and that often they suffer from too much bureaucracy and conservatism.

In the hospital arena of the Study, the researcher believes in the basic principle of there being a public health service which caters promptly for all comers. He is extremely sceptical of the espoused motives of some of those calling for greater efficiency from hospital organisations, perceiving much of what is being said as having detrimental economic and social consequences for many people. He feels that human society as a whole should devote more of its efforts to caring for people and the environment regardless of national boundaries, and less to lifestyle excesses and material consumption. He also feels that hospital organisations and health professionals could and should put more effort into the way they are organised, and that they are ever capable of improving their performance in terms of caring for the community. He sees these organisations as a vehicle for altruistic service as well as professional advancement

and "imperialism" (P. Davis, 1981, p. 175). He also believes that these organisations and the community (presumably through the state) should make a much more concerted effort in the area of preventive healthcare. In particular, a lot of hospital work arises because of consumption of harmful substances, obesity, drunk driving, speeding, stress and other lifestyle hazards (P. Davis, 1981).

In hindsight, it would seem that in self presentation (Van Maanen, 1979) up to the early 1980s, the researcher was a subscriber to the radical structuralist paradigm. In actual operation however, he tended to be pragmatic for the sake of gaining some advantages for the social underdog within the established societal and governmental structure. For example, he was ever ready to exploit gaps in the way things were normally done, and in the law and central government regulations under which local councils operated. He also took an active interest in "fixing" organisations, including such activities as planning, structuring and organising. Indeed, this interest featured in his early formulations of the Study.

He now recognises his approach to have been functionalist in nature, though probably at various times he borrowed from several regions of the functionalist paradigm, and particularly those associated with social systems theory (i.e., behavioral dysfunctions, social psychological theories, structural theories, open systems theories and contingency theories) (Hopper & Powell, 1985). His experiences led him to question these unitary functionalist theories on numerous occasions during this period, including when he observed failings of several rational approaches (e.g., corporate management and programme budgeting in English local government (1972-1979), and management by objectives and zero based budgeting in the Papua New Guinea central government (1984-85)). In the recent past, the researcher has become more aware of the unitary nature, and somewhat naive assumptions, of some of these theories; and indeed with socialist theories associated with the radical functionalist paradigm which are based on similar ontological assumptions.

These matters have caused the researcher to reassess his perspective of organisational life, and he now finds himself, as well as he is able to articulate his position, somewhere

in the pluralism/interpretive areas as discussed by Hopper and Powell (1985). In contrast, he sees the functionalists as being likely to occupy the academic mainstream, and political and economic driving seat for the foreseeable future. As a result, work which is too subjective or radical is likely to be ignored or dismissed, and so have little impact. Being disinclined to see his work come to naught, the researcher has tried to balance the constraints of conventional wisdom with pursuing opportunities which enable him to experiment with new ideas in a creative way.

Research Assumptions

The significance to research in accounting of assumptions about the nature of reality (ontology), the nature of knowledge (epistemology), and human nature are outlined by Chua (1986) and Hopper and Powell (1985). The latter advocate "that the underlying assumptions behind any piece of work should be recognized and assessed" (p. 429), and this is consistent with earlier references to the efficacy of making these matters public (see pp. 11-12, 27, 35 above). Hopper and Powell also put forward a classification of previous research based on Burrell and Morgan's (1979) basic sociological framework for grouping organisational research, and claim that this classification serves five important purposes. Two of these are particularly pertinent to the Study. The first is that the framework is a means of achieving consistency between individual values, philosophical assumptions, theoretical backing, research methods and the aims of a piece of research. The second is that it is a map from which to go forward into new areas of investigation and uncharted territory.

Chua (1986) has pointed out several problems with the Burrell and Morgan (1979) framework. Among these is its "use of mutually exclusive dichotomies" (p. 603) in functionalism and interpretivism, and she refers to Bhaskar's position that "although societies are prior to and different from individuals, they are continually reproduced and transformed by intentional human action" (p. 626). This is the same source from whom Silverman (1985) develops his *realism* synthesis (see footnote 3 on p. 2 of this thesis). There are also remarkable similarities between Silverman's synthesis and that adapted from Giddens by Roberts and Scapens (1985) (see footnote 2 on p. 2, and pp. 14-15 of this thesis). For example, Silverman points out that, "Social contexts always give

meaning to action and provide some of its consequences" (1985, p. 43); while Roberts & Scapens take the following quote from Giddens: "social systems are both the medium and outcome of the practices that constitute these systems" (1985, p. 445).

The above are an indication of the researcher's cognisance of the criticisms of Burrell and Morgan's (1979) framework, and so of the implied criticism of Hopper and Powell's (1985) classification. Notwithstanding, their ideas have been used as a basis for articulating the research assumptions underlying the Study in the confidence that the criticisms have been taken into account in the articulation.

Theoretical Posture

The theoretical posture presented in this thesis covers a range on the objective-subjective dimension of the Burrell and Morgan (1979) framework from *pluralism* (Hopper & Powell, 1985) towards *symbolic interaction* (Denzin, 1989b). The "objective" limit of this range corresponds with the work of several authors who have advanced pluralistic theories and models drawn from interpretive ideas on socially created realities, and who have used interpretive field based methods in carrying out this pluralistic work. Some models of this kind from organisational theory were cited earlier (e.g., Mintzberg, 1989; see p. 30 above). According to Hopper and Powell "pluralism tends to presume purposefulness and self-interested behaviour arising from a realist ontology" (1985, p. 445). In so far as socially created accounting is recognised, "it tends to be seen as a deliberately manipulative act to seek external legitimation and to mask underlying realities" (p. 445).

The "subjective" limit of the theoretical stance adopted in the Study is less easy to define. Certainly, the researcher has been attracted by the notions of individual meaning, people's perceptions of reality, and individuals seeking to create meaning through social interaction (Denzin, 1989b; Hopper & Powell, 1985). He has however drawn back from ethnomethodology on the grounds of inadequate resources and expertise to study "how people go about doing what they do in their everyday life" (Chua, 1988, p. 62). In fact, the field data collected for the Study were obtained using pre-arranged, *nonschedule standardised interviews* (Denzin, 1989b, pp. 105-106), rather

than the prolonged periods of observation and discussion which are consistent with ethnomethodological studies. Therefore, the subjective limit of the Study appears to coincide with symbolic interactionism (Blumer cited in Tomkins & Groves, 1983; Denzin, 1989b; Chua, 1988), which includes several pertinent accounting studies discussed not only by Chua, but also by Ferreira and Merchant (1992) and Roslender (1990).

Ontological Assumptions

The ontological assumptions underlying the theoretical posture might be expressed as follows: "Social structures are 'real' in the sense that they are partially independent of individuals and their perceptions" (Silverman, 1985, p. 34). Similarly, "society does not exist independently of human activity . . . , but is not the product of it [either]" (Bhaskar, cited in Silverman, 1985, p. 35). Moreover, "micro phenomena . . . and macro structures . . . *presuppose* each other" (p. 70); and "action and structure . . . 'presuppose one another'" (Giddens cited in Roberts & Scapens, 1985, p. 445).

Thus, paraphrasing Bhaskar, it is assumed that "[the hospital system] does not consist of individuals but expresses the sum of the relations within which individuals stand" (quoted in Silverman, 1985, p. 34). Moreover, interpretive procedures are central to the reproduction of this social system; the system is a real, constraining and enabling force; and, it is the condition of social action and is reproduced and changed by it (paraphrased from Silverman, pp. 77-78). Also, tied in with these assumptions is the idea that "explanation is never fundamentally concerned with particular elements or units but with the articulation of the relation between elements" (p. 34). These assumptions are consistent with those identified by Morgan and Smircich (1980) as relating to pluralism and symbolic interaction; that is, "reality as a contextual field of information" and "reality as symbolic discourse" (pp. 494-495).

Epistemological Assumptions[2]

Given the ontological assumptions about the hospital system enumerated above, the epistemological stance taken in the Study has two aspects. First, an effort was made to try and understand the *work situation* (Meltzer, Petras & Reynolds cited in Tomkins and Groves, 1983) and the situated practice of accounting in hospitals. This epistemological concern is often associated with symbolic interaction (see Tomkins & Groves) and amounts to trying "to understand patterns of symbolic discourse" (Morgan & Smircich, 1980, p. 492). It falls within the range of the theoretical posture of the Study towards the subjective end of the scale in the Burrell and Morgan (1979) framework, and outside the traditional concerns of accounting research. Notwithstanding, Tomkins and Groves (referring to Denzin) noted that "there appears to be wide scope for examining the impressions that both accountants and non-accountants have about 'what is going on' in the organisation and the part that accounting plays in that process" (p. 369). Accordingly, data was generated by the researcher from the participants in the hospital system based on the idea that:

> Actions can be understood not as having been *caused* but as having *emerged* from the constant interplay of its (sic) shapers, all of which are themselves part of the action, indistinguishable from it, shaping and being shaped simultaneously. (Guba & Lincoln, 1983, p. 321)

This approach is consistent with the idea of constructing theory from thick description and thick interpretation of situated practice as being a matter of "teas[ing] out plausible connections between phenomena" (Guba & Lincoln, 1983, p. 321) and inducing "explanations in terms of conditions of possibility" (Miller, 1990, p. 329) (see Exhibit 2.1 and Figure 2.1).

The second aspect of the epistemological stance involved mapping the hospital system context (Morgan & Smircich, 1980), not only in order to focus the raw data gathered in the field, but also to induce a theory-in-use in keeping with the nature of social structures as postulated by Silverman (1985). In subsequent chapters, a good deal is

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[2] Guba and Lincoln (1994) were particularly helpful in reporting this and related areas.

made of the macro-changes to organisational structures and cultures at the industry level of the hospital system, in addition to perceptions of individuals about their work philosophies and practices at the micro-organisational level (i.e., within hospital organisations). This is perceived as entirely consistent with the ontological assumptions enumerated above. In defence of this choice it is worth quoting Silverman:

> It is misleading to assume that a fundamental choice must be made between these [macro and micro] perspectives. While research data are often mainly gathered at either a structural or interactional level, sound analysis and intelligent conceptualisation requires that *both* levels (and their relations) should be addressed. (p. 70) . . .
>
> A narrow concern with social structures precludes a proper understanding of the processes of interpretation through which they are reproduced and sometimes changed. Conversely, interactional sociology has constantly to be aware of the real structures which constrain and enable social action. (p. 77)

Assumptions about Human Nature

According to Hopper and Powell (1985), "assumptions about human nature refer to the relationships between human beings and their environment" (p. 431). Consistent with the various methodological assumptions enumerated above, it is assumed that people's behaviour and experiences are determined, constrained and enabled by the meanings which they come to share. These give rise to the social structures which take on a reality of their own and in which these people participate. By the same token, these social structures are susceptible to change as the meanings from which they derive are changed, and so to some extent people are capable of creating their own environment.

Closing Pointers

This brings to a close the articulation of assumptions underlying the Study. These come at the end of a chapter in which a series of fundamental matters to do with the Study methodology, design, purposes and aims have been explained. It has been shown that the Study is outside the mainstream of accounting in adopting a perspective allied to pluralism and interpretivism rather than a unitary, functionalist one. How and why this emerged has been linked to the Study setting and the radical official and social order

changes taking place, which meant that structures and meanings were in flux. It has also been shown that there is some consistency between the researcher's values, the philosophical assumptions, theoretical backing and sources of the research methods. Even so, among the unusual features of the Study are eclecticism and theory triangulation. Finally, setting out these matters publicly the researcher has attended to the demands of sophisticated rigour, and so sought to enhance the validity and reliability from the readers' perspective. Now that these fundamental matters are addressed, the thesis continues in the next chapter with full details of how the steps in the design and control strategy were accomplished.

CHAPTER THREE
ACCOMPLISHING THE DESIGN AND CONTROL STRATEGY

This chapter sets out the events in the Study design and control strategy. Details are given of episodes of data collection and analysis, and how these were used to formulate consecutively two rough notions, a working interpretation, and a theory-in-use of accounting in hospital organisations. Included in the chapter are statements of the rough notions and working interpretation that were derived.

Introduction

The purpose of this chapter is to make more of the research activity public. The chapter includes details of the episodes of data collection and analysis. Also, it incorporates the impressions and ideas which the researcher obtained, first, as he tried to get to grips with the lump of clay in front of him (the research methods[1] and the area he was researching); and second, as he tried to become more aware of his past experiences and future prospects (Mintzberg, 1987). As articulated in chapter 2, these are vital to the reliability and validity of the human-as-instrument aspect of the Study.

The chapter is divided into four sections which cover the four steps in the analytic induction strategy of control and design that was adopted for the Study (see Exhibit 2.1). These steps were carried out in a chronological sequence. As part of step 1, first one rough notion (as at 1987) and then another (as at 1988) were induced. In step 2, the latter was refined into a working interpretation (as at 1991). This led naturally into step 3, which involved inquiry that was more substantive, thick description, thick interpretation and theory (as at 1994); and into step 4, of which this thesis is the culmination.

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[1] Despite the presentation of the strategy and its four steps as a coherent whole, these did not crystallise as such until well into the Study (see p. 10).

Step 1: Developing a Rough Notion of Accounting in Hospital Organisations

First Rough Notion 1987

One of the earliest events in the Study was a successful application to the Department of Health's Health Workforce Development Fund for a grant. In his application, the researcher framed the Study in terms which exhibited a traditional functionalist approach based on the idea of *accounting dysfunctions* (Hopper & Powell, 1985). This has been recast as a very rudimentary version of a rough notion of accounting in hospital organisations (see Exhibit 3.1).

Exhibit 3.1. First rough notion of accounting in relation to hospital organisations in New Zealand developed from Dixon (1987).

> Accounting is a coherent body of technical ideas and procedures which have been articulated in a number of well-established texts. It can be applied to hospital or hospital organisations for the betterment of these organisations in their factory-like and not too ambiguous task of providing health care for people. The challenge in making this a reality is to get people in these organisations, particularly at the front line and including doctors and nurses, to appreciate the rational uses and benefits of accounting. This can be done through endowing them with knowledge in the use of the ideas and procedures, while at the same time changing their attitudes. This is an education, training, organisation development and management development opportunity which can be handled systematically given the right amount of enthusiasm among key people at the top and among accounting specialists, educators and trainers.

Inducing the Second Rough Notion 1988

Reading played a significant part throughout the entire Study. Although some literature searching and a study of research methods were done before the grant mentioned above was obtained, on-line and manual searches of several indexes were not done more earnestly until afterwards. These searches provided the foundations for an electronic database of materials on bibliographic software called Pro-Cite. As this database built

up it became clear that people from a diverse range of disciplines had an interest in the Study area. The material deriving from this multi-disciplinary interest shaped the researcher's thinking in defining the phenomenon and developing the methodology. The searches also revealed that there was a dearth of reported prior research about hospital organisations and administration in New Zealand (see p. 2).

The researcher's early thinking was also shaped by a visit to England in December 1987. Here some first-hand tales of the experiences of accountants and managers were obtained following on from the implementation of Griffiths (1983) and NHS\DHSS Steering Group on Health Services Information (1984). These accounts, while often espousing the need for education and training in both knowledge and attitudes, impressed on the researcher that this was an insufficient explanation of the situation. Thus, he began to question the naivety and two-dimensional nature (Kilmann, 1989) of the first rough notion.

Early in 1988, the report of the Hospital and Related Services Taskforce about public sector hospital organisations in New Zealand was published. The researcher perceived that the proposals it contained were similar to those he had heard in England. These proposals were about reducing costs, bringing about efficiencies, restructuring organisations and altering the way they were managed, and introducing competition including a buyer-provider split. All these were controversial and had proponents and opponents lining up to debate them both in the healthcare industry and among politicians (e.g., see "Comments on 'Unshackling," 1988; Coney, 1988; "The Glib Report," 1988; Munro, 1994b; C. Scott, 1990). Also, the proposals had some of their roots in accounting (Arthur Andersen, 1987), and relied to some extent on better accounting information systems (allegedly) bringing about better decisions (Treasury, 1989; but on similar questionable claims put up in support of the development of accounting systems, see Ansari & Euske, 1987; and Bougen, Ogden & Outram, 1990). On the latter issue Hospital and Related Services Taskforce (1988) claimed that:

> The New Zealand hospital system is characterised by very poor management information. Management accounting and costing systems are almost nonexistent. . . .

> None of the people who make decisions are aware of the cost of the resources they use or misuse. Therefore they cannot take costs into account when considering different courses of action.
>
> Lack of cost consciousness undermines efficient resource allocation at all levels within hospitals. . . . The use of the bulk of hospital resources is determined by the decisions of individual doctors and nurses who have clinical but not resource accountability. . . .
>
> Many doctors believe they alone should determine what procedures are undertaken . . . with no regard for budgetary approval or total cost. . . . [Others] argue, however, that if clinicians were given the necessary costing information, they themselves could act as more effective and responsible managers of the resources they control. (pp. 20-21)

During 1988 the researcher participated in a course on the evaluation of educational organisations. Relevant topics were organisational effectiveness, including the pluralistic and ambiguous nature of this concept (W. R. Scott, 1977); evaluation, including a distinction between formative and summative evaluation (Patton, 1990; Scriven 1973; Stufflebeam, 1983); and, organisational culture (Kilmann, 1989). Of immediate significance was that the rough notion altered in the researcher's mind. He recognised the complexity and peculiar nature of hospital cultures, and the implications for accounting in these organisations (Bourn & Ezzamel, 1986b). Also, the paper by W. R. Scott led the researcher to that author's other work including his paper on models of hospital organisations (1982), and to the work of Mintzberg on organisational structures and forms (Mintzberg, 1989, 1991). These prompted the researcher to refine his rough notion to admit that accounting techniques born of the factory system (Kaplan, 1984) and developed to increase management control (Anthony & Young, 1994), were probably not transferable to organising professional work in hospitals (Chua, 1995; Mintzberg, 1989).

Visits to the G Hospital Board

In the autumn of 1988, the researcher made a series of visits to people working within a hospital board. These started with a doctor who was head of a residential hospital

unit. He had recently returned from working in a few hospitals in North America and was generally positive about his experiences of their use of patient, management and financial information. Equally, he was scathing about the poor state of the information, processes and structures in the hospital board by which his unit was governed.

These issues were taken up by the researcher in a discussion with the board treasurer. He spoke about a mixture of changes taking place in external reporting (NZSA, 1987), including accrual accounting; and in the board's management structure. The latter was at the stage of a general manager having been appointed as the sole head of the organisation, at least in formal terms. This was done under a policy known as *general management* (State Sector Act of 1988; Area Health Boards Amendment Act of 1988; Hospitals Amendment Act of 1988), which replaced the previous *triumvirate system* of management. The latter had consisted of three executives of equal formal standing drawn from the three major work groups in hospitals (viz., doctors, nurses and administrators). This structure applied at board level, at each institution controlled by a board, and sometimes at departmental level (Hospital and Related Taskforce, 1988, p. 19).

The treasurer also indicated that changes were being made to the board's financial and other management information systems, which he regarded as deficient. But he had reached the opinion that developing these systems was not a high priority in the board, particularly among the people in charge of the base hospital or of most of the other facilities governed by the board. Something similar was reported in Hospital and Related Services Taskforce (1988): "many boards seem to think expenditure on accounting and information systems is a waste of money and would rather spend it on clinical staff" (p. 21). The treasurer intimated that the people in charge of the base hospital and similar medical facilities were the real wielders of power in the board, and that there were quite formal divisions relating to processes and structures between people who comprised the board central headquarters office staff and the people in the base hospital, even though the two groups occupied buildings on the same site.

Following this discussion the researcher attended two gatherings of people. The first was a seminar for administrators from the board and from the local office of the Department of Health. The expectations of these people were that the government would be announcing major changes to the health system. The bases of these expectations were the report of the Hospital and Related Services Taskforce (1988) and the reforms that were happening in other parts of the public sector. For some, these anticipated changes represented progress and likely improvements to process and structure, but to others, such things were not so attractive.

The second gathering was a presentation in the base hospital organised by the board general manager. The presentation was about a system called the Resource Utilisation System (commonly known by the acronym RUS) (Ayling, 1988; Lawrence & Dumble, 1991), and was part of a process being gone through in order to decide whether or not the board should buy RUS. The way the presentation was staged epitomised the formal divisions and similar matters referred to by the board treasurer. For example, the board general manager had had to persuade as many senior clinical and non-clinical staff as possible to attend, even though a decision to buy would affect all of them and involve spending a considerable amount of money. The reception given to the contents of the presentation seemed lukewarm. Nevertheless, at the presentation, relations between the various parties came across to the researcher as cordial. But at the administrators' seminar (see previous paragraph), a quite different impression of these relations was obtained which affirmed that a major division existed along professional-administrator lines (see W. R. Scott, 1982), and along health profession lines (Akers & Quinney, 1968).

Visits to the H Hospital Board

In the winter of 1988, the researcher had dealings with the treasurer of another hospital board about organising some budget seminars. The treasurer had joined the organisation a few months earlier from the private sector, and had been amazed by the lack of financial control. He told the researcher that the previous treasurer used to keep the budget and the state of the board's finances to himself. As a prelude to introducing budget setting and monitoring, the new treasurer had divided the organisation into more

than 100 cost centres and designated about 75 people (senior medical officers, charge nurses and heads of departments) as their "managers". He was trying to gain support for this development by talking to these managers, assessing their training needs using a questionnaire, and planning some technical training. However, while the questionnaires were being completed and returned (42 were actually obtained; see below) the principal officers of the board directed the treasurer to cancel the entire initiative. The reason given was that they wanted to wait for the newly appointed acting general manager to determine what the policy on budgetary delegations should be.

In the context of the Study, various impressions were obtained by the researcher from both events and the 42 completed questionnaires. First, people believed that, as health professionals, they were involved in an honourable cause looking after the sick and infirm. There were quite a few people who would have liked to find out whether planning and controlling resources, and sharing resources on a planned basis, could have helped them do a better job, but without being overtly hostile, doctors in particular needed assurances that budgeting would improve, and not interfere with, their ability to do worthwhile things for their patients.

Second, many of the people in charge of cost centres did not see themselves as managers; they were merely senior professional or technical people who had emerged from among their fellows. Concomitantly, power was dispersed among individuals and groups who, to a significant degree, independently carried out specialist tasks. Participation in committees was relied on to negotiate, arbitrate and provide co-ordination. The structure was flat in the style of professional organisations with most people located in an operating core (Mintzberg, 1989). Lines of authority made for a matrix-like pattern (Allcorn, 1990; Janger, 1979; McMahon, Fetter, Freeman & Thompson, 1986; Young & Saltman, 1983), which seemed to have matured in a piecemeal fashion.

Third, the board seemed to be stuck in a culture-rut (Kilmann, 1989), and matters of strategy and structure were paralysed by this state of affairs. In particular, there seemed to be grounds for the treasurer's concerns about the way in which the organisation's

resources were being used, and for assuming that better information could help individuals and groups to evaluate what was happening around them. But many of the principal officers did not seem to see things this way. There seemed to be a shared belief among the cost centre managers that spending on healthcare should be unlimited, and that public outcry would force the government to find more money if the board ran out of cash.

Fourth, it seemed to be understood that political action was essential to get what one wanted as far as allocating resources within the organisation was concerned. Information was not free flowing partly because it was a source of power and negotiating strength.

Reflection and Revision

The impressions and perceptions accumulated during the above episodes were incorporated into the researcher's thinking about accounting in hospital organisations, and so the rough notion he was working with shifted to that shown in Exhibit 3.2. Evident in this notion, compared with the one in Exhibit 3.1, was a shift from a unitary perspective towards a pluralistic one, but it still embraced a traditional functionalist approach and retained the idea of accounting dysfunctions (Hopper & Powell, 1985). There were elements in it, however, which admitted both the contextual nature of accounting (Hopwood, 1976, 1983; Preston, 1992) and its constitutive capacities (Burchell et al., 1985; Chua, 1995; Loft, 1986; Roberts & Scapens, 1985); and that it has natural as well as rational aspects (Ansari & Euske, 1987; Boland & Pondy, 1983).

Exhibit 3.2. Rough notion of accounting in relation to hospital organisations in New Zealand consistent with the researcher's thinking in 1988.

Though accounting includes a collection of technical ideas and procedures of the sort which have been articulated in several well-established texts, it has to it a social and subjective side which is barely acknowledged in these articulations. This social and subjective side is bound up with it being contextual (Hopwood, 1983; Preston, 1992). That is, accounting as it is practised in an organisation is part of the forces and forms (Mintzberg, 1991) of that organisation. Hospital organisations have been represented as pluralistic and professional in several models (Becher & Kogan, 1980; Mintzberg, 1989; W. R. Scott, 1982). Each of these models places a significant emphasis on dynamics, or at least comparative statics, in the functioning of these organisations. It appears that accounting and accountants figure in these dynamics both giving force to them and being shaped by them (Roberts & Scapens, 1985, attribute this *duality of structure* concept to Giddens). Thus, accounting can figure when certain cultures, forces or groups try to gain ascendancy, and this manifests itself in new accounting procedures and systems. Indeed, one of the occasions when the social and subjective side of accounting is at its most visible is when technical ideas and procedures are being proposed or implemented as part of an organisational change. Such change is more likely to occur in a hospital organisation if professionals in these organisations, both on the committees that co-ordinate professional activities, and doctors, nurses, and so on at the front line, come to believe that these changes provide benefits of a professional nature, be they altruistic or self-interested ones (Mintzberg, 1989). One way of bringing about this belief about accounting is to educate and train the people concerned in the use of the ideas and procedures and with attitudes that put accounting in a positive light.

It is appropriate here to elaborate on the latter point because it arises several times subsequently in the thesis, including in the articulation of the theory-in-use in chapter 12. Several writers have addressed the question of what roles or purposes can be ascribed to accounting in organisations and society. Many of these were sparked by the seminal article by Burchell et al. (1980)[2] which offered "tentative observations" (p. 13) on the matter including that:

> Whilst they may be introduced in the name of particular conceptions of social and organizational efficiency, rationality and relevance, in practice accounting systems function in a diversity of ways, intertwined with institutional political processes and the operation of other forms of organizational and calculative practice. (p. 13)

Boland and Pondy (1983) have suggested that in studying organisational contexts an attempt should be made "to understand how . . . rational and natural aspects [of accounting] interact within the lived experience of individuals" (p. 223). Ansari and Euske (1987) took up this rational-natural dichotomy, and have devised a four cell (two by two) matrix by bringing in the more traditional dichotomy found in accounting between internal and external constituencies (i.e., financial accounting and management accounting). They label these cells:

1. "measuring technical efficiency", which is based on the microeconomic principle that "only those organisations which are efficient are able to survive by ensuring a continued supply of resources";
2. "resource allocations", which is based on the capital markets principle "that external constituents be provided with measures of efficiency";
3. "behavior changes", which "captures the pluralistic or socio-political role of information"; and
4. "gaining legitimacy", in which "the emphasis is on those roles that serve to legitimize the organization with its external constituencies" by

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[2] For an indication of the initial impact of this article, see Brown, Gardner and Vasarhelyi (1987). Between 1981 and 1994, the Social Sciences Citation Index listed about 100 articles in which Burchell et al. (1980) was cited.

> "present[ing] itself to its external constituencies as acting rationally" (p. 553).

Also, Kelly and Pratt (1992) in looking at the study of management accounting criticise the way in which the neo-classical economic perspective (e.g., profit maximisation, efficiency) has been "allowed to dominate in explaining the purpose of management accounting" (p. 233).

Step 2: Refining the Rough Notion into a Working Interpretation 1989-1991

Carrying out any field-based research was virtually impossible for 12 months after December 1988 when the government announced the first iteration of the reforms to the public healthcare sector (Caygill, 1988). During this time the situation was chaotic and stressful for people at the board administration level. Among other things, area health board members were elected, new service-based structures were implemented, staff were appointed to managerial positions, and other establishment activities took place. By the end of 1989, all of the 14 new organisations were operational in a formal sense, although settling down, changing and learning processes were still in full cry. It was extremely difficult merely to make contact with the kinds of people most likely to help in gaining access to the organisations, let alone finding anyone able or willing to discuss the data the researcher wanted.

During this period, some thought was given to obtaining an outline knowledge of accounting and accountants as they were emerging in the reformed hospital organisations. This was expected to be an important consideration in gathering data from the field. Despite lack of access to hospital sites at this time, however, some contact was maintained through students when, for the 1990 academic year, the researcher became responsible for a course at Massey University entitled *Utilising accounting in health management*. This course was part of a programme for health professionals and administrators on health management. From 1990 to 1994 it brought the researcher into contact with more than 100 participants who worked in hospital organisations throughout the country. Most of these were in positions created in the

new structures at responsibility centre and service management levels, and they were getting to grips with budget setting, and expenditure and cost control. These ideas and tasks were new to people in these new kinds of positions, as was confirmed by subsequent work. Dealing with the course participants also reinforced the notion that problems of change and language would have to be allowed for in obtaining the field-based data wanted later in the Study.

A Study in the G Area Health Board of Acquiring and Utilising Fixed Assets 1990-1991

The next episode of field-based activity started in October 1990 when the finance manager of an area health board wanted data to show the board's fixed assets on its balance sheet. The finance manager seemed intent on developing a fixed assets register to suit his immediate needs, and "recruited" the researcher's help. He was persuaded that some wider questions should be inquired into first, before designing and compiling the register. These included: what data already existed, who was holding them and in what form, and why? What purposes might data about fixed assets serve immediately and in the near future, for whom, and why? And, what data were required and how might they be collected, maintained and disseminated?

In order to find the answers to these questions, the researcher talked to people in various parts of the organisation, including the base hospital. The people were identified through a version of theoretical sampling known as *snowball sampling* (Denzin, 1989b), with the finance manager providing about half a dozen names with which to start. In all, the researcher tried to visit about 20 staff, but in the end only managed to interview 11 of them. Data was obtained using *nonschedule standardised interviews* (Denzin). Hand written notes were taken, and from these a paper, Dixon (1991), was developed for the managers and policy makers within the board.

Probably just as interesting as the paper, were the reasons for people refusing to be interviewed. Three reasons in particular were relevant to the Study design. First, the people who refused did not believe that the issue had anything to do with them. Second, relations between the potential interviewees and the accountants and/or the

central headquarters staff were frosty. Third, the issue was regarded as an administrative (board office) matter and not a clinical (hospital) one. Also of note was that no one suggested any charge nurses or doctors should be interviewed.

One impression gleaned from this problem of access was that the hospital organisation was partitioned. Access to one sector (e.g., corporate headquarters, hospital or similar unit, department within a large hospital unit, and staff member), or *level* (Becher & Kogan, 1980; also see pp. 98-101 of this thesis), was no guarantee of access to another. Another was that different *pigeonholes* (Mintzberg, 1989; also see p. 90 of this thesis) in the organisation dealt with different matters, and the topic in hand, fixed assets, did not belong in many of the pigeonholes, and certainly not in any of the clinical ones.

In summary, it was found that the organisation had the attributes of a professional bureaucracy with a great deal of power vested in the clinician-dominated operating core located in the base hospital (Mintzberg, 1989). But there were profound changes in progress which were shifting some of the power away from the people in the hospital. First, the formal change in name from *hospital* board to *area health* board was accompanied by an espoused change of emphasis away from curative intervention and large institutions dealing with sick people (see pp. 17-18 of this thesis). Second, the hospital-based heads of medicine and nursing, who used to be in the senior management triumvirate (see p. 50 of this thesis), had become subordinate in the formal chain of command to the general manager.

Seemingly consistent with the latter change, the number of people with formal managerial responsibilities had increased throughout the organisation, and a system of cost centres was being developed by the finance manager for the first time. The interviewees who were in charge of cost centres had all been given budgets. These seemed to be emerging as "the main financially-orientated strategy for planning and controlling organizational activities" (Abernethy & Stoelwinder, 1991, p. 106). But planning was limited in scope and was focused on sustaining functions (i.e., natural) rather than being service or output oriented (i.e., rational) (see Ansari & Euske, 1987). Budget setting was of an annual incremental kind and was limited to an incomplete

range of externally purchased inputs. Budgetary control was concerned with restricting either expenditures or payments on each input line item to the limit set in the budget. The supporting data for budgetary control came from the centralised accounting system with which the interviewees were very dissatisfied because of the poor quality of its generated reports. The system seemed to have a top down orientation and was geared only to policing overall expenditures. In any case, the data reported from it were not sufficiently timely to help with operational matters.

On the issue of fixed assets, the finance manager was interested in these from an external financial reporting perspective. In contrast, none of the staff interviewed shared this perspective; they could not have cared less about balance sheets. The initiation of proposals to construct or acquire capital items came from the people in the operating core or support services. Professional judgment and experience were behind a lot of the proposals. The process for dealing with acquisition proposals was an annual one, and involved various people making submissions to acquire replacement and new items. This involved people all the way up the managerial structure that was being put in place at the time of the Study. A frequent complaint was that the formal patterns of authority in the administration were chaotic and it was difficult for people who had made submissions to obtain decisions from above. In any case, decisions about asset acquisitions, and indeed ones relating to the initial deployment of other inputs such as new staff, were often dealt with in isolation from their effects on service volume and quality. It seemed that strategic planning was bogged down because mechanisms for carrying out this task were cluttered with short term control matters mostly relating to the consequences of the formation of the organisation. The process was a major source of frustration to most people because they perceived that their ability to continue providing existing services was at stake.

The acquisition process turned out to be the only aspect about which most interviewees might do any quantitative analysis. Decisions about custody, utilisation and disposal were done based on observation and by applying rules of thumb. In general, there was a lack of utilisation of managerial data in the organisation. This finding coincided with a traditional professional bureaucratic culture in which management control, such as it

is, is affected by political, judgmental, intuitive and expert means rather than by means of routine control founded on measurement of results and performance (Hofstede, 1981). Once people in the hospital had capital items in their possession, they regarded that as ownership and looked after the items accordingly. They did not perceive the assets as being owned by the area health board, which in their eyes was epitomised by people in the central headquarters office. The idea of there being a central register of assets was met with some defensiveness on grounds that it increased the possibility of central intrusion, interference, intervention and meddling.

Reverting to the needs of the finance manager, one of the possibilities for developing a data system for fixed assets was to use one already in place. This system was located in the engineering department, which perhaps was understandable, given some of the origins of cost and management accounting (Kaplan, 1984). The researcher obtained the impression that using someone else's system was not a solution which the finance manager found acceptable (see Armstrong, 1985). In general, systems and the data they dealt with seemed to have the same ownership characteristics as other capital items, and inferences from these data were regarded with some scepticism by others, on the grounds that they would probably be serving the interests of the people who were their source.

A Study of Hospital Organisation Central Finance Departments 1991

Another episode of gathering data for step 2 took place in mid-1991. These data were obtained from the finance managers in all of the 14 area health boards using a mailed questionnaire. They were used to find out about the structure of the central finance function department in each board; the extent to which 77 selected technical tasks of an accounting and managerial nature were completed by or on behalf of each board; and the location of the people who were involved in these tasks (Dixon, 1992). Although the instrument used had been tried in the New Zealand local government sector and in the English national health service, there are several reasons for the researcher doubting its reliability in this instance. These included: variability in interpreting the terms used in the task completion questions (Coulthurst & Piper, 1986); the lack of coverage of task frequency, intensity or technical application; the impression that many answers were

based on intentions, aspirations and pressure to do things, rather than what was actually taking place; and, the unreasonableness of expecting single respondents, no matter how senior or how inclined they were to consult colleagues, to know the answers to all the task completion questions, especially in a period of change[3].

Despite these shortcomings of data collection, the researcher was able to derive some inferences from the work for incorporation into the Study. There were obvious signs that the influence of accounting in hospital organisations was increasing between 1988 and 1991. The state of affairs in 1988 was gleaned from, among other things, the two hospital boards visited in 1988 (see pp. 49-53) and the descriptions of the state of information and information systems in four reports (Arthur Andersen, 1987; Health Benefits Review, 1986; Hospital and Related Taskforce, 1988; Owen, 1983). By 1991, there were more specialist accountants in the organisations doing a wider range of tasks, and there were more people in more places in corporate headquarters, hospitals and other hospital organisation facilities who were involved in tasks related to accounting. It could also be inferred from the data that costing and budgeting were among the kinds of tasks in which staff from both central departments and operational units were becoming involved; and that external financial reporting was still a growing area of activity.

Interviews with Commissioners and Senior Managers of Five Area Health Boards 1991

The final episode of data collection in connection with step 2 took place in October 1991. Seven interviews were conducted with the commissioners of three area health boards, the general manager of a fourth, and the corporate services director and two of his accounting staff at a fifth. The aim was to solicit perceptions about accounting and accountants in the boards. The interviews took place at the headquarters of the respective boards, and were of the nonschedule standardised type. General patterns were

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[3] These circumstances would make any form of functional paradigm study at best difficult, and at worst unreliable, useless and leading to invalid conclusions. These considerations contributed to the methodology and design choices which the researcher made within a few months of carrying out this survey (see pp. 13-14, 66).

detected from the data, although how the interviewees expressed their ideas differed. Also, because the interviewees were in senior positions, it was only to be expected that these ideas contained a great deal of espoused theory (Patton, 1990). Nevertheless, it seemed pertinent to admit the data into the development of the working interpretation, and a synthesis of the hand written interview notes and subsequent correspondence with the seven interviewees formed part of the data set for this step of the Study. A summary of this synthesis is presented in Appendix A.

Working Interpretation of Accounting in Relation to Hospital Organisations in New Zealand 1991

Step 2 of the Study was completed by revisiting the second rough notion of 1988 (see Exhibit 3.2), and reflecting on the inferences from the three episodes outlined above along with relevant literature. From this, a working interpretation was induced of accounting in relation to hospital organisations in New Zealand in 1991. This is articulated in Exhibit 3.3.

Exhibit 3.3. Working interpretation of accounting in relation to hospital organisations in New Zealand consistent with the researcher's thinking in 1991.

As a direct consequence of the nature of the work of doctors and nurses, hospital organisations are pluralistic and professional (Becher & Kogan, 1980; Mintzberg, 1989; W. R. Scott, 1982). In order to ensure that there is some cohesion, these organisations require administration. For the past few years there have been some rapid changes in this function: its size, importance and the power of the people involved in it are increasing. It has also adopted a new name: management (Hood, 1995). This growth is going hand in hand with a much greater emphasis on overall resource concerns compared with individual care concerns.

The change in emphasis from micro to macro (W. R. Scott, 1982; Ackroyd et al., 1989) derives from a shift in policy by successive governments. As part of this shift, grants have become conditional upon commissioners and general managers undertaking responsibility and accountability for services being provided, and for money being spent during the year in accordance with annual operating contracts. Money has also come to play a fundamental role in the formal and social relationships within the organisations among administrators and professionals alike.

Accounting is linked with this fundamental role, so much so that accounting ideas are far more prevalent than they used to be in the process and structure of hospital organisations. Thus, for example, each organisation's time is divided into financial periods of months and years (Roberts & Scapens, 1985). Professionals now find their operations organised into cost centres (Gray & Jenkins, 1993) or responsibility centres (Lapsley, 1994). The annual contracts between hospital organisations and government contain budgets showing allocations of grants between service categories. During a year, monthly general managers' reports have to be supplied to the Department. These reports compare spending with allocations and include other financial and service volume data, and are used by the Department to monitor the organisations.

Responsibility for each organisation's money and related matters is vested in professionally qualified accountants located in central finance departments. A few accountants are also employed closer to the hospital front line alongside medical professionals. In all this, the roles, purposes and power of accountants and accounting are increasing.

Initially, the position of accountants derived from hospital organisations having to produce better external financial reports and to carry out more cash management responsibilities. But as the changes gathered pace, the emphasis of accounting began to shift to internal structure and process matters and to funding mechanism matters. Thus, accountants participate in the contract negotiating process and contract monitoring process, and the other participants in these processes are obliged to have some understanding of accounting. Accountants and accounting play various roles in the twin processes of how money is allocated among people in hospital organisations and how its use is monitored and reported. Many people up and down formal chains of authority and accountability are obliged to interpret accounting data because of the role they play in the patterns of formal management control.

The changes to these patterns are increasing the authority of people involved in management over those in clinical areas. The traditional accountability of professionals has been along professional lines rather than managerial ones, being called to account for spending is something new for people such as doctors, nurses and other health professionals. Naturally, professionals are resisting these new patterns, but there is some cooperation, and people in many clinical areas are taking on some management duties.

Typical of the tasks which make up these duties are forecasting resource usage and patterns of spending; planning the deployment of labour and other resources; monitoring spending as it happens; assimilating reports; and policing expenditures by comparing actual spending with budgets. In order to cope with these, the people concerned are starting to acquire some accounting knowledge and skills.

Evident in this working interpretation, compared to the rough notion in Exhibit 3.2, is a shift in perspective from which the reader should sense the contextual nature of accounting. In particular, the interpretation indicates the way in which accounting figured in the social changes occurring among the main actors in hospital organisations at the time. People at government level and in the central administrative function were

employing accounting concepts to realign the basic values of the organisations from the micro ones, associated with providing care on an individual basis without any explicit rationing of scarce resources, to the macro one of spending less money on more patients. Essentially, this was being done by attempting to bring health professionals to heel by the establishment of time-limited financial boundaries, and the policing of these boundaries. By taking a much firmer hold on the purse strings, both the Department of Health and hospital organisation central administrators were able to demand more answers of traditionally autonomous professionals about how and why they were spending money[4].

Another aspect which appears in the interpretation is the two-by-two nature of accounting as expounded in Ansari and Euske's (1987) matrix. That is, on the one hand accounting was a duality of the internal (e.g., budgeting and costing) and the external (e.g., published strategic plans and annual reports); and on the other it was a duality of the rational (e.g., efficiency, goal oriented resource allocation) and the natural (e.g., power, legitimacy) (see p. 55 of this thesis). The emphasis of accounting in hospital organisations had shifted from financial administration (i.e., paying the bills and making a daily return to the Department to have their bank accounts topped up) before about 1988, to external reporting (i.e., complying with NZSA, 1987, the Area Health Boards Amendment Act of 1988, the Public Finance Act of 1989, and Minister of Health, 1990) from 1988 to 1991. Then, during 1990-91, it shifted to contracting, budget setting and monitoring. By the beginning of 1992, there were some signs of a further shift to product costing and pricing, to standard costing, and to managed care. It also appeared that while the rhetoric for these shifts tended to stress the rational (e.g., efficiency, effectiveness, accountability, improved services, the greater good of everyone) (Hopwood, 1983), in practice the natural was to the fore. For example, the data from the central accounting system promoted the legitimacy of the central administrative

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[4] In regard to developments of this kind in the USA, see Preston (1992). Also, for an elaboration of similar occurrences in the USA health sector in regard to an extension of the roles and purposes of accountants and accounting, and an increase in their power, see Michelman (1987); and for a discussion on the encroachment of accounting into a variety of new arenas, see Bougen et al. (1990).

function and of the organisation as a unitary corporate body, and inculcated a reality of managerial process and structure, even though these data were not much use, or much used, for rational quantitative analysis and operating decisions.

Step 3: Inquiry, Thick Description, Thick Interpretation and Theory 1992-1994

With the conceptual phase (i.e., steps 1 and 2) completed, step 3 in the Study strategy of control and design began. This step entailed refining the working interpretation by collecting data from the field on a basis consistent with the theoretical stance of the Study; developing thick descriptions of relevant events and experiences; and interpreting these thickly in order to induce a theory-in-use of the phenomenon being studied (see Figure 2.1). It involved making two sets of choices. The first set related to choices of which data to collect and how to go about collecting them. This set was based on the working interpretation and the researcher's experiences whilst deriving it. The second set related to choices of how to process, analyse and organise the data, culminating in the choice of how to write the thick description. In view of the degree to which the reliability and validity of the Study depends on these choices, and the already stated commitment of the researcher to sophisticated rigour (Denzin, 1989b), full and careful details of these respective sets of choices are given in the next two subsections.

Design Choices

A basic choice was made by the researcher to collect data directly from people in the field. This choice was made for several reasons but the four most important were as follows. First, the nature of what people were doing was perceived as being both complex and ambiguous. Furthermore, a great deal of change was taking place so that "symbolic meanings [we]re in flux" (Denzin, 1989b, p. 146). Thus, it was expected that potential interviewees were likely to have such complex, diverse and dynamic stories to tell and other data to impart, that anything other than face-to-face contact on their home territory was unlikely to capture the kind of data required.

Second, people working in, or involved with, hospital organisations were perceived to have a very wide range of perspectives in relation to how their work should be done and

why it should be done. The researcher anticipated a lack of common language through which to ask questions and convey answers. He would need to converse with them in order to bring about mutual understanding of the questions posed and of the answers given. Third, the basic questions to which the researcher was seeking answers were qualitative and social in nature. And fourth, there were difficulties to overcome in identifying a complete list of the names of potential interviewees. The researcher could not do this himself, being remote from their locations, and it was doubtful whether mediators could be used because of the probable lack of anyone who knew enough about the Study and the kinds of people who would make useful interviewees. The researcher was the person who best combined this knowledge, and so it seemed appropriate for him to gather names directly, while in the field.

The next choice was to use interviews, or act as *observer as participant*, rather than to assume other participant observer roles such as *complete participant* or *participant as observer* (Denzin, 1989b, pp. 163-165). This choice allowed participation in as many places as possible to achieve some kind of data triangulation within the limited resources available. These limited resources comprised a single researcher with a small budget fulfilling the demands of a full-time job in addition to carrying out the Study. In any case, based on earlier difficulties, the researcher thought it unlikely that he could gain the continuous access to any of the hospital organisations that the other participant-observer roles required.

The researcher was aware that the choice to use interviews was less suitable than others for handling "forms of interaction that are in change" (Denzin, 1989b, p. 158). Thus, he tried to compensate for this deficiency in several ways, including how interviewees were selected and approached, and how questions were posed. In particular, the researcher tried to "overcome the constraints of the 'stranger relationship'" (p. 118) and to bring about a state of interviewees as *informants* so they would trust him, give information freely and frankly, accept the researcher at face value, and provide information and aid, even though, as Denzin points out, it might jeopardise their careers. This contrasts with mere *respondents* who function primarily as persons giving answers to a questionnaire (pp. 173-174).

The researcher was also aware of other general deficiencies about interviews as a method of collecting data (Denzin, 1989b, pp. 109-111; Silverman, 1985), and some of these are alluded in chapter 2 particularly on pp. 31-33. This made the researcher more alert to counter their potential for prejudicing the reliability and validity of the Study, such as in the style of the interviews, and by triangulating between interviewees' accounts, but not making the mistake of adjudicating between accounts (Silverman, 1985).

The next two choices were about where to seek out interviewees, and what to discuss and ask questions about. These choices were approached with a certain amount of concurrency because the latter was critical in manipulating access to organisations and to individual interviewees (Patton, 1990). During the episodes reported in the previous sections of this chapter, the researcher found that the general phenomenon of accounting could not be talked about directly because it was abstract and ambiguous. In any case, most people seemed to perceive it as the bailiwick of accountants, and so were likely to suggest that, if he wanted to discuss and ask questions about it, he should visit these specialists. However, it was reasoned that if the questions were interesting to the people whom the researcher wanted to interview, and to the people who controlled access to potential Study locations, this would improve the chances of obtaining their cooperation. The researcher saw no problem with taking this line as long as the integrity of the Study and his interests were both preserved by obtaining valid data that were relevant to completing the Study.

Application of the Working Interpretation

In keeping with the Study strategy of control and design, the logical place to look for topics around which to ask questions was the working interpretation. This yielded several interrelated processes, procedures, activities and documents of an accounting nature connected with the work situation of people throughout hospital organisations. The particular significance of documents was that they could be pointed to, seen, touched and read, and no matter how ambiguous their meaning to interviewees and interviewer alike, they were something tangible on which to focus (Lofland cited in Denzin, 1989b, p. 77).

Moreover, there were three kinds of documents, and associated processes, procedures and activities, which stood out in the working interpretation. These were annual reports, budgets and cost data reports (for a summary discussion of the processes attaching to these three items, see D. J. Cooper, Hayes & Wolf, 1981). Not only were these linked theoretically to the phenomenon under study, but they appeared to be linked with quite decisive events and experiences in the changing work situation of various people, and with the changing role or purpose of accounting in hospital organisations. They proved to be items on which a wide range of people could communicate their perceptions, experiences and expectations. They also facilitated access to research sites in that the researcher was able to find some *known sponsors* (Patton, 1990, p. 254), who were interested in these choices and who were associated with three organisations about which data could be collected.

The process of gaining access to Study locations, and thence to interviewees, was congruous with theoretical or purposeful sampling, and in particular the strategy of snowball or chain sampling was used (Denzin, 1989b; Patton, 1990). Locations were chosen, and access was gained to them, as a result of encounters with people in some of the episodes reported in the first two sections of this chapter (see following paragraphs for more details). The locations are listed in Exhibit 3.4.

The known sponsor at SITE P joined the area health board's corporate headquarters staff in 1991, and by 1992 was responsible for facilitating budget setting using the OPIS system. This person was interested in how the system was working, and she arranged access to the SITE P hospital via one of its service managers, who along with many other staff there, had been critical of the system in 1991, its first year of use. She also gave the researcher a list of responsibility centre and service managers, and from this he selected six names, ran these past the service manager and his assistant, who between them added two more names, and this constituted the initial sample of interviewees.

Exhibit 3.4. Sites where the data were collected during the substantive field experience phase.

SITE P: one of a number of districts of an area health board that was centred on a general hospital. The board was using a system called OPIS[5] for compiling its budget. The district became a Crown health enterprise in its own right in July 1993;

SITE Q: the base hospital of an area health board. The board was using RUS for generating cost data reports. This board became a Crown health enterprise in 1993; and

SITE R: an area health board whose annual report had gained favourable recognition. This board also became a Crown health enterprise in 1993.

The known sponsor at SITE Q was the board office based director of corporate services who was interested in the problems of RUS vis-à-vis clinicians. The director put the researcher in touch with a staff member who was based in the hospital and responsible for maintaining RUS. This person gave the researcher the names of eight responsibility centre and service managers who constituted the initial sample of interviewees.

The researcher identified SITE R after considering the geographical location and size of population coverage of the organisations associated with the other two sites, and with the other places at which he had already done some work, as reported earlier in the chapter (i.e., he tried to avoid repetition). Of the two hospital organisations which seemed suitable on these criteria, he tried to gain access to one whose annual report had the better reputation, on the grounds that the people there would probably be a richer source of information (Patton, 1990, p. 169). Having had some minor contact with the board's then finance manager, he visited that person as a potential known sponsor. However, unbeknown to the researcher, the area health board was starting a major management restructuring involving a complete change of senior management personnel. The known sponsor seemed to lose out in this change, but eventually provided six names

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5 OPIS is the acronym of *operational planning input system*.

from among the senior managers based at the board's central headquarters who had agreed to act as interviewees. He also provided the list of addresses to which the board's 1990-91 annual report had been sent. From this the researcher selected a cross-section of addressees and attempted contact. This proved difficult (see below) but eventually the researcher managed to track down 12 recipients of the report. Thus, the six managers and 12 addressees constituted the initial sample of interviewees.

The process of gaining access to locations proceeded from March 1992 until agreement about access to SITE R was reached in October 1992. Early in this process it was decided that the research raised ethical issues and so was a matter for the University's human ethics committee. The primary issue was that the data would be gathered from individuals about the organisations which employed them. While the traditional nature of these organisations had been professional and collegiate, during the reform period, some staff who expressed criticisms about the effects of the reforms, or about events in their organisations in general, seemed to have suffered repercussions for their pains (e.g., later in the Study an incident of this sort made the national press, see Forde, 1994). Similarly, people with overall responsibility for hospital organisations probably felt threatened by the possibility of adverse data emerging. Means were devised to deal with the problem of protecting the confidentiality of data supplied by individuals and of data about particular organisations. These incorporated such matters as access to participants, participants right to decline, informed consent, arrangements for participants to receive information, confidentiality, and use of the data collected. The ethics committee supported the project on this basis.

By July 1992, the initial samples of interviewees (eight in both cases) had emerged for SITES P and Q. The researcher wrote to each potential interviewee explaining the nature of the Study, the kind of data being sought and what would happen to the data afterwards. The letters were in similar form to that reproduced in Appendix B. They were followed with telephone calls, and appointments were made to visit those potential interviewees who were willing and able to participate. As an outcome of each interview, the names of further potential interviewees emerged, and these people were

approached in the same way as the initial list. Thus, snowball sampling was repeated at each site to arrive at the theoretical sample sought.

The researcher tried to ensure that samples comprised interviewees known to have disparate points of view, and he gave this specification to the sponsors and interviewees who supplied the names of potential interviewees. The researcher ensured that samples included doctors and nurses as well as non-clinical people. This proved easier to achieve than was the case in the episodes reported in the previous section (e.g., see pp. 57-58). But it still proved impossible to contact two senior consultants who shared their time between the hospital and their rooms, and were never "in". One of these was at SITE P and the other at SITE Q. In contrast, another who was connected with SITE R proved very keen to participate.

Of the others identified as potential interviewees at SITES P and Q, only one person at each place declined to be interviewed and did so politely but firmly. One manager in a clinical area had had recent bad experiences with researchers who, having obtained data, used them to be critical without giving her the right of comment or reply. Another manager in a non-clinical support area indicated that he did not think the particular topic area of cost data had much to do with him. Of four other names whom the researcher tried to approach at these two sites, two were on leave during the researcher's series of visits; one arranged a few appointments provided the intensive care ward she was in charge of was quiet, but unfortunately it never was; and one left her job suddenly. Given the sampling method, it was possible to contact additional people to replace these non-respondents.

When the initial sample of 18 interviewees for SITE R was identified in October 1992, a similar letter to that used for the other sites was sent to potential interviewees. The letters sent to the six internal interviewees in the initial sample reached their destinations without problems and all agreed to be interviewed. However, the letters dispatched using addresses on the annual report distribution list were not very successful in reaching anyone first time around. In most cases the addressees were officials of organisations (e.g., secretary, chairman, president), most of whom passed the reports on

to someone else virtually unopened. The researcher pursued each one and in every case found someone who admitted having received the report. For the most part, these people agreed to be interviewed. But in two cases the researcher received apologetic declinations from high ranking bank officials on the grounds that it was not their organisations' policy to discuss the accounts of clients or potential clients. In another case, the person was ill on the day the interview was scheduled, and subsequently suggested that he be substituted with someone who might be better qualified to answer questions.

Sample sizes were increased as far as it seemed that additional interviewees were adding to the data set and as far as resources would allow. The researcher was aware that each interview consumed organisational staff time and costs, and did not wish to overstay his welcome either at the main sites, or when visiting the 14 interviewees at off-site locations. The latter included staff from the Department of Health, a regional health authority, Audit New Zealand, the off-site corporate headquarters of the area health board responsible for SITE P, another area health board, a local authority, a trade union, an educational institution and a nonprofit welfare agency, and three journalists from two newspapers. By the end of February 1993, the researcher had interviewed 48 people in connection with the three sites. The composition of this number by site, location and gender is shown in Table 3.1. Further details of the "cast" of interviewees at each site are given in chapter 4.

Another point deserving comment at this stage is the almost concurrent entries into the three sites, whereas the strategy of analytic induction normally involves carrying out case examinations successively. The circumstances of the Study arena tended to dictate when data were collected, and following access difficulties between 1989 and 1991, opportunities for entry into these three sites arose in close proximity. Moreover, it is the researcher's impression that if he had not made the best of the opportunities which arose in 1992-93, they would not have occurred again for some time. Subsequent contact with students who were working for hospital organisations indicates that in mid-1993 access again became difficult.

Table 3.1. Composition of theoretical samples in connection with sites.

SITE	TOPIC	NUMBER OF INTERVIEWEES				
		TOTAL	LOCATION		GENDER	
			ON-SITE	OFF-SITE	MALE	FEMALE
P	Budget	17	15	2	9	8
Q	Cost Data Report	11	11	0	8	3
R	Annual Report	20	8	12	15	5
	TOTAL	48	34	14	32	16

Interviews

The researcher visited the interviewees at their workplaces. Most interviewees had an office of some sort. The dress norms of interviewees varied a great deal, ranging from *The Terrace*[6] corporate executive suits to less formal office attire, and to clinical overalls, theatre gowns and nursing uniforms. The researcher as interviewer tried to dress in ways that would not threaten, antagonise or otherwise adversely influence the interviewees' inclination to share their stories and data with him.

Technically, the interviews took the style of nonschedule standardised interviews, rather than *schedule standardised interviews* or *nonstandardised interviews* (Denzin, 1989b, pp. 104-106). Lists of questions were compiled which enumerated what information was required from interviewees. But these were used only as interview guides (Patton, 1990), and during the interviews the "phrasing of questions and their order [we]re redefined to fit the characteristics of each respondent" (Denzin, 1989b, p. 105). This generated enough flexibility to cope with data collection problems stemming from language difficulties and difficulties caused by changes taking place in the hospital organisations. In the cases of SITES P and Q, one interview guide for each was

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6 The Terrace is a street in Wellington in and around which the departments of government are located.

sufficient, but for SITE R it was necessary to prepare two separate guides; one for the internal managers associated with preparing the annual report, and one for the recipients of the annual report. All four guides are reproduced in Appendix C. One further point applies to SITE R: A combination of the two guides prepared for that site was used to interview an auditor because of that person's involvement in putting the annual report together, as well as the possibility of his being a recipient.

Questions included on the interview guides were inspired by a combination of the immediate objective of deriving a thick description of situated practice, and of motivating interviewees to provide the information that was sought (Denzin, 1989b). They were a mix of *experience/behaviour, opinion/values, feeling* and *sensory* questions, and a few *knowledge* and *background/demographic* questions as well. The questions asked about the present, past and future. They were mainly questions of the *how* type framed to find out what was in and on the interviewees' minds and to access their perspectives (Patton, 1990; see also pp. 23, 26 of this thesis).

A high turnover of staff since the mid-1980s meant that although some interviewees had been connected with the sites for as long as twenty years, most had only been there from a few years to as little as a few weeks. Thus, many interviewees were unable to compare the present with the mid-1980s. Because changes had come about so rapidly, however, most could recall times when the topics of the interviews either had not been their concern, or did not seem to affect them as much as they did at the time of the interviews. Thus, the data captured the periods before and after more recent changes, and also the dynamic characteristics of these changes, including their cause and effect link to other organisational events and changes (Ansari & Euske, 1987).

For each site, having devised an interview guide, the researcher set up and conducted two interviews. These initial sorties gave the researcher some idea of how the interviews might proceed and whether all the material was likely to be covered. As the researcher had used some similar interview guides on another project earlier in 1992 (Dixon, Coy & Tower, in press), these initial pairs of interviews were fine tuning rather than pilot guides. As it turned out, the minor alterations to the way the researcher

conducted subsequent interviews were to his style and expectations rather than to the guides themselves. The only other change to interviews within each series was that answers obtained at earlier interviews were used to inform conversations at later interviews. Also, interview appointments were well spaced out to allow periods of reflection and elaboration between interviews (Patton, 1990).

The interviews were always "a conversation . . . where the main focus derive[d] from the questions" (Denzin, 1989b, p. 109). Within this general form, they ranged from some interviews in which the answers to original open ended questions were followed up with supplementary questions, probes, discussions and clarifications to, at the other extreme, interviewees themselves describing their working environment, amplified with anecdotes, and allowing the researcher to interrupt in order to clarify parts of the narrative. The general approach of the researcher was to include in each interview a majority of questions that had the same meaning though not necessarily the same wording (Denzin, 1989b). Thus, there was a degree of focus, and interview time was used expeditiously. But this was done without restricting either the way interviewees expressed themselves, or the subjects that they brought into conversation. In essence, interviewees were asked to describe: how they did what they were doing; how this was changing; what it used to be like; and what they expected in the future.

The opening question of "How would you describe your job?" generally set the tone of an interview, and those interviewees who were off-site were also asked about the organisations with which they were connected (see Appendix C). The duration of interviewees' answers to this question(s) varied from at least 5 minutes to as much as 35 minutes. Asking these questions allowed the interviewees to relax and encouraged them to talk more openly. This was familiar territory and demonstrated that the researcher was interested in them. Subsequent questions moved the conversation towards the specific topic about which the researcher was inquiring, but in ways that allowed the interviewees to remain at the centre of the questions, by asking what they did, how things had changed, and how they felt about it. Earlier questions invariably elicited at least partial answers to many other questions on the interview guide (Denzin, 1989b, p. 106). The researcher proceeded by picking up these partial answers and

linking them to items on the guide, and also by referring to it for new stimuli. Throughout the interview, the researcher took notes of points to which he wished to return (Patton, 1990). He also probed further on matters which were unclear or when interviewees raised important issues that were not contained on the guides (Denzin, 1989b, p. 106). Finally, the questions brought the interviewees back to how important and interesting the topic of conversation was in their work or in a similar context, and they were asked if they had anything else to add.

Interviews varied from 35 to 110 minutes. On two occasions interviewees indicated apologetically at the beginning that they would have to end the interview at a particular time due to urgent business. However, all other interviews went full cycle. All interviews were tape recorded, except for one in which the interviewee declined[7]. The tape recorder proved indispensable in that it did "not 'tune out' conversations, change what [was] said because of interpretation (either conscious or unconscious), or record words more slowly than they [we]re spoken" (Patton, 1990, p. 348). Also, the researcher tried to compensate for any threat which the tape recorder might pose by making it as unobtrusive as possible. However, on some occasions the conclusion of the interview and the switching off of the recorder was a cue for interviewees to proffer some of their most interesting anecdotes.

Interviewees were not given a copy of the interview guide at the beginning of the interviews but were promised one at the end. They tended, however, to have a perception of the main topic, and so couched their descriptions, perceptions and opinions in the context of this perception to some degree. The depth at which topics were discussed varied according to such aspects as the participant's position, responsibilities and role. Participants also volunteered or were asked for documentation, and the researcher was able to take some of this away for examination. On several occasions, as an interview wound towards its conclusion, the interviewees asked for the interview guide and went through checking it in order to be satisfied that what they had said answered the questions, and to fill any gaps.

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[7] Handwritten notes were used to record this interview and priority was given to writing these up to avoid losing even more data with the fading of memory.

In the latter part of many interviews, interviewees tried to elicit information about how the Study was going and what impressions the researcher had obtained so far. These enquiries were an opportunity for the researcher to share data already collected and to obtain the views of the interviewee about these data. Indeed, as he progressed from one interview to the next on each site, and from site to site, successive interviews were informed by what the researcher had been told previously. In particular, he tried to check the reliability of what previous interviewees had said and to develop segments of data that had come to light in these previous interviews. This was done in a general way in order not to prejudice the confidentiality of particular interviewees. It was consistent with the emphasis of the Study on developing a wholistic understanding of the phenomenon being studied (Eisenhardt, 1989; Patton, 1990); and with improving "both the quality of data collected and the quality of the analysis so long as the [researcher] is careful not to allow these initial interpretations to distort additional data collection" (Patton, 1990, p. 378). This reflexing was possible between, as well as, within sites, and so perhaps compensated in some ways for concurrent data being used as part of analytic induction even though it was not in full accord with the notion of this process as one of incremental refinement by successive entries into the field.

While virtually all interviewees seemed keen to participate (formally, all given their informed consent), there were one or two who were a little reserved, despite the assurances the researcher provided before and during the interviews. The most common defensive reaction was one of being happy to oblige the researcher by seeing him, but expressing doubt about being of any use to him. This was particularly so among recipients of the annual report, some of whom clearly felt embarrassed about the distance the researcher must have travelled only to be told that it really was not something of which they took much notice. The researcher was at pains to tell them that such data were useful, and to discourage them from exaggerating the use or importance of the report simply to please the researcher.

Processing, Analysing and Organising the Data

Analytic induction offers a way of formulating generalisations, in the sense of extrapolations, and constructing theory from case data that have been organised into

thick description. But there is still the initial challenge in relation to qualitative inquiry of making sense of massive amounts of data (Patton, 1990). Moreover, this challenge must be faced with "no absolute rules except to do the very best with your full intellect to fairly present the data and communicate what the data reveal given the purpose of the study" (p. 372). Nevertheless, there are guidelines and procedural suggestions which the researcher has tried to follow. Thus, having collected the data, the researcher was faced with a second set of choices over how to process, analyse and organise them. As Figure 3.1 shows, this culminated in the choice of how to write thick descriptions that were revealing. The elements in the Figure are explained in the subsections that follow.

Moving from Raw Data to Within-Case Analysis and Case Descriptions

The first step in this set of choices was to recognise just what constituted the raw data. According to Patton (1990), interviews "all come to naught if the interviewer fails to capture the actual words of the person being interviewed. The raw data of interviews are the actual quotations spoken by interviewees" (p. 347). Having tape recorded 47 of the interviews, and taken notes at the other, the researcher treated these as his raw data.

Next came "the challenge to . . . reduce the volume of information, identify significant patterns, and construct a framework for communicating the essence of what the data reveal" (Patton, 1990, pp. 371-372). A choice was made to begin with *within-case analysis* (i.e., doing a *case description* of each interviewee), rather than *cross-case analysis* (Patton, 1990, p. 376; Eisenhardt, 1989, p. 540). There were two reasons for this choice. First, people, and what they did, had emerged as the primary focus of the Study. And second, this approach enabled the researcher to begin processing the data as soon as possible after each interview was completed, rather than having to wait for the completion of data collection from whole sites or all three sites.

The within-case analyses were performed through listening to each audiotaped interview and committing what was heard, and what the researcher understood the interviewee to mean, to a computer file. The exact words of the interviewee were arranged into sentences and paragraphs. The sequence of some items was revised in order that similar points were linked together within broad categories including personal history, job

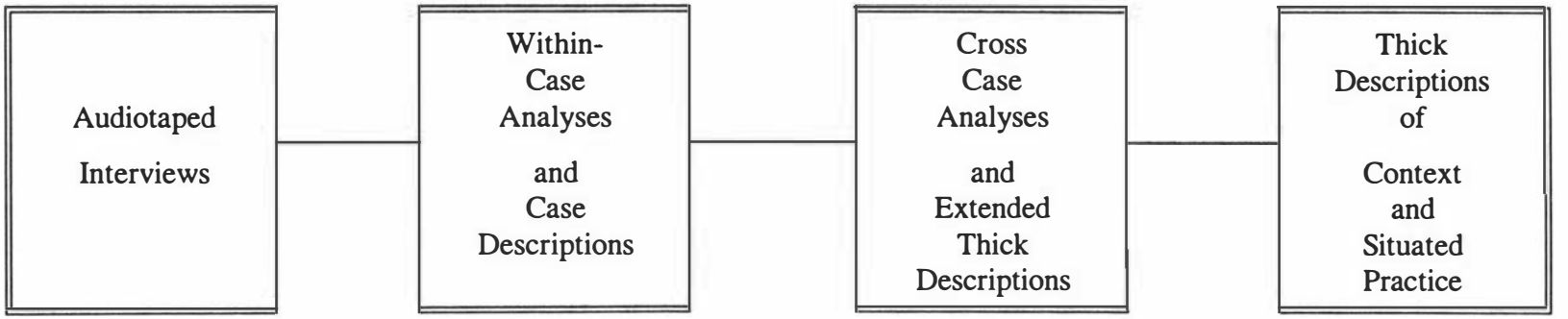

Figure 3.1. Sequence of moving from interview data to thick descriptions.

composition, processes including key events and interactions with other people, and issues (Patton, 1990, p. 377). As each case description was completed, it was produced in letter form and sent to the interviewee.

The researcher perceived these particular strategies as fulfilling several purposes. First, he was forced to reflect on the method he was using and the data that were emerging, in order to inform the later interviews. Second, he had cause to listen carefully to the interviews, and make sufficient sense of them, so that he was able to convey to the interviewees what he understood them to mean. Third, it signalled to the interviewees the researcher's ongoing interest in the subject matter and in their work, and was an acknowledgement of their assistance. Fourth, it allowed interviewees to check and possibly add to the data, as well as provide some external validity to the Study via respondent validation (Bryman, 1988, but see Bloor and Bhaskar, cited in Silverman, 1985, pp. 44-45, for rebuttals of this second notion). Fifth, it provided a link between the raw data and the thick description that was to follow, not only in terms of analysing the words and meanings, but also in comparing and contrasting what different people had said.

Another noteworthy point is that although they were recognised as the raw data, the researcher was loathe to return transcripts to interviewees. People in natural conversations rarely talk in coherent sentences and grammar tends to be atrocious (Patton, 1990), and the interviewees were no exception. It was expected that as they would be used to reading coherent material, they would find verbatim copies of the interviews off putting. Moreover, some of them might have been too embarrassed to respond to something which showed the way in which they speak. It was also expected that transcripts would engender an attitude among interviewees to the effect that if the researcher could not be bothered to organise the material in order that it conformed to the norms of written communication, why should they respond to him. Furthermore, the purpose of communicating with interviewees was not to get them to confirm merely that they had used a particular string of words and other utterances. It was to ask them whether the case description, stemming from what the researcher had understood them to say, was the meaning they had meant to convey. In other words the case descriptions

gave interviewees the chance to comment on the way the researcher had started to mediate between their words and his theory.

While the case description letters were not transcripts, neither were they short summaries. In total the interviews took up between 50 and 60 hours of audio tape, and the letters derived from this ran to about 350,000 words in total and occupied some 700 pages. The task of listening carefully to what was said in each interview and committing it to a word processor file took from between 10 and 30 hours spread over 2 to 6 days depending on the length and fullness of the interview. Although the interviews were completed by mid-February 1993, it was mid-August 1993 before the last case description was dispatched.

Finally, on the matter of case descriptions, out of the 48 dispatched, 25 evoked responses, and only a few alterations were suggested, all of them minor. The researcher supposes that the 23 interviewees who did not reply found that their case descriptions did not contain anything about which they disagreed significantly (see also Bloor cited in Silverman, 1985, p. 44, about non-response due to lack of interest in a researcher's research topic and unwillingness to voice disagreements).

Focusing the Analysis

After deriving the case descriptions, it was necessary to start synthesising them and focusing the analysis. This was done by spending time reviewing and reflecting on the descriptions wholistically and segmentally, and also revisiting the published literature. Patton (1990, p. 376) points out that the latter is a source of help for providing focus. Several iterations of this reflexive process between the field data and published literature were gone through in what amounted to progressive refinement.

The initial review of the case descriptions left the researcher with the not unexpected impression of some interviewees having more in common with one another than with the rest. By pursuing this line of analysis, and in particular using cross-case searching tactics (Eisenhardt, 1989, pp. 540-541), it was possible to arrange the interviewees into clusters according to their settings, the nature of their work and their colleagues and/or

staff, and the way this work and these people were organised. Other differences between the clusters of interviewees emerged as well, including their values, motives, perspectives, and how much power and influence they wielded over people in other clusters. Also, the nature of interrelationships between people within clusters differed from cluster to cluster, as did the interrelationships between people from different clusters.

Revisiting the literature led to four models being identified linked to both the Study area and the methodology. These models are expounded in Becher and Kogan (1980), Mintzberg (1989, 1991) and W. R. Scott (1982), which, as stated on p. 30, are of the nature of pluralistic studies employing interpretive methods. The models provided a theoretical explanation for the cluster arrangement gleaned from the case descriptions. In particular, the Becher and Kogan model provided a rationale for delineating functional levels in the hospital system, while the models of Mintzberg and W. R. Scott provided a rationale that linked these levels to other facets of process and structure within hospital organisations. What is more, these rationales gave rise to a map of the hospital system context, or *functions and values framework*, consisting of an array of interrelated elements (see Figure 3.2).

The most obvious aspect of the array is that each element is a workplace or similar kind of setting typical of hospital organisations and the hospital system. But the array is more than just a matter of administrative definition. The elements, like the clusters from which they were derived, are differentiated by other factors, including internal structures, social processes, issues, perspectives, values, power and influence. These factors, the four models, and the derivation of the functions and values framework are explained in chapter 4. It is sufficient here to say that the elements in the framework were used as a basis of carrying out eight *cross-case analyses* in which related case descriptions were synthesised. From each analysis, an extended thick description was produced. Each of these painted a picture of the work context, situations, and circumstances of action of people in different elements of the framework. They also related their intentions, motives and meanings (Denzin, 1989a, 1989b).

<table>
<tr><th>INDIVIDUAL LEVEL</th><th>BASIC UNIT LEVEL</th><th>INSTITUTION LEVEL</th><th rowspan="2">CENTRAL AUTHORITY LEVEL</th></tr>
<tr><th colspan="2">Operating Core & Support Services</th><th>Management Zone</th></tr>
<tr><td>Doctors</td><td>Clinical Departments</td><td rowspan="2">Hospital Organisation Managers and Support Staff</td><td rowspan="4">Ministry of Health

Regional Health Authorities

and Similar External Authorities</td></tr>
<tr><td>Nurses</td><td>Wards</td></tr>
<tr><td>Other Health Professional and Scientific/Technical Staff</td><td>Clinical Support Services</td><td rowspan="2">Hospital Service Managers and Support Staff</td></tr>
<tr><td>Non-Clinical Technical and Ancillary Staff</td><td>Non-Clinical Support Services</td></tr>
</table>

Figure 3.2. Functions and values framework of the hospital system which was used to focus the Study analysis.

These extended thick descriptions contained narratives, perceptions, explanations and opinions of events and experiences related by the interviewees. They were divided into several sections according to patterns, themes and categories induced from the data (Patton, 1990, p. 390). For example, the extended thick description of charge nurses included sections on wards, patients, tasks and motivations, budgeting, rostering, savings, links within hospitals, answerability for managerial matters, and feelings about other people and changes. The researcher made a conscious effort to stay faithful to what the interviewees had imparted, without conferring his own interpretation. The text of the extended thick descriptions was derived from the utterances of individual interviewees. More to the point, all the tales in these thick descriptions, the opinions expressed and "the meanings persons bring to their experiences" (Denzin, 1989b, p. 159), were those of the interviewees, rather than those of the researcher. However, it is acknowledged that like any other analysed data, the material was bound to contain underlying biases deriving from the researcher, as explained on p. 28. Also, it was balanced by "analysis and interpretation . . . [because] endless description becomes its own muddle" (Patton, 1990, p. 430). For example, sectionalising the descriptions according to patterns, themes and categories, and labelling each section with a heading, amounted to interpretation, but this was calculated to be no more than sufficient to allow it to be understood.

Next, the researcher reflected on the extended thick descriptions. First, it was necessary to move from them to interpretation and theory. And second, it was necessary to produce the descriptions in a form suitable for "communicating the essence of what the data reveal" (Patton, 1990, p. 372). Even though a thick description is by definition dense, detailed and somewhat lengthy, the researcher considered that their form and length (more than 300 pp.) was still too much of a muddle for the readers of this thesis. The descriptions were distilled even further and, of necessity, the researcher has eliminated many hours of "out takes"; thick interpretation was interspersed between thick description (with care taken to alert readers); and material from different clusters of interviewees was synthesised. The outcome of this approach are presented in chapters 5 to 11.

The first four of these chapters comprise, respectively, three thick descriptions and an interpretation. These bring to life the wholistic representation of hospital organisations and the hospital system in the functions and values framework. They show a dynamic culture replete with similarities and differences of norms, values, perspectives and ways of working both within and between the functional elements. These similarities and differences are deliberately stressed in the thick description, and were a feature of the cross-case searching tactics[8] (Eisenhardt, 1989, pp. 540-541) used to enhance the thick interpretation that appears in chapter 8. In order to enhance the clarity of this interpretation, much of it has been presented in tabular form. The tables used are explained in detail in the chapter, and focus on *orientation*, *control*, *resources*, *task interdependence*, *resource interdependence* and the *basis of being answerable* (see pp. 202-204).

Chapters 9, 10 and 11 consist of two thick descriptions and a thick interpretation of accounting and related processes, and of their outcomes. These processes have come to play a significant role in interrelationships within and between the elements of the function and values framework. Their outcomes comprise the effects of accounting on the kinds of people (e.g., doctors, nurses and other health professionals, and managers cum administrators) found at the different levels in the framework; and in particular, the changes in knowledge, attitudes, feelings, behaviours and skills that have been occurring as accounting has changed. They also encompass its effects on groups of these people, on their institutions and on the whole system. These outcomes are examined from the perspectives of these people.

Having completed the descriptions and interpretations, the researcher drew out the main ideas, and enfolded these with published literature (Denzin, 1989a, 1989b; Eisenhardt, 1989; Patton, 1990), in order to synthesise a theory-in-use of accounting at the "micro-organizational level of analysis" and at the "industry level" (Chua & Degeling, 1993, p. 292). This theory provides "explanations and interpretations of the phenomenon under

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[8] These tactics were used in the first place to derive the pattern of interviewee clusters from similarities and differences of functions and values evident in the case descriptions.

analysis" (Denzin, 1989b, p. 67) in the sense that the "interpretations . . . hold for (or make sense of) past and future occurrences" (p. 39). The theory is presented in chapter 12 and is made up of a set of "descriptive" and "operative" concepts derived from the data and formed into a "conceptual scheme", bound together by "a set of propositions . . . placed in a deductive scheme" (p. 49).

Step 4: The Thesis

From the account above of carrying out the analysis, the reader should glean a sense of step 3 of the Study gradually giving way to the final step of writing this thesis. Most of what was involved in this step has been covered already, but there are a few matters which need to be recorded.

First, the choices made of analysis and thesis presentation were inspired by discussion in Patton (1990) on *logical analysis*, *process/outcomes matrices*, and *recognizing processes, outcomes and linkages in qualitative data* (pp. 411-422). Second, in writing chapters 5 to 11, the researcher tried to balance considerations of avoiding too much "glossing" (Denzin, 1989a), with considerations of economising on space for the sake of interesting communicating with the reader. Third, quotational data are provided to illuminate and support the narratives (Patton, 1990, p. 420). In addition, the narratives themselves were compiled by manipulating blocks of text from the extended thick descriptions. These in turn were derived from the text of the within-case analyses, which in turn were derived from the actual words spoken by the interviewees. Thus, the words spoken by the interviewees tend to come through the narrative rather than through direct quotes alone, which accounts for some of the conversational and/or colloquial English. Fourth, the thick descriptions are the primary parts of this thesis. The "causes and consequences" (p. 490) that follow them in chapters 8 and 11 respectively are a "tentative, qualified, and subsidiary task" (Lofland quoted by Patton, p. 490). Even so, it is recognised that "the social world does not speak for itself" and that "theoretical considerations are . . . significant" (Silverman, 1985, p. 13).

Closing Pointers

In this chapter, rough notions of accounting in hospital organisations were stated (see Exhibits 3.1 and 3.2), and subsequently a working interpretation was induced (see Exhibit 3.3). These two steps inspired the choices of methodology and design; and provided the conceptual base for the journey through gathering valid and reliable data, deriving thick description and thick interpretation of the context and situated practice of accounting in hospital organisations, and constructing a theory-in-use (see Figure 2.1). The rest of the chapter mapped out that journey, including the choices that were made at each junction along the way, and the events that occurred en route. It was argued in chapter 2 that this description and explanation are essential to the sophisticated rigour, validity and reliability of the outcomes of the journey that was undertaken. Having completed these essentials, the results are reported in the rest of the thesis.

PART II: MAPPING OF THE HOSPITAL SYSTEM CONTEXT

CHAPTER FOUR
FUNCTIONS, VALUES, ORGANISATIONAL FORCES AND FORMS IN HOSPITAL ORGANISATIONS AND THE HOSPITAL SYSTEM

This chapter arises out of the need to focus the analysis of the qualitative data generated in the Study. It comprises a review of the literature from which the idea for a framework of the hospital system was derived. The framework is based on the contrasting functions and values of people participating in the system, and the organisational forces at work there. Incorporated at the end of the chapter are cast lists of the 34 people interviewed at three hospital sites, and of the 14 people interviewed at off-site locations. These lists show where each interviewee fits into the framework, and helps clarify the wealth of quotational data presented in subsequent chapters.

Introduction

The data collected from the people at three hospital organisations (i.e., SITES P, Q and R shown in Exhibit 3.4) were used to refine the working interpretation articulated in Exhibit 3.3. In order to focus the analysis a functions and values framework was derived (see Figure 3.2). As foreshadowed in chapter 3, this was done by examining the 48 case descriptions for similarities and differences. Several clusters were identified. The people within each cluster exhibited common functions and values. The people in different clusters exhibited differing functions and values. In addition, a pattern of relationships between clusters was discerned. Revisiting the literature led to the identification of models expounded in Becher and Kogan (1980, 1992), Mintzberg (1989, 1991) and W. R. Scott (1982), which cast some theoretical light on the framework. This process of induction is described and explained in this chapter. An elaboration of the elements of the framework based on the within-case analyses is presented in chapters 5, 6 and 7.

The Configuration of Hospital Organisations

Consistent with the working interpretation, Mintzberg (1989) points out that "what frequently emerges in the professional organization are parallel and separate administrative hierarchies, one democratic and bottom-up for the professionals, a second machinelike and top-down for the support staff" (p. 179). He describes professional organisations as seemingly upside-down, "where the workers sometimes appear to manage the bosses" (p. 173). They are needed in order "to carry out highly skilled yet highly stable tasks in society, such as replacing someone's heart" (p. 173). They "rely on the skills and knowledge of their operating professionals to function" (p. 174). Their basic structure is "bureaucratic yet decentralized. . . . within which professionals work autonomously, subject to controls of the profession [with] minimal technostructure and middle line hierarchy, . . . and large support staff . . . to support the professionals" (p. 174). While their context is "complex yet stable" (p. 174), they have "many strategies, largely fragmented, but [with] forces for cohesion too, most[ly] made by professional judgment and collective choice (collegially and politically)" (p. 174).

The *configuration* (Mintzberg, 1991, p. 56) of general hospitals as professional organisations can be represented using a five part structure diagram (see Figure 4.1 from Mintzberg, 1979b, p. 355). The dominant feature is the operating core in which one finds health professionals who exercise considerable control over their own work. They "work relatively independently of their colleagues but closely with the [patients] they serve" (p. 175), and in this work "many judgments are required" (p. 175). A key feature of professional organisations is that many of the work standards originate outside the organisation in the "self-governing associations [which] its professionals belong to with their colleagues from other institutions" (p. 176). In this way, "the professional bureaucracy emphasizes authority of a professional nature - the power of expertise" (p. 176). Furthermore, the "work processes . . . are too complex to be standardized directly by analysts. . . . [and] the outputs of professional work cannot easily be measured and so do not lend themselves to standardization" (p. 176). The workings of the operating core are simplified by a process "sometimes known as pigeonholing" (pp. 176-177). Thus, in a hospital, typically the first thing that happens is that a patient is diagnosed to determine which general programme to apply, after which the patient is treated

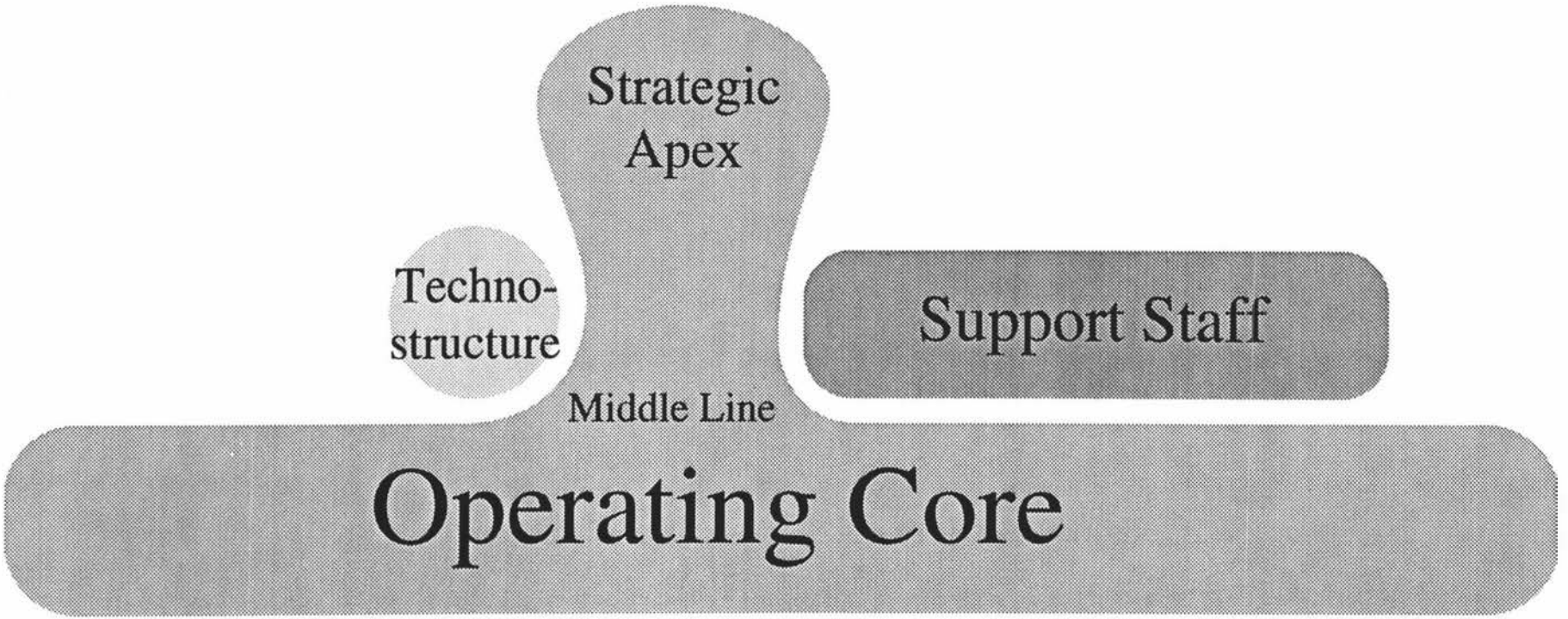

Figure 4.1. The basic configuration of the professional organisation.

Henry Mintzberg, THE STRUCTURING OF ORGANIZATIONS, Copyright 1979, p. 355.
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according to the programme as adapted for him or her. Both these tasks are performed by the relevant, specialist professionals, and pigeonholing itself "enables each professional to work in a relatively autonomous manner" (p. 177).

People in the rest of the structure outside the operating core are focused on supporting the activities of that core, and, apart from the support staff, "are not highly elaborated" (Mintzberg, 1989, p. 177) compared to other types of organisation because "they can do little to coordinate the professional work" (p. 177). In fact, many administrative decisions and much administrative work is done by professionals themselves, both individually and collectively, and "a rather democratic administrative structure" (p. 179) tends to emerge. This democracy does not extend to the support staff, and they find themselves instead subject to "the oligarchy of the professionals" (p. 179). In fact, the support units "are likely to be managed tightly from the top, in effect as machinelike enclaves within the professional configuration" (p. 179).

As far as decisions are concerned, Mintzberg (1989) claims that "professional organizations are distinguished by the fact that the determination of the basic mission - the specific services to be offered and to whom - is in good part left to the judgment of professionals as individuals" (p. 184). However, this individual freedom is really bounded by professional control in the form of what is acceptable to one's colleagues and peers. This is not the same form of control found in other kinds of organisations in which central administrators rely on direct supervision, standards internal to the organisation such as rules, policies and job descriptions, and standards relating to output or performance. Nevertheless, some decisions will fall under the control of central administrators, including some financial decisions and those relating to support services which are not critical to professional matters. Further:

> Central administrators may also play a prominent role in determining the procedures by which the collective process functions. . . . [and] in times of crisis [they] may acquire more extensive powers, as the professionals become more inclined to defer to leadership to resolve the issues. (p. 185)

This collective process is the basis of the strategic apex. Many decisions, including those relating to defining, creating or discontinuing programmes and departments, and the hiring and firing of professionals "are handled in interactive processes that combine professionals with administrators from a variety of levels and units" (Mintzberg, 1985, p. 185). This can also apply to budgeting, unless it comes under the administrators alone.

Variety of Forms of Hospital Organisations

W. R. Scott (1982) discusses three primary arrangements for structuring the work of professional participants within hospital organisations, and notes that "demarcation between professional and administrative zones of control" (p. 216) is a distinguishing feature of all of them. The first of these he refers to as the *autonomous* form, and this corresponds to Mintzberg's (1989) archetype professional organisation. W. R. Scott claims that in hospitals structured along these lines, the physicians "assume control over output (patient care) goals; and administrators [tend] to accept the definition of their own domain as limited to organizational support or maintenance objectives" (p. 216). The other distinguishing feature of the autonomous form is the way in which the professional staff are organised. Here W. R. Scott makes particular mention of *peer group control*, and argues that: "A major strength of the autonomous professional control system is that it places primary responsibility on the person to whom is granted greatest discretion" (p. 221).

W. R. Scott (1982) also argues that: "Another advantage of the autonomous professional system is the high priority which it places on the needs of individual clients" (p. 221). But this focus on the needs of one patient may be at the expense of others. In particular, "restrictions on costs cause micro-level care choices to be increasingly interdependent with macro-level care issues" (p. 222); and what is rational at, say, the institution level may make for apparent irrationality at the individual level (Bryman, 1984). This is also something which Ackroyd et al. (1989) have called attention to:

> It is our argument that the structure of public service organizations embodies and expresses the mediation of two forms of relationship. Firstly, there is the relationship between the client or recipient of the service and the person

> providing or supplying it. Secondly, there is the relationship between the paymasters and political controllers of the organization and those formally responsible for the delivery of the services (usually public sector managers). We see public service management as mediating between these distinctive relationships; in brief occupying the ground between control and delivery. (p. 605)

The second primary arrangement discussed by W. R. Scott (1982) is the *heteronomous* form of professional organisation. In acute care hospitals, this form characterises the situation of nurses and other types of health professionals (e.g., physiotherapists, occupational therapists and pharmacists) who "are more constrained by administrative controls than their counterparts in autonomous structures" (p. 223). Even so, "individual performers are granted considerable discretion over task decisions, in particular, decisions concerning means or techniques" (p. 227). Moreover, "patterns of patient care in hospitals have been moving in directions which make the heteronomous alternative more applicable to the work of physicians" (p. 223). Among these patterns are "rapidly increasing costs of hospital care [at least in the United States], sufficient to evoke the label 'crisis', resulting in greater external pressures for cost containment and improved efficiency in the operation of hospitals" (p. 224). Coinciding with this change has been "a growth of power of hospital administrators and medical managers within hospitals. . . . They are . . . encouraged and required to assume greater responsibility for the quality of the health care delivered by the institution" (p. 224). This has led to "the use of large scale organizations for health care delivery [thus introducing] a new element, i.e., the organization or institution itself, that may intrude into the practitioner-patient relationship" (p. 228).

W. R. Scott (1982) warns that due to their hierarchical nature, one of the problems arising in heteronomous structures is the unlikely presumption that "those designing the control systems know better than the performers what types of decisions and behaviors are necessary or preferred" (p. 229). A likely repercussion of this is that "in the case of professional performers, external control systems are likely to be seen as inadequate, misguided, and illegitimate" (p. 229).

The third primary arrangement is the *conjoint* form "in which, by definition, professional participants and administrators are roughly equal in the power they command and . . . they coexist in a state of interdependence and mutual influence" (W. R. Scott, 1982, p. 230). Their functions are distinguished not by:

> support (i. e., maintenance goals) attended to by administrators, and patient care (i.e., output goals) presided over by the medical staff. . . . [but] instead, physicians and other health care practitioners specialize in the delivery of micro patient care, and administrators and medical managers attend to the delivery of macro care. . . .
>
> The recognition of the presence and the legitimacy of conflict is one of [the conjoint form's] features. . . . the built-in conflict is expressed in the structural characteristics on the conjoint organization. (p. 231)

According to W. R. Scott (1982), one of the spurs to increasing collaboration in health care organisations between practitioners and administrators, at least in the United States, has to do with increasing external pressure for co-operation in curbing costs and assuring quality, and for external accountability. The conjoint form arises from such collaboration and exhibits multiple centres of power typical of a *pluralist* structure. In relation to conjoint structures, W. R. Scott (1982) argues that:

> Micro- and macro- concerns need to be kept in close proximity to one another. . . . Those attempting to devise the constraints and incentives to shape the distribution of care at the macro level must take into account the manner in which their directives will be received and responded to by those delivering micro care. . . .
>
> There may also be a defensive response to external regulatory attempts at the *organizational* level. Externally imposed requirements defined by organizational managers as inappropriate or misguided often receive a symbolic response - assurances of cooperation, gestures of support, reports of attempts to comply, [structural modifications] - accompanied by little change in the specific behaviors that were the target of the change attempt. (p. 236)

Forces in Hospital Organisations

Mintzberg (1991) advanced a second model which derived from his work on forms of organisations using inductive methods (Mintzberg, 1979a). This put his configuration of the professional organisation (Figure 4.1) into a wider scheme of forms of organisation and of forces whose interplay captures "much of what happens in organizations" (1991, p. 55). He enumerates seven forces, of which *proficiency* "for carrying out certain tasks with high levels of knowledge" (1991, p. 55) gives rise to the professional form of organisation. The others are *direction*, *efficiency*, *concentration (diversification)*, *innovation*, *competition (politics)* and *co-operation (ideology)*. The organisational forms which two of these give rise to figured in the working interpretation and are relevant to later chapters. The first is the machine form which is associated with:

> the force of efficiency becom[ing] paramount; this typically occurs in mass production and mass service organisations (automobile companies, retail banks). . . . Middle management and staff functions are fully developed; they focus on regulating the work of the operating employees by imposing rules, regulations and standards of various kinds. (Mintzberg, 1991, p. 56)

The second is the diversified form which is a natural progression from the machine form in that "such organizations first diversify and then divisionalize. Each division is given relative autonomy, subject to performance controls imposed by a small central headquarters. . . . When governments speak of accountability, they have [this] structure in mind" (Mintzberg, 1991, p. 57).

Mintzberg (1991) argues that an organisation in which the force of proficiency dominates is drawn towards the "consistent and highly integrated" (p. 56) form of the professional organisation configuration. Not only does that facilitate its management, "but it also raises the question of *contamination*" (p. 56), in which "the dominant force sometimes dominates to the point of undermining all the others" (p. 58). As an example of contamination Mintzberg refers to "medical care in the United States [which] could well be described as the contamination of efficiency by proficiency." (p. 58). In his view:

> with too much proficiency in a professional organization, unconstrained by efficiency and direction, the professionals become overindulged (as in [much] of today's . . . medicine); with too much technocratic regulation in a machine organization, free of the force for innovation, an obsession with control arises (as in far too much contemporary industry and government). (Mintzberg, 1991, pp. 58-59)

Mintzberg (1991) argues that the *containment* of a dominant force by the constraining effects of the other forces is what keeps a configuration effective. For example, "administration may not be powerful in the professional organization, but if it is allowed to atrophy, anarchy inevitably results. Thus, to manage configuration effectively is to exploit one form but also to reconcile different forces" (p. 59). In fact, one often finds some sort of *combination* of forces, and "in reality, combination of one kind or another is necessary in every organization" (p. 61). Moreover, organizations and their environments are dynamic, and their needs change. Thus, from time to time organisations "must undergo *conversion* from one configuration or combination to another" (p. 61).

Mintzberg (1991) claims that "most conversions require periods of long and agonizing transition. Two sides battle" (p. 62). During these periods of *contradiction* "in dealing with change, [organizations] often turn to the co-operative force of ideology or the competitive force of politics" (p. 62). Ideology describes "a rich culture in an organization, the uniqueness and attractiveness of which binds the members tightly to it. They commit themselves personally to the organization and identify with its needs" (p. 62). In contrast, "politics represents the force for competition within an organization - for conflict and confrontation" (p. 65). He claims that both forces can facilitate and impede change, and can render an organisation more effective or less effective. Ideology "promotes change by allowing an organization to reconcile contradictory forces. . . . [but it] discourages change by forcing everyone to work within the same set of beliefs" (p. 64). Thus, if fundamental change is called for "the ideology that may for so long have been the key to the organization's effectiveness suddenly becomes its central problem. Ideology becomes a force for the status quo." (pp. 64-65).

Contrastingly, politics, which is ostensibly destructive by encouraging people to pursue their own ends, can be beneficial by pulling the organisation apart to ensure that people address fundamental change. Politics provide challenge to the people behind the dominant force in an organisation, and it "may be the only force capable of stimulating the change" (Mintzberg, 1991, p. 65). Mintzberg argues that:

> pulling together ideologically infuses life into an organization; pulling apart politically challenges the status quo; only by encouraging both can an organization sustain its viability. . . . Ideology helps secondary forces to contain a dominant one; politics encourages them to challenge it. (p. 66)

According to Mintzberg (1985), the latter gives rise to "the functional roles of politics in organizations" (p. 148) in contrast to the dysfunctions of politics. He argues that political means can be "used to pursue legitimate ends. . . . [such as] against formal authority to correct . . . inefficient behaviours" (p. 148). Furthermore, "the system of politics is often required to promote necessary organizational change blocked by the legitimate systems of influence" (p. 149). The thesis returns to these themes in chapter 12.

Process and Structure in Social Policy Systems

Whereas both W. R. Scott (1982) and Mintzberg (1989, 1991) are concerned with individual professional organisations (e.g., a hospital organisation), the model of Becher and Kogan (1980) is useful in analysing a social policy system at the "industry level" (e.g., the New Zealand hospital system). This model derives from the intellectual tradition of "analytical philosophy and its associated procedures of conceptual clarification" (p. 5). It consists of "categories, components and relationships [which] can be compactly summarized in tabular form" (p. 10). The model was derived as a means of providing a coherent and conceptually sound analysis of the complex phenomena of British higher education. In addition, the authors explored its implications for "hospital medicine within the [British] national health service" (p. 181).

In order to derive their model, Becher and Kogan (1980) made two distinctions about aspects of the system being explained. The first was between the structural components

or levels. They stated that these could vary in number according to the number of functions and significant differences in value sets in the system. It is noteworthy that the number of entities or similar formal tiers given by administrative definition is of no consequence in determining the number of levels, except when they correspond to differences of functions and values. The second distinction was between a normative mode and an operational mode. The normative mode "relates to the monitoring and maintenance of values within the system as a whole" (Becher & Kogan, 1980, p. 13). Meanwhile, the operational mode "refers to the business of carrying out practical tasks at different levels within the system" (p. 13). The contrast between them "is related to what people actually do - or what they are institutionally required to do - and what they count as important" (p. 13). The authors acknowledged that there are close interrelationships between the two modes, but noted "a familiar and recognizable difference between the rationale of a group or organization and what it does in practice, between its espoused causes and its functions, its values and its tasks" (p. 23)[1].

These two distinctions gave rise to a model in matrix form. In the version of the model shown in Figure 4.2 (reproduced from Becher & Kogan, 1980, p. 19)[2], there are eight cells in the matrix formed by a combination of four levels and two modes. Becher and Kogan labelled the relationships between adjacent cells or elements in the matrix. As far as horizontal relationships are concerned, "all the relevant relationships [in the normative mode] involve appraisal or judgement. . . . [and] all the main relationships in the operational mode can be characterized in terms of allocation of resources, responsibilities and tasks" (p. 17). These aspects, as they apply in the New Zealand hospital system, are developed in chapter 8.

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1 In Becher and Kogan (1992), Argyris and Schon (1974)'s dichotomy between espoused theories and theories in action is acknowledged.

2 During the thesis phase of the project a second edition of this work was obtained (viz., Becher & Kogan, 1992). The new edition was based on substantially more interview data. The most relevant aspect compared with the 1980 edition was that appended to the model was an allowance for the greater external influence on operations at all levels of the system, and on the professional values at the individual and basic unit levels of the system.

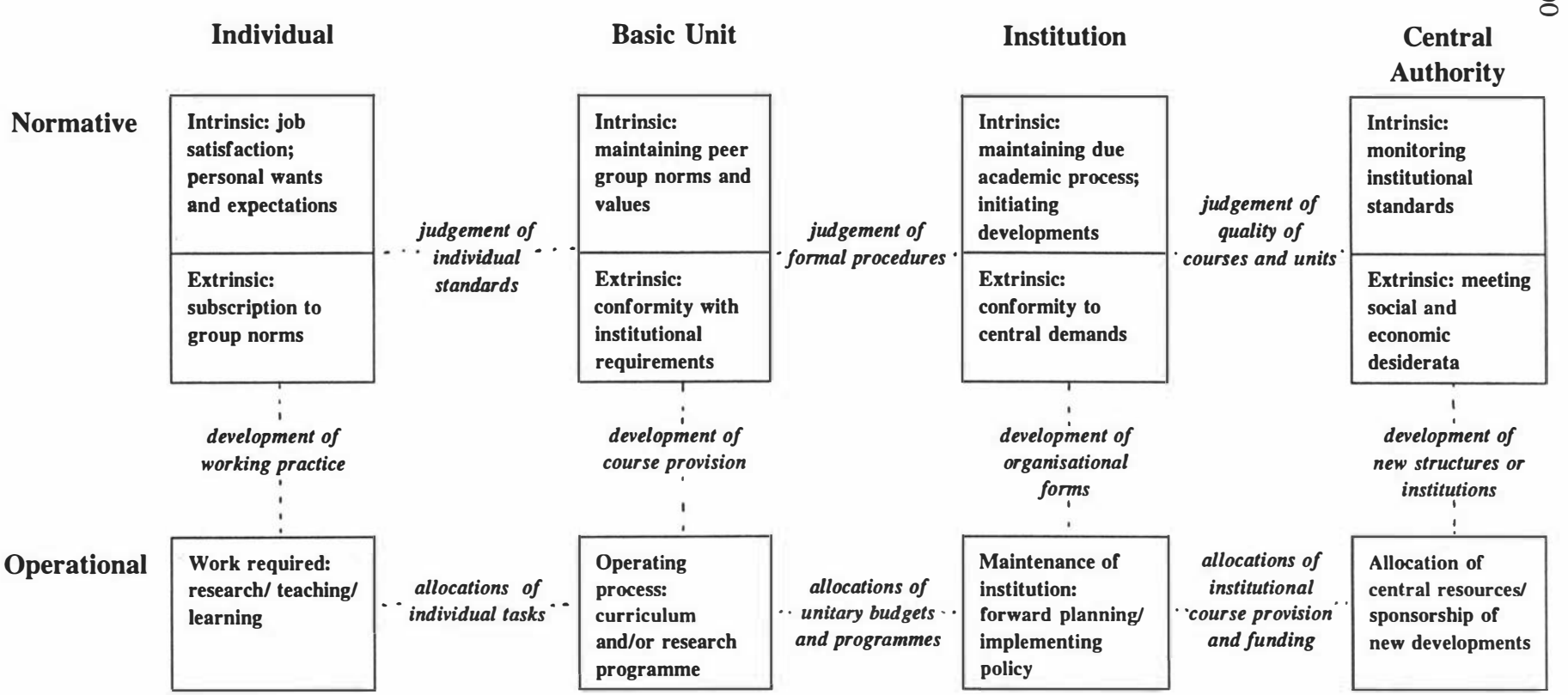

Figure 4.2. A model for higher education.

(Note. From Process and Structure in Higher Education (p. 19) by T. Becher and M. Kogan, 1980, London: Heinemann. Copyright 1980 by Tony Becher and Maurice Kogan. Reprinted by permission)

In addition to the four levels, and the notions of norms, functions and relationships, a salient feature of the model is that it deals with initiating and adapting to change. Becher and Kogan (1980) argued that a dynamic equilibrium of harmony or balanced tension exists in the system as a whole as long as normative and operational modes are in phase. But if these modes become out of phase, "some kind of adjustment is necessary to avoid breakdown and to restore the possibility of normal functioning" (p. 18). In this adjustment, some oscillation would be expected to occur between values and actions, but "when there is a clash between what people do and what their values are, then the values will affect the actions more strongly than the actions affect the values" (p. 18).

The Functions and Values Framework

The within-case analyses coupled with the work of Becher and Kogan (1980) and Mintzberg (1991) inspired the idea of distinguishing levels in the New Zealand health service according to the values and functions of people at each level, and/or according to forces including proficiency, efficiency, diversification, ideology and politics. While three levels may have been sufficient to model the British national health service system as it was in 1980 (Becher & Kogan, 1980, pp. 181-183)[3], it seems that in the New Zealand system the hospital represents a level akin to the institution in the higher

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[3] In examining the application of their model to hospital medicine in the British National Health Service of 1980, Becher and Kogan (1980) argued that the first two levels were clear enough:

(a) the hospital doctors working "according to their own norms, the better to serve the individual patient" (p. 182); and

(b) the basic unit level comprising departments of doctors working cohesively in the same specialty with some discretion over resources and choice in the recruitment of professional colleagues. These departments also have a responsibility of "responding to and maintaining [clinical] norms within [their] particular field of relevance" (p. 22 adapted from a reference to an academic setting).

They were less certain about making a distinction between the district and the central government. They observed that these tiers were concerned with making priorities "between widely divergent forms of health care, over large and varied geographical areas, so that scarce resources can be used in a proper priority setting" (Becher & Kogan, 1980, p. 182).

education model[4]. This may be because of the prevalence of base hospitals in the old hospital board system, and their apparent re-emergence as the core of Crown health enterprises[5], albeit with values linked to being a successful business rather than to traditional ones of welfare or "motherhood" ({RHA Official R}[6]). W.R. Scott (1982) has also referred to "the institution itself" as "a new element . . . that may intrude into the practitioner-patient relationship" (p. 228) in times of financial crisis (see p. 94 of this thesis). Thus, in applying the Becher and Kogan (1980) model to the New Zealand hospital system, it seems plausible to have four levels.

The within-case analyses and the work of W. R. Scott (1982) and Mintzberg (1989, 1991) provides a basis for further elaboration and delineation within the hospital institution, basic unit and individual levels as follows. First, there is the split between administrators and professionals according to functions and values, and/or according to forces of efficiency and proficiency. Second, there is the notion of different professionals being in possession of different degrees of power to withstand encroachment on their domain and intrusion into how they perform tasks. That is, the

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4 In the higher education system Becher and Kogan (1980) perceived an institution level whose "primary task is to maintain and develop a collective character, style and reputation, incorporating but reaching beyond those of its constituent basic units" (p. 22). This was distinct from a central authority level which had "responsibility for collating the demands of society . . . in terms of its consumers . . . and of its sponsors (the taxpaying public and its elected representatives)" (p. 22).

5 The disappearance of individual institutions during the short area health board period seems to have been merely a temporary aberration in the official order of the New Zealand hospital system. Moreover, as far as their internal social order was concerned, this "disappearance" was perhaps a virtual non-event because of the traditional domination of health services by hospital institutions (P. Davis, 1981; Department of Health, 1989a). This domination subsumes: the higher standing of hospital doctors in the medical profession; the high tech and high drama associated with general hospitals; the symbolism attaching to institutions in the eyes of their communities, which go to great lengths to "save our hospital" if it is threatened with closure; and much more being spent on institutional care than on primary and community care.

6 This is the name given to one of the interviewees. A full list of their names is given in Tables 4.1, 4.2 and 4.3. The style of including the names in the form {X} has been adopted throughout.

physicians tend to be autonomous, whereas the nurses and other health professionals tend to be heteronomous. Third, there is the notion of the operating core at the basic unit level comprising:

(a) clinical departments, or similar groupings of quasi-autonomous doctors, including physicians and surgeons, established around specialties or similar;

(b) wards on which the dominant staff group are nurses, whose situation is more heteronomous than the doctors in (a); and

(c) departments of clinical support services (e.g. laboratory, radiology, pharmacy) in which the staff might also be regarded as heteronomous professionals, and which run along professional lines.

Fourth, there is the notion of support service units of a non-clinical nature (e.g., laundry, transport) which run along more machinelike lines. However, from the within-case analyses it seemed that the distinction between the operating core and the non-clinical support services was blurred, and that some services were straddling the two parts of the configuration (e.g. dietetics and food services). Thus it was appropriate to classify all basic unit settings collectively as the *operating core and support services*, while recognising the fairly clear four-way division arising between the elements.

The areas and functions of hospitals and hospital districts outside the operating core and support services virtually all fall into the institution level. These might be classified as being part of a zone of middle line and general managers, central technostructure and similar, and governing boards, all of which relate to more macro-concerns and to the values of the institution. While describing this as the administrative zone would be consistent with W. R. Scott (1982), the description *management zone* is more in keeping with the new vernacular of the New Zealand hospitals visited. The function and values framework is shown in Figure 4.3[7].

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[7] This Figure is the same as that shown in chapter 3 as Figure 3.2, except for the element codes, which are explained in the next section.

<table>
<tr><th>INDIVIDUAL LEVEL</th><th>BASIC UNIT LEVEL</th><th>INSTITUTION LEVEL</th><th rowspan="2">CENTRAL AUTHORITY LEVEL</th></tr>
<tr><th colspan="2">Operating Core & Support Services</th><th>Management Zone</th></tr>
<tr><td>Doctors</td><td>Clinical Departments
(Element code = OCSS 1)</td><td rowspan="2">Hospital Organisation Managers and Support Staff
(IL 1)</td><td rowspan="4">Ministry of Health

Regional Health Authorities

and Similar External Authorities

(CAL)</td></tr>
<tr><td>Nurses</td><td>Wards
(OCSS 2)</td></tr>
<tr><td>Other Health Professional and Scientific/Technical Staff</td><td>Clinical Support Services
(OCSS 3)</td><td rowspan="2">Hospital Service Managers and Support Staff
(IL 2)</td></tr>
<tr><td>Non-Clinical Technical and Ancillary Staff</td><td>Non-Clinical Support Services
(OCSS 4)</td></tr>
</table>

Figure 4.3. Functions and values framework of the New Zealand hospital system.

The Cast of Characters in the Thick Description

This completes the theory underlying the functions and values framework shown in Figure 4.3. It seems appropriate to indicate where the 48 interviewees at SITES P, Q and R were located in terms of this framework. The following chapters also include thick descriptions in which the words of the interviewees dominate. In order to increase the clarity of these parts to readers, it is useful to give the interviewees at each site a name in the form of a job title or similar rank by which their quotes can be labelled and identified in the description. As the sites and the interviewees were promised confidentiality, it has been necessary to use fictitious job titles in some cases. The lists of names are shown in Tables 4.1, 4.2 and 4.3, corresponding to SITES P, Q and R respectively. Also given in these Tables are brief details of each interviewee which indicate any interconnections (e.g., who reports to whom), and a code corresponding to the organisational location of each interviewee according to the functions and values framework.

One ambiguity in classifying and coding interviewees was the place of the hospital organisations' central headquarters or *board office*. The answer of how to classify these was "it depends". At SITES Q and R the people interviewed in 1992-1993 in the board offices (i.e., {RUS Support Person Q}, {Cost Accountant Q}, and the six {Central HQ Manager R}s) were on the same campus as the base hospital and were in Crown health enterprise mode, even though the changeover had not happened to their hospital and its district when the interviews took place. These interviewees have been classified as being at the institution level. In respect of SITE P, the area health board office was remote from the hospital, and had concerns and values paralleling those attributed to the central authority level in the way Becher and Kogan (1980) applied their model to hospital medicine in Britain. Thus, the interviewee in the headquarters at this site (i.e., {Central HQ PA}[8]) has been treated as being at the central authority level.

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[8] A few days after his interview this person was due to move to a regional health authority.

Table 4.1. Titles used in the thesis to label interviewees at Site P.

TITLE	*BRIEF DETAILS*	*ELEMENT CODE*
Nurse Manager PS	An assistant to the service manager for the *S service.* She assisted responsibility centre managers in this service.	IL 2
Chairman P	A doctor who was the chairman of his clinical department. This department was a responsibility centre and part of *Service S.*	OCSS 1
Charge Nurse PA	A charge nurse, and so a responsibility centre manager, for a ward within the *Service S.*	OCSS 2
Charge Nurse PB	A charge nurse, and so a responsibility centre manager, for a ward within the *Service S.*	OCSS 2
Nurse Manager PM	An assistant to the service manager for *Service M.*	IL 2
Service Manager PC	The service manager for *Service C.*	IL 2
Clinical Support Manager PL	A manager of several responsibility centres which comprised one of the clinical support services. This manager reported to *Service Manager PC.*	OCSS 3
Clinical Support Manager PP	A manager of one of the clinical support services who reported to *Service Manager PC.* This particular clinical support service comprised one responsibility centre.	OCSS 3
Service Manager PB	The service manager for *Service B.*	IL 2
Non-clinical Support Manager PH	A manager of several responsibility centres which comprised one of the non-clinical support services. She reported to *Service Manager PB.*	OCSS 4
Non-clinical Support Manager PE	A manager of one of the non-clinical support services who reported to *Service Manager PB.* This support service comprised one responsibility centre.	OCSS 4
Clinical Support Manager PD	A manager of a partly clinical, and partly non-clinical, support services who reported to *Service Manager PB.* This support service comprised one responsibility centre.	OCSS 3
Site Coordinator P	An assistant to *Service Manager PB* who coordinated the preparation and monitoring of the site budget.	IL 2
Financial Controller P	An accountant who reported to *Service Manager PB.*	IL 2
OPIS Support Person P	A computer specialist who reported to *Service Manager PB.*	IL 2
Central HQ PA	An accountant at central headquarters.	CAL
Government Analyst	A financial analyst formerly with the Department of Health.	CAL

N.B. In order to preserve confidentiality, fictitious job titles have been used in some cases. The element code corresponds to the organisational location of each interviewee according to the functions and values framework shown in Figure 4.3.

Table 4.2. Titles used in the thesis to label interviewees at Site Q.

TITLE	*BRIEF DETAILS*	*ELEMENT CODE*
Doctor QC	A doctor who held a budget for surgical implants.	OCSS 1
Doctor QP	A doctor whose patients were to be found entirely on the *P Ward*. He did not have any managerial responsibilities.	OCSS 1
Service Manager QS	The service manager for the *S Service*.	IL 2
Charge Nurse QA	A charge nurse for a ward, and so a responsibility centre manager. She reported to *Service Manager QS*.	OCSS 2
Charge Nurse QB	A charge nurse for a ward, and so a responsibility centre manager. She reported to *Service Manager QS*.	OCSS 2
Charge Nurse QP	A charge nurse for the *P Ward*, and so a responsibility centre manager. He reported to *Service Manager QS*.	OCSS 2
Clinical Support Manager QP	A manager of a clinical support service in *Service Z*. This clinical support service comprised one responsibility centre.	OCSS 3
Non-clinical Support Manager QL	A manager of one of the non-clinical support services within *Service N*. This support service comprised one responsibility centre.	OCSS 4
Non-clinical Support Manager QT	A manager of one of the non-clinical support services within *Service N*. This support service comprised one responsibility centre.	OCSS 4
RUS Support Person Q	The manager of the RUS section which was located in the hospital but was formally part of the central headquarters function. He was also a responsibility centre manager.	IL 2
Cost Accountant Q	An accountant who though attached to central headquarters performed most of his work in relation to the hospital.	IL 2

N.B. In order to preserve confidentiality, fictitious job titles have been used in some cases. The element code corresponds to the organisational location of each interviewee according to the functions and values framework shown in Figure 4.3.

Table 4.3. Titles used in the thesis to label interviewees at Site R.

Title	*Brief Details*	*Element Code*
Central HQ Manager RG	The hospital organisation general manager.	IL 1
Central HQ Manager RF	A manager who was also an accountant and who was answerable to *Central HQ Manager RG.*	IL 1
Central HQ Manager RC	A manager answerable to *Central HQ Manager RG.*	IL 1
Central HQ Manager RP	A manager who was also a doctor and who was answerable to *Central HQ Manager RG.*	IL 1
Central HQ Manager RA	An executive assistant to *Central HQ Manager RG.*	IL 1
Central HQ Manager RN	A manager answerable to *Central HQ Manager RG.*	IL 1
Doctor RT	A doctor without any managerial responsibilities, but holding a position in a professional body.	OCSS 1
Doctor RP	A doctor without any managerial responsibilities, but holding a position in a professional body.	OCSS 1
Ministry Official	A manager with the Department of Health.	CAL
RHA Official R	A manager with a regional health authority.	CAL
Auditor R	An official of Audit New Zealand.	CAL
GM Neighbour Hosp Org R	General manager of neighbouring hospital organisation B.	IL 1
FM Neighbour Hosp Org R	Finance manager of neighbouring hospital organisation B.	IL 1
Journalist RHR	A health reporter with a regional newspaper.	*
Journalist RTS	A sub-editor with a local newspaper.	*
Journalist RTR	A reporter with a local newspaper.	*
Voluntary Body Official R	A manager of a local disability service voluntary organisation.	*
Union Official R	A trade union official who represented hotel services staff.	*
Nurse Educator R	A university lecturer involved in nursing teaching and research.	*
CEO Local Council R	Chief executive officer of a district council.	*

N. B. In order to preserve confidentiality, fictitious job titles have been used in some cases. The element code corresponds to the organisational location of each interviewee according to the functions and values framework shown in Figure 4.3. The interviewees marked * in the element code column are those from outside the hospital system as depicted in this framework. Their inclusion in the Study came about because they were recipients of annual reports of the SITE R hospital organisation.

Closing Pointers

In this chapter, literature pertaining to social policy systems, and organisational processes, structures, forces and forms has been synthesised to map the hospital system according to the functions and values of the participants in that system. Various distinctions and delineations are pointed out including a professional and administrative dichotomy between system participants, a micro and macro-dichotomy between levels across the system, and an autonomous and heteronomous dichotomy among professional groupings.

The framework that is proposed (see Figure 4.3) has 11 elements. Each one comprises people who, either as individuals or brought together in organisational units, could be expected to have more in common with others in the same element than they would with people in the other elements. The lists of interviewees in Tables 4.1, 4.2, 4.3 serve to illustrate people included in each element. The commonality within elements and the differentiation between elements derives from people's operational modes (e.g., what they do, how they function) and normative modes (e.g., what their values are, what drives them). These aspects are expanded in the thick descriptions in next three chapters, and then, in chapter 8, a thick interpretation is put forward which, among other things, reflects on the suitability of the framework as a means of focusing the Study data, and so of articulating the theory-in-use.

In addition, the opportunity has arisen to point out ideas contained in the literature under review which are pertinent to the theory-in-use articulated in chapter 12. These include Mintzberg's (1989, 1991) notions of configuration, contamination, and the forces of proficiency, efficiency, ideology and politics; Scott's (1982) ideas on conjoint structures; and Becher and Kogan's (1980) ideas on the interrelationships between the normative and operational modes of elements in a social policy system, and of the notional state of a dynamic equilibrium.

CHAPTER FIVE
THE PEOPLE IN THE OPERATING CORE AND SUPPORT SERVICES: THEIR ENVIRONMENT, WORK TASKS AND MOTIVATIONS

In this chapter within-case analyses are used to elaborate the operating core and support service elements of the functions and values framework of the hospital system.

A Signpost

Chapters 5 to 11 form a kind of loop which begins at the hospital front line with the present chapter. Chapters 6 and 7 make their way across the levels of the hospital system to the central authority level and bring in perspectives from people in the community. Once outside the hospital, much more room is given in the thick descriptions to accounting and related processes. Chapter 8 is an interval of interpretation which analyses the context of accounting in hospital organisations and the hospital system. The thick description is resumed in chapters 9 and 10 which revisit, and are located entirely in, the hospital. These chapters make evident comparisons and contrasts between the practice of accounting among service managers and support staff, and basic units. This is interpreted in chapter 11, paving the way, in chapter 12, for a theory-in-use of accounting at both the micro-organisational and the industry levels of analysis.

Operating Core and Support Services

The majority of people working in hospitals work at the front line of the operating core and support services. They comprise nurses, doctors, various kinds of health professionals (e.g., pharmacists, physiotherapists, laboratory technologists) and non-clinical technical and ancillary staff. The purpose of this chapter is to thickly describe the environment, work tasks and motivations within the basic units with which these individuals are associated.

People in the operating core have traditionally been organised along professional-administrative lines into four basic units shown in the functions and values framework

(see Figure 4.3). Since 1990, these basic units have become known collectively as *responsibility centres*, and staff in positions of authority are known as *responsibility centre managers*. Of the 18 people interviewed from the basic units (i.e. those with an element code which included OCSS in Tables 4.1, 4.2 and 4.3), 14 were managers of this kind. They comprised five charge nurses, four clinical support service department managers, four non-clinical support service department managers, and a chairman of a clinical department. This chairman ({Chairman P}) and the four other interviewees from the operating core were all doctors. One of these four ({Doctor QC}) had some budget responsibilities, but the other three did not have "much of an administrative role at all" ({Doctor RP}).

Another noteworthy point is that {Chairman P} obtained his chairmanship as a result of being elected by his professional colleagues (in point of fact he was the only person to volunteer). By contrast, the other 13 responsibility centre managers, none of whom were doctors, were appointed by institution level managers.

The chapter is divided into five sections. In the first, the researcher outlines his impressions of the hospitals he visited in connection with Sites P, Q, and R, and includes in this some data about patients. The rest are thick descriptions of the four basic unit elements of the operating core and support services, and the individuals in them. These derive from within-case analyses and extended thick descriptions culled from the original tape-recorded interviews (see Figure 3.1).

Hospital Sites and Patients

In order to conduct 34 of the 48 interviews, the researcher made several visits to each hospital campus associated with SITES P, Q and R. One impression he obtained at all three sites was the difficulty of finding people and places. He attributed this to a combination of size, the warren-like nature of the buildings, and signposts on which unintelligible technical/medical names abounded. For the most part, the buildings were quite old, and their designs would not be what one might select from choice. {Service Manager PC} believed that anyone "taking over the hospital site for health or other

industry purposes would probably start by bulldozing the present buildings and starting again."

The researcher's understanding of enormous upheaval being characteristic of hospitals in the Study period was reinforced by what he saw on his visits. The upheaval was physical as well as social and organisational. Many signposts were out of date because people and departments were on the move. Staff of whom he asked directions seemed to lack familiarity with the names of people sought or where departments were located. The researcher also saw and heard (and audio taped) much building work. The interviewees linked this work with the way services and functions were being physically reorganised. {Central HQ Manager RG} made the point that his organisation was taking advantage of the new discretion it had to demolish unused and unwanted buildings. Previously, the Department of Health had to give permission for this to be done and the procedure had been seen as too difficult to be worth the bother.

Patients

Staff at the front line were either dealing with patients first hand for diagnostic, intervention or caring purposes, or they were providing support services for the 'hands on' health workers. Patients were either being referred to doctors working at the hospital for further assessment and treatment by doctors in general practice in the community; or were arriving at the hospital door in need of treatment. More than 70% of patients were *acute*; that is, their conditions were such that they required urgent hospitalisation and so could not be turned away or asked to return at a later date. The remaining patients were *elective*; that is, their conditions were such that they could be put on a waiting list and called to the hospital on a more planned basis.

Patients had many clinical conditions both in terms of general diagnoses, and in terms of acuity or severity. Moreover, doctors found a great deal of heterogeneity among patients even after they were differentiated on diagnostic or similar clinical grounds, and allotted to a doctor and department according to a preliminary diagnosis. They came from a variety of family, social and educational backgrounds, and these aspects played a significant part in the differences among patients. {Doctor QP} indicated that in the

vicinity of his hospital there were no private health services because virtually everyone was quite content to get their services from the local hospital organisation. Thus, the patients he encountered ranged from some whose families were poor, to a few whose families were millionaires. This social and economic heterogeneity was a cause of variation in the treatments patients required and of the amount of care they needed. "Even though patients with similar medical conditions will receive, by and large, the same sort of treatment, patients from poorer backgrounds may need more of it." Moreover, those from an impoverished background are "much more likely to use the ward inpatient facilities than those who are well off educationally, financially and everything else." These points were echoed by many other interviewees.

Wards and Charge Nurses

During their time in hospitals, inpatients stay on wards. From the five he visited, the researcher's impression was that wards were large enclosed spaces on a single building level, filled mainly with beds and bed spaces, and divided by walls and screens. They had treatment rooms, bathrooms and lavatories, small kitchens, store rooms and cupboards, sitting and/or television rooms, areas designated for smoking, and a nurses' station. The latter comprised a desk or counter serving as a reception, and a small cubicle used as an office primarily by the charge nurse.

{Charge Nurse QA} likened her job to "running a house on a big scale", and indeed the researcher found that entering a ward was like entering a house from the street. He was aware of leaving the system of lifts, corridors and pathways by which he had reached a ward, and crossing the threshold onto the ward. The wards were physically set apart from their surrounds by the signs and doors, and socially by the atmosphere and activities inside. The researcher took in the sights on a ward with mixed feelings. He felt sad to see people in need of care, but was pleased to see that they were receiving care. He admired the staff for doing the work that they did. He felt disconcerted by the sight of some of the nasty looking equipment that was used on the unfortunate patients. He was glad to be merely a visitor, but felt some trepidation that someday he might be a patient.

The charge nurses reinforced the separate social character and distinctness of their wards by referring to themselves and their nurses as *we*, and to the patients sometimes as *our patients*[1]. For the most part, wards specialised in patients with a common characteristic such as clinical specialty, diagnosis, age, length of stay. For example, the researcher came across wards specialising in children, orthopaedic patients, patients requiring intensive care, and patients having a length of stay of less than five days. Nevertheless, the patients passing through any particular ward varied medically and socially. For example, on a children's ward, the patients could range in age from babies to adolescents. The charge nurses interviewed found the range of care required by patients on their own wards was very wide; and even wider variations occurred between wards.

The focus on people as individual living things was inherent in life on wards. The vital activity was patient care, and this was operationalised by enrolled and registered nursing staff looking after patients admitted on the basis of being in need of clinical care. The patients were dressed mainly in sleeping garments and spent their time either in bed, or moving around the ward, or preparing to go off the ward temporarily to visit the operating theatre or x-ray facility. They were not only in various stages of diagnosis and treatment, but were also suffering some pain or discomfort, and their emotional states varied. Meanwhile, each nurse, in the requisite uniform, was caring and coping with the set of patients to which she (or sometimes he) was assigned. Caring entailed comforting patients, helping them as necessary with feeding, bathing, dressing and providing bed pans, making up their beds, checking their body temperatures and pulses, carrying out treatments, administering their medicines, assisting them in moving around the ward, and responding to their call buzzers.

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1 The charge nurses also referred to other parts of the hospital and to outsiders as *they* and *them*, though not necessarily in any adversarial or derogatory sense. The researcher noticed that virtually throughout the 48 interviews, people tended to use the plural form of pronouns, rather than the formal *it*, in referring to organisations and units within organisations (e.g., laundries, laboratories, wards, entire hospitals and their administrative hierarchies, board offices, the Ministry/Department and the government). Furthermore, they tended not to reify these abstract concepts, or ascribe to them the faculties of human beings; and they spoke of the people of whom these abstract concepts were comprised without depersonalising them.

While the atmosphere and activities on wards derived primarily from patients and nurses, this social drama was added to by frequent visitors to the ward. These included doctors of varying statuses doing the rounds of their patients; people on the ward in relation to their job, including ward cleaners and maintenance people; orderlies collecting patients to take them to radiology, physiotherapy or the operating theatre (and returning them afterwards), or delivering food and fresh linen, or collecting dirty dishes and soiled linen; and visiting families, relatives or friends.

Among the professionally qualified nurses on each ward was a charge nurse. The five who were interviewed had been in this job position for between 6 years and 21 years, and for 59 years all told. All, except for {Charge Nurse QP}, were female. They had all been nurses for several years prior to becoming charge nurses. They were in charge of their wards in a professional sense, and increasingly in a managerial sense. The primary motivation of charge nurses was to act in the interests of people admitted to their wards as patients. This entailed ensuring that patients were not inconvenienced either while they were being admitted or during their period of stay, and that they did not have to stay in hospital longer than was clinically or socially necessary.

Patient admissions on the wards visited were primarily acute, and elective surgery was so minimal that its impact on activities was also minimal. Patient admissions stemmed from various circumstances and decisions in which, generally, the charge nurses and the rest of the ward staff had little say. In terms of control over total patient numbers from day to day, or for a longer period, anything which the charge nurses did was oriented towards "admitting patients whenever they need care" ({Charge Nurse QA}). If a ward was open, there was no question of its charge nurse "turning patients away." The basic ethic was one of "responding to however many patients come along."

Various decisions were made about patients during the course of their stay. These related to admissions, methods of diagnosis and courses of treatment, and lengths of stay and times of discharge. A separate set of decisions applied to each patient and each one was made by the patient's doctor. Moreover, between them the patients on a ward were likely to be under the care of several doctors. These decisions and their implications

were also largely outside the direct control of charge nurses and other ward nursing staff. But these staff could influence how decisions were implemented by planning for early intervention, ensuring proper care was given, and having regard to other considerations of a clinical/nursing nature.

This influence was particularly prevalent during doctors' rounds or at other times when doctors visited their patients. It could include pointing out to doctors the courses of actions which other doctors followed in dealing with patients in similar circumstances, and conveying to them news of how their patients were responding to treatment and care. The basis of exercising this influence was primarily patient comfort, care and recovery, rather than concern for the effect a particular course of action would have on spending. However, the latter was becoming a consideration as long as it did not jeopardise care outcomes. This used not to be the case in times before wards had budgets (see below) and when "everyone did what they did without having the faintest idea of what anything was costing" ({Charge Nurse PA}).

The charge nurses were at the centre of what was happening on their wards most of the time, though at times they needed peace to do the staff duty roster, meet privately with staff and job applicants, or catch up on other paperwork. This reflected the dual roles which they were playing, and domestic as well as clinical matters figured in both these roles, which extended to responsibility for what was purchased and spent.

Their most important role was to be in overall charge of how patients were responded to, looked after and cared for. An essential part of this caring entailed providing clinical expertise, support and tuition as seniors among professionally trained nurses. Two other key features of this role were efforts to keep everybody on the ward happy, and maintaining goodwill with visitors and suppliers. Charge nurses were responsible for ensuring that doctors' rounds were organised, that test results and other patient information were available, and that prescribed care plans for each patient were carried out. The charge nurses were also called upon to act as an advocate of patients vis-à-vis medical staff "because the latter are still revered and treated with deference by many patients" ({Charge Nurse QA}). Charge nurses were often asked by relatives about the

family member in their care. The ward suppliers included the staff in clinical support services, such as radiology, occupational therapy and physiotherapy, to whom ward patients went as part of diagnosis or treatment. Charge nurses also had to ensure that appointments were made and that patients attended them. Suppliers also included the staff in non-clinical support services who provided services, for example, the food services and laundries. Charge nurses had to ensure that the proper number of meals and appropriate quantities of linen were obtained.

The second role was that of being responsible for the predominantly female staff, and for personnel and related matters. This entailed interviewing applicants and hiring nurses and conducting staff appraisal interviews, about which they felt positive. It also included management tasks which they referred to as "paperwork" and saw as "pushing a pen." These tasks included placing job advertisements, rostering and monitoring the spending consequences of staff rosters, acquiring items through purchase or internal requisition, budgeting and managing spending. Some of these tasks used to be done by staff in the central nursing administrative hierarchy. This hierarchy supported the chief nurse in the previous triumvirate management structure[2], but had been dismantled along with that structure. The rest were not done at all, which was a situation that the charge nurses attributed to a lack of emphasis on managerial tasks in the past.

The number of managerial tasks performed by charge nurses had been growing "like Topsy" ({Charge Nurse PB}) since the late 1980s and was still growing. Among other things, personnel matters took up time, so much so that some of the paperwork encroached on the charge nurses' private lives because it often had to be done at home. However, this was not all due to pressure of time. Location was another factor, and rostering in particular required a time of uninterrupted concentration. Thus it was more

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[2] {Service Manager QS} related that at his hospital there used to be "one great, massive nursing structure entailing a chain of responsibility from the principal nurse, to an assistant principal nurse, a supervisor and a charge nurse." The administrative side of the wards, and of the nursing done on them, was carried out by the people in the chain above the charge nurses. These included human resource management, planning and budgeting. The charge nurses' responsibilities had related purely to the clinical management of patients.

conducive to do it at home away from the ward reception area. According to the interviewees, new tasks were being imposed on them by people in the largely new management positions in hospital organisations. Also, these managers were holding them much more answerable than in the past for what happened on their wards. For example, charge nurses were involved in some activities which they referred to as budgeting or doing the budget.

The inception of *ward budgets* occurred in about 1990-91. The charge nurses saw budgets and budgeting as being about money, including looking after and using money in terms of how much was spent, what it was spent on, and when it was spent. The budgets consisted of a series of classes of items (e.g., salaries, consumable supplies) on which money could be spent, and of the dollar amounts allotted to each class. These amounts were bounded by financial years, which ran from July to June, and a new budget was set each year. The budget was the amount available for paying staff and buying items for their wards. Charge nurses were permitted by the managers of their hospital organisations to spend these amounts during the financial year. The budgets of the wards visited contained between $900,000 and $1.5 million. These were wards on which the number of beds varied between 25 and 35, and the number of nursing staff varied between 15 and 25 full-time equivalents[3]. The cost of these staff made up between 70% and 80% of the budgets. The budgets were fixed in that the dollar amounts allotted for the year remained the same regardless of fluctuations in patient numbers and the amount of care given to individual patients. Annual periods were subdivided into monthly intervals, and as the year proceeded these were added together to give the year-to-date. This year-to-date was the main period of interest to the hospital organisations' managers for monitoring purposes (see chapters 9 and 10).

The growth in managerial tasks performed by charge nurses was causing changes to the nature of their jobs and to their roles on wards. In order to distinguish them as managers (and perhaps divest them of their nursing roots), the notion of charge nurses as *ward managers* had started to emerge, although the charge nurses themselves were

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[3] Full-time equivalents are the units used universally to measure and report about staffing in the organisations which were visited.

not keen on this label. Even so, they felt that this was how they were perceived by other people, and that it was what they would become. They also felt that there were some managers who perceived them as spending too much of their time "making up the beds" ({Charge Nurse PB}) and not enough time in the ward office managing their wards. Conversely, they interpreted the periods they spent out of the office on the ward among their staff as exercising social skills in order to "motivate people and keep abreast of what is going on and how they feel."

The charge nurses acknowledged that they needed strong people management and similar social skills. In addition, getting the best out of staff, and being with them on the ward among the patients, were aspects of their work which all the charge nurses enjoyed. They were a source of intrinsic rewards, pleasure and motivation deriving from jobs which none of them were in for the money they received. Notwithstanding this preference for being among their staff, with the patients, or attending to clinical and professional nursing matters, they were finding that there was not as much time as there had been for it.

Another aspect of change in their job related to the amount of managerial data with which charge nurses were expected to deal. The volume and scope of these data had been increasing ever since the central nursing administrative hierarchies were scrapped and more personnel and finance related burdens began to be imposed. These data came in various forms including personal contact and documents and computer printouts. The people from whom these data emanated included staff in service managers' offices and elsewhere in the managerial hierarchy, and staff in other parts of the operating core and support services such as laundries and food services departments. The data on printouts in particular tended to be quantified, though not necessarily in dollar units. For example, until 1992-93 the quantified data reaching some charge nurses about staff were expressed only in full-time equivalents by grade and did not indicate the amounts paid to staff, either individually or collectively.

The charge nurses felt that the encroachment of managerial tasks on their time had been exacerbated by the way these changes in their jobs were being put into effect. The

changes had been happening quickly, and the charge nurses did not feel adequately prepared. Very little training was provided, and many changes were imposed without much explanation. Much time was taken up in learning-by-doing, which they felt was not very efficient or satisfactory. However, they felt that there was little they could do about this situation.

Doctors and Clinical Departments

Doctors are professionally qualified people. They were organised rather loosely into clinical departments specialising in various branches of medicine, surgery and other broad categories of specialties. The five doctors interviewed specialised in cardiology, anaesthesia, pathology, vascular surgery and paediatrics. Between them they had been practising for some 60 years, much of this from their present locations. The doctors in each clinical department responded to people coming to hospitals in need of treatment and care in the area of their specialty.

Although there was some variation in doctors' activities, frequent contact with individual inpatients and outpatients was normal, and this tended to be on a one-to-one basis. For example, {Doctor QP} described himself as "very much a front line worker" and the things he was doing from day to day were almost entirely connected with individual patient contact and contact with agencies with which his specialty interacted. Part of the normal work of senior doctors entailed giving instructions and guidance to the junior medical staff who were completing their professional training, and some of this instruction occurred in the presence of patients. Team work sometimes occurred; for example, during a surgical operation on a patient. Indeed, the work of the doctors in some specialties was such that, although they dealt directly with individual patients, they did this as part of surgical teams. This was true of the doctors in {Chairman P}'s department. Their work was of a support nature before, during and after operations, and was atypical of doctors in most clinical departments. Notwithstanding either circumstance, the usual situation was one of each doctor being oriented to achieving the best result for each patient severally.

Another characteristic of clinical departments was that most doctors shared their time between the public hospital and private work. The latter was done either in their own practice *rooms*, or at private hospitals. Of the five doctors interviewed, three of them did some private practice concurrent with the work they were doing in their hospitals. In fact, according to {Chairman P}, it was "atypical of most departments in big hospitals to find that the staff are mainly full-timers." Even so, he thought that most doctors had a "positive disposition to working in the public system, even though there is more money to be made in the private system." But this doctor warned that "this altruistic and/or political view is starting to change because of the economic pressure within the system." {Doctor RT}, who was interviewed at his private consulting rooms, also pointed out that the majority of hospital doctors did most of their work in the public hospital, and "want to see it work."

Doctors spent most of their hospital time on the move between patients staying on the wards, or at a set location at which they were consulted by patients. These locations were fitted out for clinical work, rather than being traditional offices. Many doctors did not have an office of their own, but relied on either the use of space on wards, or in clinical support service departments, or wherever else they spent significant proportions of their time. This tended to be according to the interface of their specialty with that of the ward or department. For example, {Doctor QP}'s patients tended to all be on one particular ward, and so he relied on that ward's office facilities.

The work of doctors interfaced with the tasks performed by nursing and other professional and support staff. Many of these people were clinically oriented, although each performed different roles and tasks. As {Doctor QP} noted, "It is necessary for all of these staff to interface extremely cleverly to make sure all of the respective jobs get done in the way that is most beneficial to each patient." The doctors perceived that it was their responsibility to decide on what courses of action were to be taken for patients. However, according to {Doctor QP}, these decisions were taken with appropriate input from everybody, and it was "old-fashioned to say that the other staff look to doctors for clinical direction." Nevertheless, doctors tended "to make decisions in regard to activities which are be undertaken in relation to patient care." These

included diagnostic procedures and management procedures relating both to individual patients and to types of patients. However, doctors as such did not have any "administrative or authoritarian function among those with whom they work."

In addition to their interest in patients as individuals, doctors had an interest in the general development of their particular specialties in their hospitals. They also had an interest in the availability of services pertaining to their specialties for people living in the region in which their hospitals were located, and possibly further afield. These wider concerns were usually addressed on a shared basis with departmental colleagues. Even so, it was fairly atypical for the doctors in a department "to hold reasonably similar views about their specialty" ({Chairman P}). Also, these concerns were "not primarily to do with where the hospital's resources get spent in a global sort of way." Even so, "resources are something about which doctors are aware, and they realise that the amounts available to departments in broad terms differ for various reasons."

According to {Chairman P}, among the things which had contributed to these inequities in funding allocations were, first, "different degrees of political articulateness within the medical fraternity"; and second, "variations in perceived public importance of the different specialties." Similarly, {Doctor QP} described how some areas, such as child health, "command terrific input of money and things in kind" from the community. This was giving such a service "the best of everything that it has wanted and a few other things besides." {Chairman P} also indicated that for these kinds of reasons the way a hospital's slice of the total health resource cake was divided was likely to be "inappropriate compared with the benefit to the community." For example, cardiac surgery with its "high tech, high drama and incredibly high cost is well supported", even though it was "not of any great value from the perspective of society as a whole, compared to, say, treating hearing disabilities such as glue ear." The latter disabilities among children were leading to learning disabilities and other problems. These disabilities continued in adult life and affected not just the sufferer but also many other people. The repercussions in early life for sufferers of these disabilities seemed to be a factor in them committing crimes and ending in prison at a high cost to the state, as well as to victims, families and so on. Unfortunately, "glue ear treatments, and the like,

lack glamour, high tech and public profile, so they do not get the resources." {Chairman P} went on to relate that it could be argued that, apart from interventions of a preventative nature:

> the whole hospital system from the perspective of benefit to the community is probably a waste of money. In the long run the community would be better off if it let the present hospital population die, and put all the money into preventing things that currently require treatment.

He acknowledged that this would obviously not be very comfortable or satisfactory to a lot of people but "overall there would be greater benefit than is being generated by the present hospital system." He added that hospitals in New Zealand were generally about "keeping people comfortable, rather than keeping people alive."

According to {Doctor QC}, "Traditionally, cost data, resource management and the like" have not been part of the work of doctors. However, it was being recognised increasingly that "the personal decisions which individual doctors make about their patients, such as prescribing treatments, tests and so on, generate most of the costs in hospitals." Nevertheless, only some doctors believed that these circumstances obliged them to be involved in managing resources and spending. Furthermore, only a minority had started "to take any interest in budgets and related matters" ({Doctor RP}) in the course of these things being developed since the late 1980s. Moreover, those who had done so tended to take on the director or chairperson positions of their departments. In contrast, most doctors "choose not to be involved in these matters probably because they lack the necessary drive" ({Doctor RP}). Indeed, "some are fairly cynical about management, and would prefer to just go on practising medicine" ({Doctor QC}). They were "happy doing what they can for their patients" ({Doctor RP}) and felt "busy enough without having to worry about" budget matters as well.

In any case, little budgeting information was reaching individual doctors, except those with managerial responsibilities. This was seen as a benefit rather than a problem by many of the doctors concerned. Budget related decisions were left to the person in charge of particular organisational units, rather than taken by doctors. For example,

{Doctor RP} related that in the laboratory in which she was based, decisions about employing another laboratory technologist, or purchasing another piece of laboratory equipment, were made by the charge technologist, rather than the doctors. Indeed, she suspected that there had been an attempt in her laboratory to exclude pathologists from being involved in decisions on equipment and so on, and from having budgetary information, because most of them were in private practice, and thus perceived as having "vested interests." In any case, it was the charge technologist who held the laboratory's budget and who was responsible for its control.

She also related that further up the administrative hierarchy, the budget was looked after by people in management positions, including accounting staff. Many of these positions were new to hospitals, and were introduced specifically to look after these matters. She and her colleagues expected that eventually these people would put constraints on them. These would include telling doctors that they could not do certain procedures because of costs, and supplying data to reinforce these constraints. She related that there was some concern that when this happened it might put individual doctors "in a bit of a bind" ({Doctor RP}). That is, circumstances would arise when each doctor could be torn between their primary commitment to getting the best for a particular patient, and being good managers of broader resources by balancing outputs and costs overall.

The interviewees felt that in general there had not been many constraints imposed on doctors up to 1992. As a consequence, the choices they were making were still very much oriented towards getting the "best results for the individual patients" ({Doctor QC}). Budgetary considerations in the form of "having an idea of what things cost were only taken into account if they seemed relevant" ({Doctor RP}). Also these considerations were limited to the costs of particular procedures, and not directly to considerations about the overall budgets for particular items, types of patients, or departments. Even so, it was reckoned that doctors were becoming "more aware of the costs of some procedures, and as a result are choosing not to do some of them quite as readily as they used to because of costs" ({Doctor RP}). In fact, the interviewees felt that more doctors were acknowledging that the resource management aspect of practising medicine was important. Nevertheless, it was expected that there would be much

resistance to any change that would interfere with a doctor's commitment to his or her individual patients.

{Chairman P} was the only responsibility centre manager among the doctors interviewed. He explained that his role involved representing his colleagues to hospital managers, and vice-versa; and "trying to run the department in terms of keeping both junior and senior staff happy, and rostering enough of them to cover the department's workload." He had to do this within the financial and other limits set by the hospital. These financial limits were set through a budget for the department, which consisted of staff and various other consumables and equipment typical of the other responsibility centres at SITE P.

Both {Chairman P} and {Doctor QC}, who also had some budget responsibilities, related that their managerial work was in addition to doing full-time jobs as doctors. {Chairman P} indicated that, on average, his working week was about 45 hours "squashed" into the four days he was at the hospital. But this was not sufficient time to fulfil both his clinical role and his managerial role, even though he had discovered which tasks needed to be done and what could be "ignored or filed in the rubbish." In fact, both of them tended to do the managerial work at home in their own time, in addition to the work they would expect to do then in order to maintain their clinical knowledge. They put forward two reasons for this situation. First, philosophically, they perceived that it was the clinical side of things which they and their colleagues were in their hospitals to look after. Second, in practical terms, these hospitals did not have enough doctors in their respective specialties to deal with the patients who arrived wanting treatment; and furthermore the level of supervision provided to registrars was not really adequate. These doctors felt that the more doctors with managerial responsibilities backed out of the clinical area, the more dealing with patients and supervising junior doctors would suffer. Despite attempts to prevent it, {Chairman P} was finding that the work associated with managing a department was encroaching on the time he had available for clinical work while at the hospital.

{Chairman P} also felt that what he was doing was "very much a matter of crisis management lurching from one problem to the next", rather than having "the time to plan and achieve anything, or having long term goals in mind." He related that these problems tended to be associated with staffing, including "not enough staff", "staff leaving because they are fed up with the system", attracting staff and "covering shortfalls", and trying "to stay within the financial resources." In the last regard, he opined that "saving money or spending less money is what is being sought" by the hospital organisation and the central authorities, as opposed to "economic efficiency and getting value for the money spent." This was "the very clear message" he was getting from the way things were done, including that "resources are not allocated according to productivity." For example, he noted that neighbouring hospitals were known to be getting more resources for handling fewer cases than his hospital. He added that he did not think this necessarily meant they were overfunded.

Clinical Support Services

Clinical support services were well-defined and self-contained areas of activity. They were integral to providing the care prescribed by doctors for inpatients (i.e., those staying on wards). They also provided support for emergency and outpatient care. The activities were professional to varying degrees, and they entailed the exercise of uncommon technical or scientific expertise by qualified people. The services were organised into separate departments comprised of professionals, scientific and technical, and other staff according to such specialties as radiology, laboratory services, physiotherapy, pharmacy and dietetics. The managers of these departments were health professionals who had emerged from among their fellow professionals in a similar manner to the charge nurses. For example, the four interviewees (one male and three females) had been in either their present jobs, or similar ones, for between 2 and 16 years. Furthermore, they had all been in the health service since between the 1970s and mid-1980s.

The degree to which people involved in providing clinical support services had direct dealings with patients varied according to the nature of each service. Among the interviewees, {Clinical Support Manager QP} was in charge of a service which was

mainly provided directly to patients. Strikingly, the sentiments she expressed about what motivated the people in her department, and about other areas, were very similar to those related by the charge nurse interviewees. The services of the other three interviewees either lacked face-to-face dealings with patients, or, in one case, were overshadowed by the main part of the department's operations. The case in question was a department combining clinical dietetics and food services. The latter had come to dominate the former so much that, although its manager ({Clinical Support Manager PD}) had a clinical dietetics background, the department had much in common with the non-clinical support services described below. Moreover, the service manager to whom she reported (i.e., {Service Manager PB}) was oriented towards non-clinical and commercial activities.

The interviewees all had offices adjacent to the areas in which their professional colleagues were doing most of the work of their departments, along with technical and support staff. These offices were slightly bigger than the makeshift cubbyholes that served for the offices of the charge nurses, but were no more than adequate. The departmental areas were tucked away in the hospital buildings, and were less easy to find than the wards. They varied in nature from scientific laboratories, to rooms in which equipment and materials were located, to more officelike rooms.

Naturally, the work done in each clinical support service department stemmed from the specialty to which it was dedicated. In contrast to the homogeneity of the wards (not to be confused with the fact that the patients who stayed on them were quite heterogeneous), clinical support services were comprised of a range of quite disparate, highly specialised services. Furthermore, there was a great deal of heterogeneity in the individual tasks. The only exception to this among those support services visited might have been the non-clinical food service, but this is dependent on the perception of cooking and the range of meals that could be prepared. This heterogeneity also derived from the heterogeneity of the patients being supported, and from differences in the locations where patients were dealt (e.g., physiotherapy services were provided at hospitals and in patients' homes).

Notwithstanding the disparities between them, all the clinical support services had in common their contribution, in labyrinthine ways, towards the workings of hospitals. The primary motivation of the clinical support service managers was delivering good quality services in the interests of patients. The notion prevailed that this overriding professional care ethic was separate from living within the money and physical resources that were available. But this separation was not as pronounced as it was among the charge nurses, especially in those services in which providing care directly to patients was not involved. Even so, the managers who were interviewed perceived the rest of their hospitals as collections of people who were engaged in worthy and demanding endeavours which deserved support. Their demeanour towards these people was generally convivial and empathetic.

The clinical support service managers who were interviewed generally portrayed their services as professional team efforts, talking about *we* in the same way as the charge nurses. They saw their staff as enjoying much professional freedom to exercise their individual expertise. In the main it was through individual effort that the departments responded to demands placed on them explicitly or implicitly by the actions and decisions of other professionals, mainly doctors. The managers saw themselves as team coaches who were obliged, for reasons of form and the interests of their team and the service recipients, to perform a variety of managerial tasks. These ranged from relative trivia, such as sorting out minor hiccups in specific jobs, to more profound tasks such as strategy, survival, growth, pricing, contracting, capital projects, budget setting and service evaluation. These had come to the fore since 1990.

Clinical support service managers were going through a similar experience to the charge nurses in that managerial tasks were taking increasing time. For them to do professional and technical work was much more the exception than the rule, and in contrast to the charge nurses they were generally willing to be labelled as managers. Also, they were conscious of possessing some managerial acumen and skills[4] in addition to their

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[4] The managers interviewed seemed more assured than the charge nurses about the managerial topics which they perceived the researcher had come to discuss. (continued...)

professional abilities. Nevertheless, they saw their roles as dichotomous. They were both responsibility centre managers and the senior professionals in their respective areas. They worked in collegiate, consensual fashion with the staff in their departments.

The clinical support service managers and their staff could not decide unilaterally on the volumes and mixes of the services that they would provide, except in so far as, for example, physiotherapy did preventative and non-referred work in the community. Furthermore, the extent to which people in the support services could exercise discretion over how tasks were done, and what inputs used, was limited because it was important to follow established professional, scientific or technical protocols in carrying out many of the tasks.

Non-Clinical Support Services

Non-clinical support services comprised staff organised into a range of departments each performing tasks in well-defined areas of activity (e.g., laundry, building and plant maintenance, transport, hotel services). While these tasks provided support of a non-clinical nature, it was integral to the delivery of care to patients. The departments generally did routine work, so much so that "they are probably taken for granted" ({Non-clinical Support Manager QL}. For example, groups of cleaners worked to keep their assigned parts of hospitals clean (there seemed to be broom cupboards from which the cleaners oriented all over each hospital campus). Other parts of the hospitals sent their dirty washing (e.g. bedclothes, staff uniforms, patients' clothing) to the laundry. Food and similar was expected by patients, staff and visitors to be prepared and served out of kitchens, cafeteria and kiosks in various locations. And staff on wards expected orderlies to be assigned to them for certain periods to do appropriate work. These services also reacted spontaneously to informal requests for additional work.

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[4](...continued)

Their demeanour was more positive in that they generally believed that they had something to offer him, whereas the charge nurses were apologetic, expecting that they might have been wasting the researcher's time with what they regarded as their rambling comments.

The managers of these departments tended to be people who had a mix of knowledge about the tasks performed and some experience in administration, supervision and management. All four of the managers interviewed were male. They had been in jobs like their present ones for between 2 and 21 years, and for 32 years all told. Moreover, three of them had been in the health service for more than 20 years apiece. Two of these had had experience in numerous clerical and administrative jobs at their sites since the 1970s. The third had come from the private laundry sector, and although some 20 years had passed, he felt that he had "remained up with the play" in his industry outside the hospital sector. The fourth one had come to the hospital from the private building sector in 1989.

The offices occupied by these managers were similar in nature and location to those of the clinical support service managers, except for two things. First, three departments (laundry, transport and building maintenance), and their managers' offices, were located in premises detached from the actual hospital, but on the same campus. And second, the office occupied by {Non-clinical Support Manager PH}, was located among those occupied by institution-level hospital service managers and support staff, rather than being adjacent to the workplace of the staff he organised. These staff (e.g., orderlies, cleaners, telephonists, security guards) did not orient from a single departmental location, but instead were based individually or in small groups throughout the hospital.

The incidence of requests for non-clinical support services fluctuated with, *inter alia*, patient numbers. From a quality perspective, non-clinical support service managers saw it as important that their departments could respond to peaks in demand. But from a cost perspective, having too many staff at work compared with the amount of work to be done meant spending money unnecessarily. The basic problems facing non-clinical support service managers in balancing these perspectives were as follows. Patient numbers were unpredictable and could change by the hour without most hospital personnel being able to do much about it (this was also reported by the charge nurses). The non-clinical support service managers appreciated that their hospitals were dealing primarily with acute patients and the actual case mix depended on admissions. It was virtually impossible to anticipate what specific treatments patients would require before

they were admitted, their length of stay, or its outcome. Nor was there much choice over whether to accept or reject a patient whom a doctor deemed clinically qualified for treatment. "About 80% of admissions are unplanned and non-discretionary and planning in this environment is horrendously difficult" ({Non-clinical Support Manager PE}), especially in areas in which patient mix or case type made a difference. This interviewee was the one who came in from the private business sector in 1989. He emphasised that hospitals had very little discretion over whom they admitted. In contrast, the business sector "can accept or reject potential customers on the basis of what they are willing to pay, and how much the job they want doing will cost."

In addition to these general problems over fluctuating patient numbers, non-clinical, and indeed clinical, support service managers were at an even greater disadvantage in adjusting supply to cope with demand. This was because they literally could not see patient numbers fluctuating in the same way as, for example, charge nurses could. However, upward fluctuations were fairly easy to discern because they usually evoked requests for more support. In contrast, downward fluctuations were not easy to detect at all until, for example, "food waste comes back to the kitchen" ({Non-clinical Support Manager PH}). Even so, compared with clinical support services managers, most of the non-clinical support services managers had an easier task because numbers rather than mix were the main determinants of service demand. For example, patients needed meals, linen and clean wards irrespective of why they were staying in hospital. The task of producing them, while not devoid of skill, did not depend on the exercise of a level and sophistication of skills and judgement that might be associated with members of a profession. Even so, the non-clinical support services were not about mechanical mass production, but instead reflected the complexity and personal human service nature of hospitals.

Even though the support nature of the non-clinical support services and the clinical support services meant that there were many similarities between them, there were also several differences. Perhaps the main ones were, first, that non-clinical support services lacked the professional glamour or prestige attached to clinical support services (and indeed clinical services generally). Second, the status of their managers and staff was

fairly low vis-à-vis other groups in the operating core and management zone. Indeed, their managers perceived that these services had a "Cinderella image" ({Non-clinical Support Manager QL}) among some staff on the rest of the hospital campus. This interviewee in particular thought that he was probably perceived by many of these staff as merely "the chief nappy washer." He also suggested that "nobody really wants to have a laundry, but they need the linen, although they do not want to have to pay for it." Also, {Non-clinical Support Manager PH} and {Non-clinical Support Manager QL} mentioned having to motivate their staff in the face of low self-esteem. Third, the nature of some of the work which the staff were required to perform was "repetitive and boring" ({Non-clinical Support Manager QL}). As a consequence, the job of the managers entailed more supervision and motivation than among the health professionals in the clinical support services. Indeed, traditionally the non-clinical support service departments tended to have an administrative and supervisory structure, rather than a professional and consensus one, both within themselves and vis-à-vis hospital service managers (and their predecessors in the defunct hospital administrators' departments in the triumvirate structure).

Despite these differences, or what anyone else thought, the non-clinical support service managers were in no doubt that hospitals could not function without the services their staff provided, and that these services made a fairly high profile contribution as far as patients were concerned. Even though nothing done under the auspices of the non-clinical support services was of a clinical nature, many of the staff dealt with patients directly. For example, transport service drivers carried patients in their vehicles, and orderlies assisted patients to move around the hospital. In addition, the impression patients and visitors obtained about a hospital derived in part from the state of repair, decoration, signposting and cleanliness of the buildings, and the cleanliness and repair of the bedclothes, towels and staff uniforms.

There existed among the non-clinical support staff and their managers, moreover, an element of pride and dedication in what they did and how they did it. This pride and dedication was exercised in the context of hospitals as places which responded to patients by looking after them and making them well again. The interviewees all

enjoyed their jobs and found them challenging. They also believed that hospital staff in general had a positive attitude and liked their jobs, "otherwise they would not be in them" (Non-clinical Support Manager PH}), since the financial rewards were not particularly attractive. This was especially so following the changes which had been imposed in recent years and their negative aspects. These included "reduced pay, less job security and more work allotted to fewer people." It was not untypical for "the equipment in these services to be old and getting older" (Non-clinical Support Manager QL}), but it was "kept going by good maintenance and care exercised by the people responsible for using it."

The jobs of non-clinical support service managers were affected by the changes to managerial tasks described in relation to other parts of the operating core. The consequence was that, along with many other people throughout this core, these managers now had far more responsibility and authority vested in them. They had access to much more information and could exercise much greater discretion, but were now accountable for what happened. In contrast, "under the old triumvirate structure, the ship was run by the three people at the top. They told the people below what they wanted to happen without providing much explanation" ({Non-Clinical Support Manager PH}). At the same time, no one below the level of hospital managers and their immediate staff had "any knowledge about how much money there was or how it was distributed." There was a certain amount of secrecy and staff often had to rely on newspapers "to discover what was happening." Furthermore, "accountability seemed to stop with the members of the triumvirate."

These changes began about 1988 when what {Non-Clinical Support Manager PH} referred to as the concept of *unit management* was introduced. He described how the triumvirates were replaced by general managers, followed by the appointment of many people to management positions within a formal structure of service groupings and responsibility centres. These appointments began in hospital organisations' corporate headquarters and spread in tiers throughout all areas of the operating core. In the course of this change many older staff left, and the new middle or senior administrative positions were filled in two ways. First, people from inside the health service were

elevated sooner than would have happened in the old system. And second, people were brought into the health service, either from other parts of the public sector, or from the private sector. He related that before this it was virtually unheard of to bring people into the service at this level on the basis that staff needed to be familiar with the peculiar workings and environment of hospitals. Naturally, outside recruitment initially caused some resentment, but that tended to subside as people got used to the idea.

Jobs similar to those labelled, non-clinical support service manager, existed in corresponding departments under the old triumvirate; they were part of the traditional administrative and supervisory structure of these departments. Even so, since their formal creation within the responsibility centre manager structure, the size and scope of the jobs increased significantly. This change was effected for the most part by people in higher management positions tacking on extra tasks and areas of responsibility in a brisk but piecemeal fashion. Accordingly, each manager's involvement varied cross-sectionally and longitudinally, but could include production management, customer servicing, dealing with sales people and suppliers, dealing with a wide range of people in other parts of the operating core from nurse aids to surgeons, public relations, maintaining the impetus of their unit, and bolstering staff morale. Furthermore, the responsibility for money and finance, formerly the prerogative of the hospital manager, was now very much part of the jobs of non-clinical support service managers. It was not uncommon for one person to be the manager of more than one responsibility centre, and in order to cope, supervisors reported to this manager from each centre. {Non-Clinical Support Manager PH} declared that he started out with one responsibility centre and this had grown to six. Incidentally, {Clinical Support Manager PL} reported that his service comprised four responsibility centres and was organised with supervisors reporting to him.

The non-clinical support service managers did not have much trouble in accepting the basic ideas entailed in their new jobs, and saw themselves very much as managers of their departments, whereas previously their work was more supervisory in nature. Their broad aims were a mix of ideas to do with quality and costs. They sought higher quality by continuously improving what was done, and were doing this subject to cost

constraint. They tried to reduce costs continuously because of future expectations about competition, contracting out and privatisation. Quality was defined variously, for example as ensuring that the right quantity of service or the right quality of product was at the right place at the right time.

In order to achieve these aims, the emphasis of their work was to get the best out of their staff. They also tried to control staff costs which made up their services' main expenditure. On this point, {Non-clinical Support Manager PH} referred to hospital staff as "government servants" who for the time being were charged with changing things on "government instructions." These instructions placed restrictions on budgets and meant that staff had to try to get the "best possible service with the money available." In order to do this, staff in general were having to strive continuously to provide services in a better way at less cost.

Closing Pointers

In this chapter the researcher has outlined his impressions of the hospitals he visited, including the longevity of buildings and the physical and social upheaval in progress. This upheaval is also evident from the thick description drawn from the within-case analyses of the interviewees located in the operating core and support services. This description encompasses the participants, intentions, motives, meanings, work context, situations, and circumstances of action. A key aspect is the way in which members of each group of health professionals (and other workers) are dependent on one another when dealing with individual patients, among whom there is a great deal of heterogeneity. This occurs in a loosely structured way to enable each professional to exercise their skills in each individual case. Another aspect is the duality in the work of the health professionals who occupy management positions within their responsibility centres. This duality is accentuated by growth in the structures and processes of managerial responsibility, including budgets and monitoring spending. Even so, most participants still see the managerial side of this duality as secondary to the professional side, although that is less true in the clinical and non-clinical support areas.

These matters are revisited in chapter 8 when matters of orientation, control and resources, drawn out of the above, are examined to show cross-sectional differences between elements within the operating core and support services, and with other levels in the hospital system; and to show longitudinal differences within elements. Similarly, matters of task and resource interdependence, and of answerability are examined to show relationships between elements and levels. In addition, matters to do with the situated practice of accounting, including budgets and answerability for spending, are further thickly described and interpreted in chapters 9 to 11.

CHAPTER SIX
THE PEOPLE AT THE INSTITUTION LEVEL: THEIR ENVIRONMENT, WORK TASKS AND MOTIVATIONS

In this chapter within-case analyses are used to elaborate the elements at the institution level of the functions and values framework of the hospital system.

Institution Level Management

In the area between the front line and the boundary of the hospital campus were people who occupied the management zone at the institution level (see Figure 4.3). The purpose of this chapter is to thickly describe the environment, work tasks and motivations within the management zone. From both the within-case analyses, and during earlier episodes reported in chapter 3, a division was discerned among these people according to those working as part of the hospital and those in the *board office*. {Central HQ Manager RG} had worked at his hospital organisation as a doctor, and then in both parts of this division. He related that given this experience he was "probably better placed to break down the us and them attitude which has traditionally divided the board office from the hospital even though we are next door."

Eighteen people were interviewed at the institution level (i.e. those with an element code which included IL in Tables 4.1, 4.2 and 4.3). Ten were service managers and support staff from the hospital (i.e., coded IL2). Six of these were male, and four were female. Eight were managers and support staff from the board office (i.e., coded IL1). All of these were male. All 18 had been appointed either by the governing body of their organisations, or by more senior management. Their backgrounds and career histories were a mix of health and non-health, and more details are given in the two sections below. Also of relevance is that six had an accounting background.

The chapter is divided into two sections dealing in turn with people working in the two elements in the management zone. The data used are derived from the within-case

analyses and extended thick descriptions culled from the original tape-recorded interviews (see Figure 3.1).

Hospital Service Managers and Support Staff

The People

Various managers and support staff were working in hospitals one or two places removed from the front line staff. The ten who were interviewed had in common their frequent dealings with responsibility centre managers (i.e., charge nurses, clinical department managers, and clinical and non-clinical support service managers). In fact, five of them (i.e., the service managers and the nurse managers) had managers of this type reporting to them about managerial matters.

The length of time the 10 had been in their present kinds of job ranged from 1 year to 3 years. Essentially, this was because their positions were all new ones created in the 1988-90 period of internal structuring. They had all arrived at their present sites within the previous 6 years, except for one who joined his hospital in 1974. Nevertheless, between them they had 80 years of hospital organisation experience. Three of them were qualified nurses with more than 35 years in either nursing, or in nursing administration in the previous triumvirate structure. None of the other six were from health professional backgrounds, although one was married to a nurse, and another to a midwife. Other pertinent pieces of personal information about the 10 were as follows. Four had business degrees, and two were qualified accountants. Three had worked in the private sector outside health before joining the health service after 1990.

All 10 interviewees had their own individual offices, and all but one of these were in the main hospital buildings at the respective sites. The other (that of {Cost Accountant Q}) was in an office immediately adjacent to his hospital in converted houses that served as that hospital organisation's central headquarters. The 10 offices varied in size and comforts. {Nurse Manager PS} and {Nurse Manager PM} occupied small, narrow and cramped rooms which were part of suites occupied by their respective service managers and his and her support staff. The service managers' rooms were more spacious but no more than adequate.

Another point of interest was that {Financial Controller P} and {OPIS Support Person P} had just moved into their, as yet uncompleted, offices. These were in a suite being prepared for those appointed as Crown health enterprise managers, most of whom were already working at the hospital in other jobs in other offices. A few others were due to arrive in the Autumn of 1993, mainly from the central headquarters offices which were being disbanded. This new suite was tucked away on the first floor of what was otherwise a single storey hospital building. They looked adequate but far from ostentatious. A few months after the interview, this suite featured in a television news programme[1] as being typical of the extravagance at the hospital under the, by then defunct, area health board system!

Their Work

The work of all 10 interviewees was concerned primarily with "managing the resources available" ({Service Manager QS}). None of the 10 was involved in clinical practice, although they did become involved in clinical issues "when these cut across into managerial matters." Furthermore, only one of the 10 ({Service Manager PC}) retained a professional brief. A minority of her job entailed coordinating all professional activities involving the nursing and other health professions, except for the doctors. The most significant aspects of this part of her job related to "setting professional standards" and ensuring that "quality assurance programmes are consistent."

Service and Nurse Managers

Between them, {Nurse Manager PS} and {Nurse Manager PM} helped the charge nurses of 32 wards and the heads of 6 clinical departments do their budgeting, staff rostering and monitoring of spending. With around 800 staff in these responsibility centres, human resource issues played a large part in their day-to-day work. {Service Manager PC}, {Service Manager PB} and {Service Manager QS} were also quite heavily involved in these issues. They indicated that their services were labour intensive with over 80% of the responsibility centre budgets in them relating to staff. Financial management was the other major part of their work, and included monitoring events and

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1 No reference is provided because to do so would reveal the identity of the site and breach the confidentiality of the data sources.

spending, discussing these matters on a regular basis with the responsibility centre managers, and reporting to the person on the next level up in the managerial hierarchy. At the larger SITE P, this was the hospital district general manager (see footnote 5 on p. 142), and at the smaller SITE Q, it was one of the three assistant general managers of the hospital organisation.

The service managers related that much of their work dealt with change in their services and hospitals. It was more strategic, or about overall control, than about daily operational management at responsibility centre level. {Service Manager QS} related that his role was about providing "the most cost-effective service possible in conjunction with the various department[2] managers and doctors." He saw this as entailing meeting the "fairly well-defined expectations" of his service for which the hospital organisation is contracted with the Minister of Health, and the "less precise demands which the public put on the service." As his service was clinically oriented, and he was from an administrative background, he perceived his role as being about "facilitating the process" by which the various clinical people in his area "delivered the services in which they had actually been trained." He also enjoyed encouraging people to make use of data and saw this as a responsibility for anyone in his kind of role.

The work of service managers was not limited to an interest in their own service. They had a collective interest in the financial and related affairs of their hospitals as a whole, and comprised "management teams", which looked at hospital-wide management issues, including budgets and spending compared with budgets. At SITE P this team met each month under the chairmanship of the district general manager.

Financial Support Staff

Of the five financial support staff, {Cost Accountant Q} was working "pretty much in the area of costing non-clinical support services", although he had just completed a

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2 At SITE Q, general references by interviewees to "departments" was synonymous with responsibility centres of which the wards were the most recent addition. The support service departments and the clinical departments had been included in the term in previous structures.

temporary stint as the hospital organisation's acting internal auditor. Much of what he was doing in 1992 related to providing cost information about the operations of the planned Crown health enterprise. This was also true of {Financial Controller P} and {OPIS Support Person P}. {Financial Controller P} was responsible for putting into place the financial systems needed when his hospital became a Crown health enterprise. He expected that when this changeover happened, most of the work, such as payroll and general ledger, would be devolved to the hospital. In 1992-93 these were still being run on systems located some miles away at the hospital organisation's central headquarters, whence he himself had come less than a year earlier. In early 1993, he was dealing with these devolution issues, and with educating staff.

{OPIS Support Person P} arrived at SITE P a few days before being interviewed in December 1992. He too had come from central headquarters where, for the past two years, he had been involved in the design and implementation of OPIS. This system was a planning tool which headquarters used to collect planning and budget data, to build budgets, and to produce the corporate annual operating plans and budgets (see chapter 9). His new job entailed expanding OPIS by the acquisition of its strategic planning module, and finding what data people in the planned Crown health enterprise were collecting to incorporate them into the system.

The other two financial support staff were involved in maintaining records and disseminating data to responsibility centre and service managers. {RUS Support Person Q} was in charge of a section looking after the mechanical computing and technical costing data sides of RUS[3]. He described how "the basic philosophy of RUS is that patient discharges are the end products of the [hospital organisation] and everything produced [in the organisation, and its many departments], are merely intermediate products supplying or making up these end products." {Site Coordinator P} was responsible for coordinating some interrelated activities within her hospital district. These activities included using OPIS to compile the budget and to collect data on outputs, monitoring spending within the hospital district, and reporting on spending to

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[3] {Cost Accountant Q} was due to take overall responsibility for this activity within days of being interviewed in September 1992.

the hospital organisation's central headquarters. She also had the hospital's only direct computer link to the central headquarters general ledger system.

New Hospital Structures

The interviewees described the changeover in their hospitals from the triumvirate structure (see p. 50) in the days of hospital boards, to the service management structure of the area health board era. According to {Service Manager QS}, the State Sector Act of 1988, and the concept of general management which it introduced, were among the elements underlying the restructuring[4]. General managers were appointed to head hospital organisations, and they in turn had new organisation structures drawn up along service management lines. These were implemented in 1989 and 1990.

{Service Manager PC} had been the chief nurse in the three person triumvirate which had jointly run the hospital. However, since 1990 her managerial responsibilities had derived from being one of half a dozen service managers in her hospital. These positions were typical of service management structures, wherein hospital organisations, (or in some cases hospital districts[5]), were divided up by broad functional areas into main services (e.g., clinical support, surgical, and primary and community health). These main services were each made the responsibility of a service manager who reported to either the general manager, or an assistant general manager, of the hospital organisation (see Figure 6.1 which derives from Manawatu-Wanganui Area Health Board, c. 1991, and was typical of the organisation chart of a middle-sized board with a service management structure).

The wards and departments of the old triumvirate structure were also restructured, designated as responsibility centres, and grouped under services. The number of

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4 {Central HQ Manager RG} also spoke of the "profound" effect of these on the health service. See also Caygill and Salmond (1989), 'State Sector Act' (1988), and p. 477 of this thesis.

5 In large area health boards with facilities that were dispersed, a tier of districts was created in the organisation's structure with each district having a district general manager and service managers who reported to this district general manager.

responsibility centres varied according to organisational size and choice of structure. For example, {RUS Support Person Q} related that at his hospital there were 35 or so direct, clinically oriented responsibility centres, and 14 indirect, commercially or non-clinically oriented ones.

Accompanying the change in structures, aspects of general, nursing and medical administration that were formerly in the separate arms of the triumvirate structure were relocated in the general and service management hierarchy. Some were retained by staff at the hospital organisations' central headquarters, others were passed to service managers and their support staff located in hospitals. In turn, the service managers passed many of these aspects onto the responsibility centre managers. {Service Manager QS} referred specifically to nursing and ward administration having been devolved primarily to the charge nurses because of the disappearance of the previous nursing hierarchy. As a consequence, the job of charge nurse had changed considerably, and people in these positions had required "a bit of a mind shift in order to get used to the new concept."

A significant feature of the service management structure was that some responsibility for money and spending was pushed down to service and responsibility manager level. In the previous system, people outside the triumvirate group had been told very little about money, except on occasions to "keep spending down" ({Service Manager PC}). As part of this devolution process, much training was given to staff because many had "never managed any money at all", and "certainly had never budgeted before." Even by 1993, "the whole financial planning side of things [was] still relatively new to everybody", and "keeping within budget [was] a big problem for the various people involved in management."

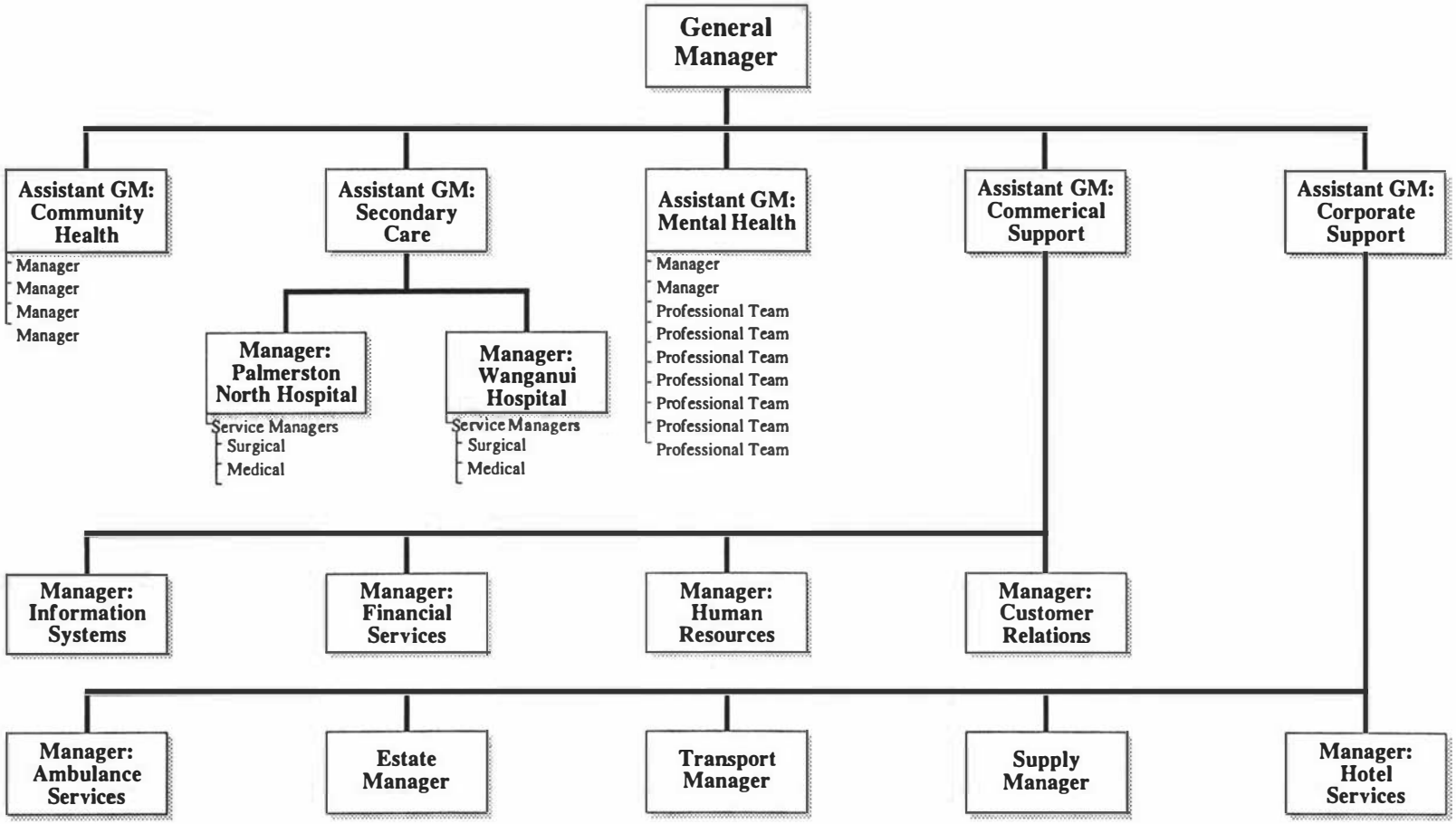

Figure 6.1. Diagram of service management structure of a medium sized area health board. (Source: Manawatu-Wanganui Area Health Board, c. 1991)

"Massive Changes"

By all accounts, hospitals had come a long way since the old triumvirate structure. This structure was described as being "fraught with difficulties" ({Service Manager PC}), and the structural change which saw its demise was "a complete one." The interviewees reported that everything in hospitals had changed during five hectic years (1988-1992), and the changes had been massive, affecting structure, working practices and personnel. According to {Service Manager PC}, "The people who left were those who, for whatever reason, were not going to cope with the future." Meanwhile, people who were retained were those who showed "some sort of aptitude and a keenness to get on and meet the challenge."

A related aspect of the changes was the large number of new managers. Although most of them were appointed from among existing staff, many people were brought from other fields. One of the problems which hospitals then encountered was that most of these people did not know "anything about health." {Service Manager PC} mentioned "an exception which proves the rule." This was the appointment of an accountant who was also a qualified health professional. She had found his approach to be very different from the other outsiders, because he could envisage "what someone on the health side was actually talking about." He was able to "talk the jargon" and to speak to people in a professional capacity knowing the nature of some the problems they faced on the wards and in departments. This was mutually beneficial to him and to the people he dealt with in the hospital. In contrast, things had had to be explained to non-health people "in great detail", and "this can be very frustrating."

All the people who had become managers had to be taught about planning, assessing outputs, manipulating staff and consumables, and measuring, and this had been difficult because all these had been changing continuously. In particular, hospitals had done very little measuring and, as a result, there had been delays in increasing the amount of measurement done due to lack of means, particularly lack of computers. {Service Manager PC} related that because three significant areas in her hospital, namely laboratories, radiology and pharmacy, were only just being computerised in 1993, the hospital was without information about them, and this had presented major difficulties

in its quest to become more efficient. Lack of personal computers had also been a major problem for some people trying to do their jobs. Without ready access to these, they lacked the tools and information needed for their work.

Reviews of the Service Management Structure

The service management structure endured more or less intact during the period 1989-1993, and was generally seen as working well. In particular, most of the interviewees remarked that the changes had resulted in a better appreciation of the interrelationships between support services and other services than under the old structure. {Service Manager PC} opined that until this happened, support services in hospitals had been "notoriously neglected", including "a lack of love and care, money, ongoing education and buoyancy." She added that hospitals were "still living with the repercussions" from this situation.

Despite the overall success of the service management structure, however, there were still problems. {Service Manager PC} spoke of a situation in one area where a group from the "old school" seemed "to undermine everything the new responsibility centre manager tries to do." Many of these problems had been tackled in the frequent reviews that took place after establishing the structure. {Cost Accountant Q} related that in one review the hospital organisation's building services department was renamed and reorganised. The new department has two fewer layers of management, and "more autonomy has been given to the foremen." This was subsequently perceived as being years overdue, and the people concerned were now "chasing after new business outside the hospital." He felt that it had become common for people to wish for changes to the management structure in their own areas if they were not happy, whereas previously this kind of impetus was not there.

The interviewees reported that similar reviews had led to a steady stream of minor reshuffles or other changes, of two sorts. First, there had been occasional transfers of responsibility centres from one service to another. The motive for such transfers had often been to increase the compatibility between a centre and a service area. In particular, a dividing line seemed to exist between what was clinically oriented, and

what was commercially oriented, and some activities had been moved from one side to the other. Second, there had been changes to budgets, and consequent shifts in spending power to the responsibility centres which had actual use of staff and items purchased. For example, rather than have all orderly services under one responsibility centre, these were being devolved to the particular clinical areas in which the orderly staff actually worked. Similarly, rather than the electricity for an entire hospital being under one responsibility centre budget, its cost was being passed to the responsibility centres whose staff and activities were using power. As a result of these changes, responsibility centre managers had acquired more scope for making decisions and were holding bigger budgets.

Coordination

{Service Manager PC} related that while both these developments were generally thought to be improvements, the increasing amount of devolution to responsibility centre level had resulted in coordination becoming an issue. This was because some decision makers at this level did not always "appreciate the ramifications of their decisions in other parts of the hospital." Indeed, {Service Manager QS} voiced similar concerns about the level he was at, saying that its perspective was "a little bit narrow." However, he guessed that his boss in the next level up would be "looking to cover the bigger hospital picture", and in turn, "the general manager of the [hospital organisation] would be looking at the whole picture." Nevertheless, he thought that constraints on their time might mean that "the attention of these people is attracted only by significant variations from, say, financial or output targets", or some other indicators of "what is supposed or expected to be happening."

As a consequence of coordination becoming an issue, {Service Manager PC} expected that by the time the Crown health enterprises were due to take over, the focus of control would switch to hospital service managers. These managers would need to "coordinate what is going on and to deal with this kind of problem." She thought that most of these service managers would need to know "a lot about the health industry", and to possess "good financial skills." Indeed, she considered that it would be preferable for them to be drawn from the clinical side and educated in the management side. She emphasised

that this sentiment did not mean the Crown health enterprises would not need financial and similar experts; but it did mean that these people would not fit in key positions without considerable health knowledge and experience.

A similar point was made by {Site Coordinator P}. She was enthusiastic about the service manager with whom she was working. He was new to health, and was in charge of the non-clinical and commercial side of the hospital. She found that he had been able to motivate people and promote a culture of excellence with such mottos as: "get it right first time", "take a risk", and "be a manager." {Site Coordinator P} thought that this manger had coaxed people into treating their work as a challenge, and they were continually attempting to improve things both financially and as a service. But she doubted whether it would be easy for other more clinically oriented services to adopt these kinds of measures.[6]

Preparations for Crown Health Enterprises

The interviewees spoke about the changeover to Crown health enterprises. {RUS Support Person Q} related that it looked as though his new enterprise would adopt the principle of institutional based management. This entailed hospital general managers, who were institutionally oriented, replacing the hospital organisation's functionally oriented assistant general managers, with similar repercussions about the orientation of service managers. He thought it was ironic that this basis of management had been used in the short time between the demise of the triumvirate structure and the establishment of the service management structure. Some doctors at his hospital had been labelled chairpersons and put in charge of clinical departments based on specialties. They were made responsible for their departments' case-mix throughput, and entailed in this was the attribution of patient costs to these departments. He indicated that the cost of

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6 The manager concerned was {Service Manager PB}. He thought that he had put a "commercial rationale" behind the things with which he was involved, and had introduced "core values, aims, delegation, coherent structures and so on." He had been recruited to reorganise some activities and responsibilities in this way, and when he arrived in 1990, he encountered a "government department type of approach to operations" throughout the hospital, and the hospital organisation. He perceived this as a situation in which there was "a great deal of very fertile ground that could be worked in order to produce beneficial results."

everything that was done for each patient would be attributed on the basis of the departmental affiliation of the doctor who discharged the patient.

{RUS Support Person Q} perceived these developments as indicative of trying to differentiate between affairs and issues bound up with clinical management on a collective basis, and managerial and administrative planning and control responsibilities. Under the emerging structure, these responsibilities seemed set to remain the concern of departments that would continue to be headed by responsibility centre managers. This differentiation seemed to reflect that there were "two groups of people in the [organisation] who mattered," namely, the doctors and the administrators. These embodied the organisation's "two major sub-cultures," and were "clashing quite badly" as representatives of each one "vie for power in the emerging Crown health enterprise." They had "two different criteria and agendas (sic), and they never met to discuss these." However, he hoped that the latest set of organisational changes would break down the barriers between the two, "regardless of whether they wanted it to or not."

{Financial Controller P} related that preparations for the change to organisation structures were "going ahead very quickly", in time for July 1993. As a result of the central headquarters of the hospital organisation being disbanded, many staff were joining the districts which were to become Crown health enterprises. Work handled by the headquarters was gradually being "pulled back" to his hospital district, and by July 1993 it was expected that most of it would be done at the hospital.

Before this process began, the headquarters was functioning in "a very centralised manner" ({Financial Controller P}) looking after accounts payable, revenue and accounts receivable, payroll, stores, etc. The district administration at the hospital had been limited to "some very low level management accounting", which was supported by a small financial services division of two or three staff based at the hospital. The role of the division used to be "a processing type role" and this had only started to change in 1991. Up until then, financial services had played "a very, very minor role", and the work had been done by people, "who though good at their jobs, were unqualified and lacking enough technical ability to support some of the questions that were arising."

The mainstay of the division was {Site Coordinator P}, who related that she was originally hired as a relief clerk in the medical superintendent's office for the last few months of the old triumvirate system. She was moved into the division when it was set up in 1990, and had found that her job, and the responsibility associated with it, "had got bigger and busier", especially since 1991.

{Financial Controller P} related that the turnover of functions from the central headquarters to the hospital was taking place "slowly but surely", and had been "a mixed bag of smooth and rough." He was finding that there was "still some resistance in some areas to handing things over" (i.e., particular functions such as accounts payable, stores and payroll) because the people in these areas wanted to remain as a single servicing entity for several Crown health enterprises in the region. He attributed the awkwardness just described in the changeover process to "purely political reasons." As devolution involved "breaking up some centralised structures," there were inevitably people connected with different groups in those structures, who did not want the change to happen for various reasons, including "not wanting to see the empires they may have established being broken down," or not wanting to have to relocate their place of work and possibly their homes.

{Financial Controller P} also commented on the capabilities of people in different parts of the hospital to understand things of a financial nature. He perceived that there was "a noticeable distinction between various groups." He considered that "non-clinical services, and probably clinical support services like pharmacy, radiology, laboratories and physiotherapy, were probably the best out of the bunch." Meanwhile, nurses in charge of wards, on whom "something like 65% of the costs fall," were the ones he felt were going to have to be "hammered into, to get their understanding up." He thought that this difference might be because it was possible for non-clinical and clinical support services to be provided externally in a competitive environment. He perceived also that people running these services had more interplay with professional colleagues, or similar, who were working in commercial environments. Through this interplay they became exposed to the "real commercial conflicts" which face these colleagues; some of them had also worked in such environments before coming to the hospital. By

contrast, the people on the purely clinical side, such as doctors and nurses, were less exposed to influences such as management training or commercial competition. He thought this was a weakness in medical training and advocated that it should be rectified because of the environment in which doctors and nurses would work in the future. He also thought that even those with private practices were not likely to encounter budgeting, or to cope with cost-related issues, in the same way as in a large and complex organisation like the hospital.

{Service Manager PB} also felt that there was "an enormous amount of untapped capability" among people in his hospital, and indeed "in much of the health system." However, he felt that up to 1993 the hospital organisation was "too large"; had "Kremlin-like central headquarters control"; inappropriate management structures; too big a gap between the decision makers and those who actually knew what was going on; and general stifling of innovation and creativity. He related that these circumstances had been "keeping this capability locked up," and preventing the organisation from achieving its implicit desire of "getting more service from less money."

Hospital Organisation Managers and Support Staff

The central headquarters function was carried out in most hospital organisations either on the campus of the main base hospital, or very close by. The staff involved usually comprised the general manager and his/her deputies or assistant general managers, which some organisations labelled the *executive team*; and the corporate services division within the service management structure (e.g., see the structure illustrated in Figure 6.1).

The eight interviewees from among these staff were all members of the *executive team*, but two of them headed corporate service divisions. The eight had been in their present job for between less than 1 year and 5 years. Many of the positions were new ones. Some were created in the 1988-90 restructuring period, but most came about with the 1993 iteration of formal reorganisation. Moreover, although two interviewees had been doctors, and at their present sites for 10 and 25 years respectively, the rest had arrived only within the last 5 years, and all except one had come from the private sector. The backgrounds of these six were business/managerial and/or financial, and apart from one

who combined this with some links with the pharmaceutics industry, none had health backgrounds. However, during their interviews all exhibited some empathy with the work of health professionals and indicated that what their organisations were doing was more than just a business.

Changes in Responsibility and Orientation

Each interviewee occupied his own office in the administration building which comprised the board office. The offices were no more than adequate and looked similar to those occupied by service managers. The work of all eight interviewees was concerned primarily with strategic matters, organising other people, and keeping affairs under control in a business sense. The work also had a future orientation, and in particular the interviewees regarded their area health boards as "history" (Central HQ Manager RF}), and were preparing for "the new regime" in which "things will be quite different." {Central HQ Manager RA} indicated "the first priority is the strategic planning round which has just started [in February 1993]." All the interviewees spoke about hospital organisations developing into "successful businesses", although most qualified this statement by stressing that financial success was not the only or main consideration. {Central HQ Manager RG} indicated that the business approach to running the organisation:

> is fine as long as everyone remembers all the way just what the Crown health enterprise is in business for. That is, it is not primarily about manipulating assets and turning profits; it exists to provide health services for New Zealanders in the most cost-effective way possible.

{Central HQ Manager RG} also thought that there was "a question mark over the political will to see things through," and thought that it would be interesting to see "if the government softens its approach in the run up to the [1993] election[7]." He related that, despite more local autonomy, "the dead hand of Wellington is still there where

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[7] This did not happen then, but in the wake of the National government's uncertain position in the Selwyn by-election in August 1994, some changes in political posturing occurred (see Ross, 1994d).

capital is concerned[8]." He indicated that this control had "stuffed up everything," and made managing an area health board "a very difficult job. It means that the board is faced with more than just an element of playing around with numbers in order to be able to do what it wants to do."

According to {Central HQ Manager RG}, over the period 1990 to 1993, the general manager of each hospital organisation had been responsible, successively, to an elected area health board, a commissioner appointed by the Minister of Health, a Crown health enterprise advisory committee (he noted that this was "indirect but quite significant"), and a Crown health enterprise board appointed by the Minister of Crown Health Enterprises. For him, this responsibility has included "the unspoken agenda of keeping on budget, no surprises and no scandals."

Most of the interviewees echoed {Central HQ Manager RG}'s view that changes in culture and ways of working, and regard to financial indicators on balance sheets and profit and loss accounts, "are part of the process of providing cost-effective health care which the nation can afford." They also echoed his view that "financial things are going to play a much bigger role than they ever did in the past." This would entail all staff, including the chief executive, having "to understand some financial things," and having "people around who are skilled in this way."

One Person's History

{Central HQ Manager RC} indicated that he was brought into the hospital organisation in 1991 to give it a commercial view and appearance. He involved himself in everything that was commercial, and this included "instilling some commercial attitudes in what the board was doing because of the paucity of these attitudes in the business itself." He believed that the organisation was:

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[8] This was a reference to a Credit Control Committee, appointed in mid-1992, with power over what capital items area health boards could and could not spend money on in their final year of operation.

> a product of what it has been asked to be and therein lies the tragedy, and the same could probably be applied to any other government department, particularly in health because it is high-tech and therefore very expensive. . . .
>
> [The organisation was] never considered to be other than an organisation which would perform good things for the public good. It did not even have to measure outputs let alone outcomes if it was doing good, and it was because everybody involved did, and did good very well. The government only made demands in terms of output in procedures . . . [such that] if the Board kept the waiting list down everyone was happy. [But] the waiting list is a political football and it does not amount to a row of beans in the scheme of things, but it becomes important every election year for the people who want to win the election and it becomes important to the opposition in between elections. . . . Rather than demand better value for money, politicians were really looking at the high profile political footballs.

He recollected that in the late 1980s the politicians, or the Treasury in particular,

> realised that health could no longer go on being all things to all people, specifically because they could not afford it, but not because they did not agree with what was happening. . . .
>
> The patient was not ailing; it was a burgeoning patient. It was very hale and very hearty, and that was the problem because it did not really consider what it was doing to itself. It was overweight and not just obese; it had coronaries and heart problems. {Central HQ Manager RC}

The Minister of the day stipulated that "she [i.e., Helen Clark] would have the health business managed and people became managers rather than surgical superintendents and what have you" ({Central HQ Manager RC}). He saw the fatal flaw in this being that departments of the hospital were "not in a position to generate revenue." Thus, a situation arose in which departments were "desperately trying to increase their throughput and productivity to reduce their unit costs, while the organisation was acting within a finite budget." This meant that additional productivity was "actually sending the organisation broke." {Central HQ Manager RC} thought that it was very difficult

to change this attitude in departments into one of "a purely commercial thrust." He also thought that people in the health sector really needed to think commercially about what they were doing, but that "this is not quite the same commercial approach which one would find in the private sector in which things like sales-mix, or case-mix, or product-mix, or whatever the case may be, would have a bearing on what is done." Thus, although he anticipated "putting the information systems right" and "getting financial systems which will report the sorts of things people in the organisation need," he also saw a need for an approach which said that "what is done must be maximised for the money which is received." In addition, "more revenue has got to be generated in order to do anything more that is done above that." He felt that "all this sort of thing reflects on the sort of accounting and reporting system that the organisation requires internally."

{Central HQ Manager RC} saw the problem of culture change as "quite massive for the whole of the health system." He felt that what mattered was not just the approach managers took to do well in the commercial sense (i.e., "doing well with what is there and getting the most out of what is being done"). "Whether everyone likes it or not, it is the clinicians who are the gatekeepers and the drivers of the organisation and they always will be." Thus, he saw the need for a massive change in regard to the clinical sense of doing well "encompassing both the approach which clinicians take, and their use of resources." He indicated that he was more critical of the previous system than of the people in it because:

> the people are products of the system. Within the system they have all done a very fine job, but nothing else has been asked of them except to mend broken legs and stick plasters on, and do the job of healthcare. This they have done extremely well, but to the extent that they cannot really respond to the expense side because it is completely new to them and they just do not know.

{Central HQ Manager RC} indicated that this situation was changing, and that "the thrust in the board is towards a more commercial view of what is being done." This includes:

> looking at opportunity costs, feasibility studies, to look five years out as to what the organisation is doing, to examine what its product streams are and where its

> money and its effort should be put, to downsize accordingly, and to reorganise and restructure. . . . [But] the organisation is a bit hamstrung in this area because its systems cannot keep up with the thinking.

Even so, by 1993, the stage was being reached at which an examination was possible of "why the organisation does things, where they are done, how they are done, and whether they should be done" ({Central HQ Manager RC}). Nevertheless, {Central HQ Manager RC} thought that it would still "take some time to produce the systems to support this stage and then change the thinking." It would not be necessary to do this very much at executive level because "to some extent new executives had been brought into the organisation who think the right way. However, they are captured by the 5,000 people out there [the interviewee pointed through the wall in the general direction of the base hospital] who are still working the other way." He did not see it as "an easy or simple exercise" because "health is a highly complex organisation, and it will always be highly political too which increases the complexity."

Aspects of Work

One of the doctors related he was finding his clinical background helpful to his present work, "though there are pluses and minuses" ({Central HQ Manager RX[9]). He accepted that his lack of a managerial background was an issue and thought that "in a mature organisation it would have been an impossible issue," but this was not so with his organisation, given that it was still "immature." This immaturity had given him "the opportunity to grow with things and this has been good." Also, his medical background had given him a knowledge of the business which he thought was "fundamental in the game we are in." He described himself as "financially unsophisticated", and so he depended on advice about what he was supposed to read in financial reports and for making financial decisions. The "most significant and frequent routine financial reports" he received were monthly ones.

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[9] Revealing the full title of this manager would prejudice the anonymity promised to interviewees.

A key aspect of the work of most of the interviewees was the number of people for whom they were responsible as employers of the staff. Two interviewees mentioned figures around 5,000, and another spoke of 1,000. Functions such as industrial relations, staffing policies and productivity came with this responsibility. Restructuring and reorganising were spoken of frequently, along with the challenge of appointing managers and the pain of causing job losses. Capital works and managing assets were also mentioned by some interviewees. Linked to all these were money, budgets, and spending; the financial amounts spoken of were in the tens of millions.

Another common theme related to dealings with government over funding, contracting and accountability, and the political and public arena in which hospital organisations often found themselves. While the interviewees wanted to be involved in the strategic side of these dealings, some also referred to trivial matters arising which would not involve people in corresponding positions in private companies. According to {Central HQ Manager RC}, these included being rung up by an irate motorist who felt he had been passed rather too briskly by a hospital organisation vehicle, or trying to eradicate a pigeon nuisance in the face of opposition from the nurses. This interviewee also found it peculiar that groups with whom he was negotiating pay claims felt able to appeal to one of the other interviewees who had been a doctor in the hospital, and to take their complaints to the media.

Also on the political theme, this interviewee claimed that one of the problems in health was that a great deal of expenditure had occurred which had not necessarily resulted in improved service. He gave as an example instances where it had been "a good thing politically to throw $1m at a district hospital for a new wing because the local MP was flagging in the polls" ({Central HQ Manager RC}). He thought that "this type of action seems to have got votes even though the hospital probably did not really need the wing and there was no real market for the new or expanded services." As a consequence, Crown health enterprises were "inheriting assets which are not always capable of providing an adequate return on the capital invested in them." Similarly, {Central HQ Manager RG} recalled a time in the late 1980s when the situation was "just silly" in that the hospital organisation he had inherited "just could not count." It had had "a big

spend up", and when things were looked at afterwards, he and his colleagues realised that if it continued to spend as it was doing, it would overspend by tens of millions of dollars, which among other things "would have been illegal."

Financial Management and Systems

As a result of this realisation, "jobs were dropped right, left and centre and all that we were concentrating on really was the budget" ({Central HQ Manager RG}). It was also realised that the organisation did not have "basic financial information" and {Central HQ Manager RG} had decided "to supervise the financial performance of the organisation personally" even though he had to do this in a crude way because of his lack of financial sophistication. He noted that it was "quite frightening really, trying to be the general manager when you are just working on the seat of your pants." {Central HQ Manager RP} also alluded to this situation by providing figures about his responsibility area and stating that they were "just approximate because the board's accounting systems are such that I haven't got the foggiest idea of the exact position."

{Central HQ Manager RG} became personally involved in the improvement of reporting within the organisation. This had been achieved steadily in that "improvements have occurred in the reports we have been receiving from month to month," and by about April 1993 he was expecting that reporting would be of "a very high quality and very believable." In particular:

> a whole new general ledger is due to come on stream by February 1993 and the reports for that month are due to be based on the new ledger. The whole of the accounting systems have changed and been turned around.

He also reported that there were "a whole lot of new people in the organisation and whereas at one time the organisation only had one accountant, it may end up with about 15 accountants altogether though not all of them will be in accountancy positions" ({Central HQ Manager RG}). In fact, there were two or three accountants among the senior management of the organisation and he saw some irony in there being "more accountants than doctors at the board office."

One of the new accountants was {Central HQ Manager RF}, and he saw his task as "redeveloping, or developing from scratch in some cases, the finance function into a modern support function for a multi-million dollar business which is what the organisation is having a turnover of [about $300m] a year." He saw three main priorities in his work:

(a) information systems and "getting a good solid modern financial and inventory system . . . along with the procedures behind normal accrual accounting and businesslike reporting;"

(b) costing services and "to appropriate activity costs to where they really belong." This would mean that for the first time "the organisation will have a view of what it costs to do all the things which it does." Having information about "the costs of carrying things out is going to be essential to the organisation under regional health authority contracting;" and

(c) non-financial performance information.

{Central HQ Manager RF} indicated that having taken a decentralised approach to restructuring the finance function, "there will be divisional accountants in all the major business divisions." These accountants would report to the divisional general manager and "their day-to-day mission will be to keep their general manager happy." But {Central HQ Manager RF} intended having an overall strategic brief on these accountants "to drive both the pace of development and direction, and the establishment of standards from an overall board-wide perspective." He saw this as a big change from the previous set up and probably quite innovative in health. Nevertheless, "it is not so innovative generally in that most big corporates tend to move in that direction naturally." He related that in the past the organisation had been "very heavily centralised."

{Central HQ Manager RC} stated that in most of his areas of responsibility he had established monthly trading accounts and monthly balance sheets, whereas "this is unheard of in health absolutely." The information was being produced by his divisional accountant. The first monthly trading account and balance sheet was produced for the laundry in mid-1992, and that was followed with stores and transport. The next area

due to do this was food and dietetic services. In this way, he could "actually train managers to react to what is an extremely live document in the trading account." He felt that if people reacted to a monthly profit and loss statement and balance sheet, then he was really moving towards some sort of commercial success. He felt that until the whole organisation was doing this, and until there was a profit and loss account and a balance sheet for laboratory, x-ray, ward X and so on, the organisation was lost. He believed that providing a profit and loss account on a monthly basis "is the quickest way to change the culture."

Cash, Accruals, Outputs, Balance Sheets and Profitability

{Central HQ Manager RG} hoped that after the new general ledger was in place the organisation would be able to predict its end of year figures from information during the year. Not being able to do this had made for "a trying time" for him and his colleagues. "Once upon a time it did not matter that such predictions could not be made. Nothing mattered except for coming in on budget. But it does now." He explained that hospital organisations used to get annual cash grants and "they had to meet that cash budget[10]." The most important thing was the operational budget, and if money was tight an organisation would temporarily not pay its bills. "Budgeting has been everything really, and certainly it has been far more important than annual reporting. Whatever else the board did, did not matter at all." He thought that this was changing and that this change was "for the good."

{Central HQ Manager RA} echoed these sentiments. He explained that external accounting requirements had been changing since 1987, and this had meant changes to internal systems as well. Essentially "things used to be accounted for on a cash basis and there were no accruals." Also, Vote Health was a cash vote and each hospital organisation was expected to live within the annual amount of money it was given.

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10 {Central HQ Manager RG} made an interesting aside here. He wondered whether his area health district (and the organisation) would not have been better off overspending because other boards regularly got away with this. It was not clear whether he had an inkling of the overspending by the Auckland Area Health Board referred to by a report of the Controller and Auditor General (1994) which appeared shortly afterwards.

After 1989, contracts were brought in between the Minister and each organisation. These supposedly established "the outputs that are required and the standards that are to be met by each board. However, the cost of what is done and how the money is allocated is left purely to the hospital managements concerned." He added that the output side of these contract arrangements were "very fuzzy", while the financial side is "a fixed, capped amount of money."

{Central HQ Manager RF} related that there was a monitoring process associated with the hospital organisation's capped budget and this had been in place for two or three years. A key aspect was the sending of monthly reports to the Department of Health. He indicated that it was difficult to describe this process because it "is a rapidly changing animal." {Central HQ Manager RA} related that these aspects of the contract tended to be "mirrored in the way money is allocated within the Board, and this may be typical of what happens elsewhere." He recalled his experience of this when he was working in the base hospital in 1991:

> The hospital would be told its allocation for a particular year by the Board, say $100m. However, the demands in the health sector are infinite and as soon as the hospital starts knocking people off the waiting list then others are put onto the list. In addition, there is the question of when do people go onto waiting lists and when do doctors take them off or put them on.

In this situation {Central HQ Manager RA} found that "the game became one of what resources does the hospital have in terms of cash, and how can as many people as possible be best serviced given the Board's contractual outputs with the Department of Health." It was entirely up to management to say that "as many people should be got through the system at the cheapest price possible so that the hospital lived within its overall budget." He discovered that "there is a whole science about waiting lists."

{Central HQ Manager RA} added that "the board's balance sheet has never been a focus for anything. Whatever its gearing ratios, capital structures and all the rest were was irrelevant." Under the new hospital system he expected these kinds of items "to become increasingly important." He felt that the system needed changing "to focus on income

generation, profitability, return on assets, and all the other things which are incorporated in the new Crown health enterprise model." He indicated that this model was the "state-owned enterprise model," although "the criteria of profitability has been taken out of the legislation which will apply to Crown health enterprises." He favoured this change because he was uncomfortable with the whole concept of profitability. He described it as "an imprecise one open to many definitions." Even so, he was not sure how Crown health enterprises would be held accountable in practice for being "successful businesses which have to fulfil ethical requirements and social obligations as well." Notwithstanding, he felt that having:

> a business type structure, competitiveness and accountability cannot be argued with, and that the only way to pull all of these together at the end of the day in some sort of measure is to have a financial measure, . . . [along with other] performance measurement standards, including quality and output, to give a broader understanding of the success of the organisation. {Central HQ Manager RA}

{Central HQ Manager RF} expected that after July 1993 the regional health authority would want an equivalent of the monthly information which was currently sent to Wellington. In February 1993 he had received some guidelines on new key performance indicators information that should be sent each month to the "Crown health enterprises' head office[11] in Wellington." {Central HQ Manager RG} related that internally certain matters would be of major importance in the immediate future. These included treasury management, inventory management, getting value for the Crown health enterprise's assets, and assessing the return achieved on investment. All these were now "much more real world stuff and part of getting value for money, whereas in the past many of them were not done at all."

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[11] This was a reference to the Crown Health Enterprises Establishment Unit which in July 1993 became the Crown Health Enterprises Monitoring Unit, and by June 1994 had become the Crown Company [Monitoring Advisory] Unit.

Future Prospects

{Central HQ Manager RN} also thought that financial result and financial management generally "will be quite important contractually and politically." Ultimately the Crown health enterprise's financial performance would be of major interest to the purchasers of services. In particular:

> regional health authorities will not want to see [the Crown health enterprise] making lots and lots out of providing the services they are paying for, and if such circumstances do arise they will want to do something about it such as getting more service for the dollar or by reducing the dollar.

He also thought that health would continue to operate in a very political arena and, if there were misunderstandings about hospital organisations' reported financial performances, this would lead to "adverse publicity and political comment" ({Central HQ Manager RN}).

{Central HQ Manager RG} related that as the changes occurred he and his colleagues had gained "a bit more freedom," whereas once "everything was decided in Wellington." He was fairly positive about the future, although the staff in general were "bemused and slightly cynical about the things that are transpiring. They are not too enthusiastic but they are passive rather than actively opposed to the changes. In the present environment this is probably pretty good." He thought that there was potential for "a better value for money health service although it remains to be seen whether that can be delivered." But he also thought that "the current ideology based on the notion that business somehow has a magic wand which will transform health is unsustainable."

Closing Pointers

In this chapter a thick description is drawn from the within-case analyses of the interviewees located at the institution level of the hospital system. This description encompasses aspects (i.e., intentions, motives, meanings, work context, situations, and circumstances of action) corresponding to those dealt with in chapter 5 in relation to people in the operating core and support services. It also traces the way the hospital organisation managers and support staff element has emerged from the board offices of

the hospital boards; and shows the dual concerns of people in this element with people and issues originating, respectively, at the central authority level and in the hospitals. Similarly, the genesis of the hospital service manager and support staff element is traced, including their key role in mediating between, on the one hand, the emerging macro-demands of the hospital organisation element and the central authority level, and on the other hand, the work of professionals and others in the operating core. Whatever else emerges, the number of people in these two management zone elements has grown along with the way in which actions at this level have reverberated at the basic unit level, including in the form of budgets and spending reports. Further changes were imminent as people at this level prepared to work in a mode they expected would be necessary for the survival and growth of their institutions in the hospital enterprise period that was about to begin officially.

These matters are revisited in chapter 8 in which matters of orientation, control and resources are examined to show cross-sectional differences between the two elements at the institution level, and between them and elements in other levels in the hospital system; and to show longitudinal differences within elements. Similarly, matters of task and resource interdependence, and answerability are drawn out in order to show relationships between elements and levels. In addition, matters to do with the situated practice of accounting, including budgets and answerability for spending, are further thickly described and interpreted in chapters 9 to 11.

CHAPTER SEVEN
PEOPLE AT THE CENTRAL AUTHORITY LEVEL AND IN THE COMMUNITY WITH AN INTEREST IN HOSPITAL ORGANISATIONS

This chapter elaborates on the central authority level and on the way changes promulgated centrally have affected hospital organisations. It also contains some perspectives from people in the community.

Central Authorities

There were five interviewees whose jobs were at the central authority level. All their backgrounds were of either a general business/managerial nature or a specialist financial one. Most of their experience was outside the health service, although for some years hospital organisations had featured sporadically in the careers of three of the five. Between them they were involved in:

(a) carrying out financial audits of accounts and annual reports;

(b) contracting by government and regional health authorities with hospital organisations and other health service providers;

(c) financial analysis of contracts, budgets, monthly general managers' reports and annual reports; and

(d) setting up systems in the context of purchaser-provider arrangements between regional health authorities and healthcare providers for making services contestable, and for contracting and pricing.

All the interviewees had their own offices. These were located on floors of multi-storey office blocks in city business districts well away from hospitals. They were better appointed than anything encountered in the hospitals, and enjoyed reception areas, support staff such as receptionists and secretaries, and office equipment including desks, PCs, telephones, facsimile machines and photocopiers.

Three of the interviewees were located in provincial cities, and two were in Wellington; all were male. Ostensibly two were interviewed in connection with SITE P ({Central HQ PA}, {Government Analyst}) and three were interviewed in connection with SITE

R ({Ministry Official}, {RHA Official R}, {Auditor R}). However, they all preferred to talk more generally, having had dealings with several hospital organisations, and not wanting to divulge anything confidential about a particular hospital organisation.

{Auditor R} had been in auditing work for 20 years. By contrast, the other four had been in their present jobs for between a few months and 4 years. These relatively short periods were primarily due to positions having been created in connection with various developments after the 1989 iteration of reforms, and/or with the putting in place of the formal reorganisation that was due to take place in July 1993. The interviewees talked about various aspects of these changes. All their jobs were figuring in them and were changing because of what had already happened or was to happen.

The Pre-reform Period

According to {Auditor R}, there were several financial aspects of the health system and hospital organisations which started to change before the 1989 iteration of reforms. He tied these to the influence of the Audit Office in the late 1970s and early 1980s. He made particular reference to the Shailes Report (Controller and Auditor-General, 1978), which advocated making "significant improvements to financial management and financial reporting in government departments" and in government in general. He also associated these and other more general changes that had affected the health system with "Roger Douglas[1] and the Fourth Labour Government." {Auditor R} claimed that "performance reporting and things like that have come to the fore" since this period, and that the people championing these particular ideas from the Audit Office and elsewhere had been "behind the issuing of a public sector accounting concepts statement [(NZSA, 1987)] by the Society of Accountants." Two facets of the statement were references to "accrual accounting" and "commercially oriented entities." He also explained that his was one of the branch offices of the Audit Office which had been "keen to get organisations which they audited to adopt the NZSA statement as soon as it was formally approved and before it had any legal backing."

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1 Sir Roger Douglas was Finance Minister in the Fourth Labour Government (1984-90) from 1984 until he resigned in 1988 (see p. 248).

According to {Auditor R}, the Public Finance Act of 1989 "provided statutory backing for much that was in [NZSA (1987)]," and that Act affected both the Department of Health and hospital organisations in other ways as well. But only some of the annual reporting provisions of the Act were applied to hospital organisations. Nevertheless, between the mid-1980s and the early 1990s the annual report documents were "transformed from simple cash accounting documents of a few pages which did not mean much, to far more meaningful and much better reports of 40-odd pages with accounts prepared on an accrual basis and a lot more financial and performance information."

A New Period of Central-Local Relations

{Auditor R} related that the 1989 reorganisation of hospital organisations was accompanied by "the beginnings of change" in the relationship between them and the government. Instead of being "driven by directives from the Department," and being dependent on it "for their daily cash," the hospital organisations began to gain "more independence from government." At the same time they started to be the subject of "more commercial type influences" and so took on "a greater commercial orientation." {Auditor R} related that personnel changes were more or less forced on the hospital organisations, and these reinforced the change of orientation in that "a lot more business people" were recruited. Also, the years 1988-1990 "were major learning ones for all the parties involved," and as time went on "there were many improvements to the way everyone carried out their respective tasks" ({Central HQ PA}).

{RHA Official R} had been recruited from business when he took on his previous job as a manager in a hospital in about 1990. While in this job, he had played "a leading role in [the hospital's] reconstruction along commercial lines." The hospital organisation was one of the few to adopt "a decentralised model." Within this, his hospital and the others in the organisation's area were classified as independent service providers. Meanwhile, the central headquarters took the role of funder. This model suited the hospitals involved because they had been the base hospitals in separate hospital boards before the 1989 reorganisation and, "cherished their independence." While it took time "to win the elected members over" to the decentralised model, this eventually happened.

Their replacement by a commissioner in July 1991 "hastened the whole change" in the organisation concerned, and the decentralised model meant that the organisation was "finding it a lot easier" than it would have done to establish the Crown health enterprise it was to become in 1993. He contrasted its experience with other more centralised hospital organisations, and reported that centralisation was "making for an absolute nightmare"[2] in larger hospitals organisations which were being divided to form more than one Crown health enterprise.

Contract Negotiations and Analysis

The work of all five interviewees had some connection with contracts between the hospital organisations and the government. These contracts were introduced once area health boards were established. In essence, a contract was negotiated annually by the Department with each hospital organisation. Among other things, the contracts covered costs, budgets and capital plans for the forthcoming year. According to {Ministry Official} and {Government Analyst}, the Department's side of the negotiations was handled by contracting teams from people in the Department. There was a different team for each organisation, but most people were on several teams. From 1991, the Department also employed financial analysts who each dealt with three or four hospital organisations. Their job entailed analysing data supplied by the organisations as part of the contracting negotiation process, and then monitoring actual results against the agreed contracts.

{Government Analyst} related that the analysts' work in relation to contract negotiations was restricted to budgets and other financial aspects. Like the rest of the process, this work evolved with experience and events. In the run up to the start of the 1991-92 and 1992-93 financial years, the analysts supplied data on each hospital organisation to the contract teams. The analysts obtained the 1992-93 budgets just after the financial year started in July. These budgets came as part of the organisations' annual operating plan documents and were in a standard accounting format very similar to the one laid down in Minister of Health (1990). Their main components were four statements:

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2 The Auckland Area Health Board's system came in for public criticism from the Controller and Auditor General (1994).

(a) an operating statement showing income and expenditure;

(b) a balance sheet including fixed and current assets and liabilities;

(c) a cash flow statement; and

(d) a cost of services statement showing costs divided into eleven broad service categories.

As in 1991-92, the statements were prepared on an accrual basis of accounting. An innovation introduced in 1992-93 was that the budgets of income and expenditure were phased; that is, divided into mainly unequal monthly parts according to expected seasonal or similar fluctuations.

After the government's own 1992-93 budget was approved by Parliament, the Minister was able to advise each hospital organisation of their funding allocation for the year. One of the analysts' tasks was "to evaluate whether the hospital organisations' budgets were consistent with this funding allocation" ({Government Analyst}). This entailed checking that each budget "made sense" and was "internally consistent," and that each of the lines of proposed income and expenditure was "reasonable." Year on year comparisons were done of these line items. In addition, particular attention was paid to the capital plans of the organisations which "tended to have shot up" compared with what had been due to take place in 1991-92.

According to {Government Analyst} the analyses were done from "a Crown ownership perspective," and the primary considerations were "the projected overall surplus or deficit" and "how it would alter the size of the Crown's investment[3]." He noted that this perspective was not something which the hospital organisations agreed should be applied. He often detected "a feeling of wonderment, even resentment, at what analysts are doing." He attributed this to the people at the boards perceiving themselves as "managing what they feel is their own business," dependent on government merely for

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[3] {Government Analyst} stated that the 1992-93 year end forecast balance sheets came in for closer than usual scrutiny because many items on them, particularly fixed assets, were due to be taken over by the Crown health enterprises in July 1993.

funding. They tended to see themselves as independent, and "this feeling increases the further the board is located away from Wellington." He saw this independence deriving in part from the period up to July 1991 when "elected boards" headed first the old hospital boards and then the area health boards, and it had continued after the elected people were stood down.

The analysts passed their budget findings to the members of the respective contracting teams and were ready to play a supporting role in the contract negotiations. This was done mainly from Wellington, but sometimes involved accompanying a team visiting a hospital organisation site. The parties to each set of negotiations were the team from the department and senior people from the hospital organisation, including financial people. According to {Ministry Official}, negotiations focused on the organisation's output targets for the coming year, how funding would be used to achieve these negotiated targets, and how inputs were expected to relate to outputs. {Government Analyst} related that in preparation for the negotiations, the teams took soundings among people from within the Department to ascertain their collective expectations for each hospital organisation as far as outputs were concerned. These expectations were "an indication of the Department's priorities," and by "taking them to the negotiating table" it was thought that teams were giving the hospital system "more focus in terms of priorities." In any case, the main aim of the Department's team was to keep the output targets up to previous levels. Their other important aim was to establish a budget in which overall costs were consistent with funding allocations.

{Government Analyst} related that the negotiating team looked at the proposed budget in some detail and "raised any matters it was not happy about." These matters were not exclusively about costs, but also related to the "financial position" that would result if the budget was followed. The relationship between target outputs and the expected cost of producing these outputs was usually the aspect of the contract from which "conflict and tension arose" in the negotiations. This matter was complicated for the Department teams because of a conflict between their role as "the owner of the organisations they were negotiating with," and their role as "negotiators of purchases of outputs" from the organisations. Three of the interviewees made mention of this conflict and expected it

would be removed by the regional health authority-Crown health enterprise, purchaser-provider split.

{Government Analyst} explained that after the experience of the 1991-92 contract round, it had been hoped that negotiations would normally take about three weeks to finalise from the time the Department received a hospital organisation's operating plan and budget. It was also anticipated that agreed contracts would be given to the Minister during September of each year with a recommendation that they be approved, and that he or she would then sign them. On occasions when an agreement could not be reached even after protracted negotiations, the whole matter would be presented to the Minister and a final decision would lie with that person. Whatever he or she decided would in effect mean a directive to the organisation to accept a particular contract. In the 1992-93 round, the "normal three week period" had to be extended in all cases because of the magnitude of the negotiations, particularly in relation to the "extensive capital plans" which many organisations put forward. In addition, some delays were due to personnel changes that had begun in the lead up to the creation of Crown health enterprises and regional health authorities. Also, while most contracts would normally have been signed by the Minister in September 1992, some had still not been formally signed in February 1993.

Contract Monitoring

The work of the analysts also included detailed financial monitoring of contracts in 1991-92, and copies of the monthly analyses were sent to the contracting teams. After the 1992-93 year started, however, this monitoring process became involved in the arrangements for the 1993 reorganisation. First, the analysts were relocated outside the Department. Then their jobs were phased out, and the monitoring work was contracted to one of the major accounting firms. But it was still coordinated by {Government Analyst}, and in both years it followed the pattern reported below. Meanwhile, the Department's contracting teams who used to receive copies of the monthly analyses were phased out. But the analyses still went to the Minister, Bill Birch. Furthermore, Minister Birch had begun to submit a summary of the analyses to the Cabinet.

The output side of contracts was monitored separately. Output results were supplied by hospital organisations on a quarterly basis. These went to a performance group in the Department which sent its reports to the Minister. {Ministry Official} indicated that monitoring the output side of contracts was not as prominent as monitoring the financial side. Even so, more had become known about what was being produced by hospital organisations, and by implication what was being "purchased by the Department" ({Ministry Official}). This kind of knowledge "was not available in the past."

Monthly Financial Monitoring

{Government Analyst} indicated that monitoring began for a financial year once actual results started to be received from hospital organisations. For 1992-93, this did not happen until November, when the year-to-October's results were available. Only then were most formal contracts in place and arrangements for the contracting out of monitoring finalised. In any case, the patterns that made monitoring possible did not normally start to emerge until a few months into a year. About 10 working days into each month, every organisation sent in its financial results covering the previous month and the year to the end of that month. These results were on discs and followed the standard format (i.e., Minister of Health, 1990).

The monitors in 1992-93 evaluated what was happening by "comparing the actual results for the year-to-date with the phased budgets which were agreed as part of the contracts" ({Government Analyst}). The organisations' were monitored against how their budgets were originally phased. Thus, rather than being allowed or encouraged to rephase their budgets for formal monitoring purposes in the light of events, organisations were monitored against fixed plans set when the year started. This meant that they were "held accountable to one thing only," ({Government Analyst}) rather than against something which was moving. Even so, some organisations chose to rephase their budgets in the material that they submitted.

According to {Government Analyst}, monitoring was done on "an organisation-wide basis", rather than on the basis of the large individual institutions which made up some bigger organisations. Nevertheless, some organisations provided supplementary data on

an institution-by-institution basis. Monitoring was also done from the perspective of what the results to date meant for the whole year; and for 1992-93 the hospital organisations were asked to submit projected out-turns for the year as part of their monthly submissions. Analysts had relied previously on their own centrally prepared projections of each organisation's out-turn. The latter were still done, and remarkably they seemed to be "more accurate than those received from the organisations themselves."

From Spending Reports to Balance Sheets

{Ministry Official} and {Government Analyst} related that the monthly reports described above were introduced in 1990. They were proving essential to Departmental staff for evaluating each hospital organisation's progress towards contract targets. The reports meant that these people "had a much clearer idea of what was happening" ({Government Analyst}), and "helped reduce the risk of over expenditure in the service" ({Ministry Official}).

At first the reports merely improved the information available about spending during a year, which was the emphasis of the past. By 1991-92, the primary concern in analysing each report was to see "how the projected overall surplus or deficit compared with that which was included in the original budget" ({Government Analyst}). It was felt that future services would be prejudiced by actual surpluses being lower than were budgeted, or actual deficits being higher than were budgeted.

While the concern over surpluses or deficits "continued to feature strongly in the monitoring process in 1992-93, the focus on the balance sheet became almost as strong" ({Government Analyst}). This was to ensure that "the Crown's investment" in hospital organisations was "protected" in the changeover from area health boards to Crown health enterprises due at the end of the year. Thus, the focus changed towards "ownership matters" and towards considering future implications by "doing year on year assessments."

"Fiscal Risk" and "Value for Money"

{Ministry Official}, who was on some of the contracting teams before they were disbanded, indicated that he and his colleagues had two concerns about each hospital organisation:

> The primary one is that, once having appropriated and allocated money to a board, the board will stay within that fiscal cap, and also as far as possible will not run down its balance sheet or damage it in other ways. . . . The Department are concerned to preserve government's fiscal risk and its ownership of the board entities. The second level is one of deducing whether the government is actually getting value for money from what money it is spending.

{Ministry Official} explained that by spending the money it had been given on healthcare, staying within its cap, and maintaining its capital and not running down its balance sheet, a hospital organisation was using only the money available for current spending. Thus, it was not prejudicing future access by overspending and depriving the future of the capital base which the organisation would need. He saw fiscal risk as being addressed adequately by the monitoring process in that if an organisation was overspending and using up its capital, this would be signalled by the data in its monthly reports.

{Ministry Official} explained that, by contrast, these reports were not adequate to address the value for money area which broadly speaking was about how an organisation spent its money allocation and the value obtained from the outputs. All the interviewees indicated that this area was widely recognised as a very difficult one, and the hospital organisations' reporting systems were inadequate for this purpose. They encountered difficulties of output and service definition, and the tradition that care of any kind was good and costs did not matter. {RHA Official R} referred to this tradition as the health service's "motherhood" philosophy of looking after everything as it arose. He felt that while such a tradition was "all very fine," it had been accompanied by the difficulty of being unable to "state precise long term intentions or to quantify things." He also pointed out that the new Crown health enterprises would inevitably inherit this tradition.

Despite these and other difficulties, it was generally felt by the interviewees that there was great scope for improvement, and this included finding better ways of relating costs to procedures, and recognising capital costs rather than just current expenditures in measuring current costs. Recalling past experiences in the health service, some interviewees indicated that there had been a tendency for many direct costs and overheads not to be devolved to what were now responsibility centres. Thus many internal support services and external services were free at their point of use. In the meantime, much effort had been put into changing this situation. Internal charging and the breaking up of "huge overhead buckets" ({Ministry Official}) were key parts of this effort, and were still being implemented.

The two broad purposes which interviewees identified for this more elaborate cost information were pricing and reducing costs by changing behaviour. In regard to the latter, {Ministry Official} indicated that while people in hospitals did not have much discretion over which patients to admit, particularly in the area of acute admissions, they had some discretion over how to treat them, and the way treatment was provided. He indicated that there were huge variations in treatment protocols between clinicians, and from hospital to hospital. Different decisions were made in different places about similar circumstances or situations. This gave rise to variations in how patients were cared for, what testing was carried out and how, what drugs were prescribed and how they were dispensed, and how services in general were organised. These choices affected the costs involved, or, put another way, variations in procedures had different cost consequences. All interviewees expressed the hope that a combination of relevant data about costs, and a collection of personal and patient benefit incentives, might induce changes in behaviour leading to better value for the money being spent. But they did not think that using these data would entail operating people having to have a great deal of accounting knowledge.

{Ministry Official} and {Government Analyst} perceived that changes in focus, and the development of the output side, had started to affect people at hospital organisations. Their senior managers were learning to manage for the longer term, and by 1993 had

probably extended their horizons three years or more ahead. But before this could happen, these people and people at the Department had "to put in a large amount of effort" ({Ministry Official}) so that the data in the reports "improved", and the reports reached the Department "promptly" after the end of every month. At first, reports were received a month or six weeks later than the 10 days which became the norm, and they were totally retrospective. {Ministry Official} thought that the improvements which occurred in these reports also had an impact within organisations because internal reporting became more timely and the data were of better quality. But better data did not necessarily remove some risks, such as a hospital having to deal with an unexpected and particularly expensive care episode. Another risk stemmed from healthcare activities being dynamic. A sudden treatment breakthrough could change not only its frequency and costs, but its very nature from being surgical to becoming medical. These events usually occurred out of sight of managers and accountants and meant that their data were "perpetually behind the times."

Annual Reports

The year end for 1992-93 had not been reached when the interviews took place, and so {Government Analyst} described what happened at the ends of previous years. For 1991-92, monitoring based on the monthly reports continued until the reports for June 1992 were received, in July 1992. These last reports in the monthly monitoring routine were followed by audited annual reports from each hospital organisation some time later. The analysts used the annual reports to check the data which they obtained in July. If the two reports differed significantly, an explanation was sought from the organisation. Generally, these annual reports did not add much to what was known already. Even so, the analysts prepared a report for the Minister on the annual report's information.

One of the problems with the 1991-92 annual reports was that on the whole they were very late, and this seemed to apply to annual reports in general. Only 4 of the 14 hospital organisations' 1991-92 reports had been received by the analysts by February 1993. This state of affairs was attributed partly "to preparation and audit hold-ups" ({Government Analyst}). It was thought that these were due to those responsible for producing the reports having to feel their way in the new accrual accounting regime and

to contend with poor accounting systems. In addition, it was thought that reporting work had been given a low priority in the 1993 reorganisation, and there were no statutory time limits applying to the publication of reports. {Auditor R} related that some lateness of the 1991-92 reports was because people wished to ensure that their organisations' balance sheets were "reasonably accurate", particularly in relation to asset valuations[4]. This was attributed by {Auditor R} to expectations among these people of running the new Crown health enterprises which would inherit these assets. In their new circumstances, they expected to be judged on the basis of return on assets, and so were keen that balance sheets did not show these assets with too high a valuation. In particular, {RHA Official R} stressed the importance to senior managers of Crown health enterprises of inheriting assets valued on the basis of use and value to the business, rather than on the basis of their full capacity or replacing that capacity. He referred specifically to general hospitals often being too large compared with their existing use.

Outstanding Problems in 1993

Despite feeling that progress and improvements were embodied in all of the above, {Ministry Official} and {Government Analyst} were conscious in 1992-93 that much was still problematic with the contracting and monitoring processes, and with hospital organisations' accounting systems whence much of the data originated. However, by then these processes were giving way to alternative ones under the Crown health enterprise-regional health authority. Far from seeing these developments as overtaken by events, the interviewees had hopes that this new set up would help overcome some of the outstanding problems. Two of these problems are discussed below.

Poor Accounting Systems

Four interviewees (all except {Central HQ PA}) frequently encountered data from more than one hospital organisation's general ledger system. They related that while these data were easy to obtain, they varied considerably between being "extremely good to atrocious" ({RHA Official R}). Some of the problems were attributed to too much

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[4] Similar circumstances arose in relation to finalising the 1992-93 reports (see Controller and Auditor-General, 1994, pp. 37-42).

centralisation of systems like the general ledger, payroll, accounts payable and stores. They were thought to be more to do with people than technical accounting matters. It was also known that people on the wards and at other operating levels found timeliness of the data from these systems a big problem. Data about patient volumes and mix were also suspect (e.g., {RHA Official R} recalled instances of male patients appearing in data relating to a gynaecology department). Many of the data problems were attributed to poor accountability for the systems themselves, and the traditional low priority accorded their development by management, as well as by some other staff[5]. Poor accounting systems were seen as contributing to the poor financial performance of some hospital organisations. However, these organisations usually had a "constellation of difficulties and poor data and slow reporting were just symptomatic of other more general problems" ({Ministry Official}).

Funding-Output Paradoxes

According to the interviewees, a paradox existed between funding goals vis-à-vis output goals, because contracts were based on fixed budgets. Inevitably, fluctuations occurred from month to month and year to year in the quantity and mix of services supplied by organisations compared with forecasts. These fluctuations accorded with hospitals not being able for the most part to select their patients. Moreover, money was paid to hospital organisations on the basis of their approved spending allocations, regardless of whether output performances were "good or bad" (i.e., in the sense of being up or down on those specified in contracts). In particular, if an organisation was "beating its output targets and was overspending as a result" ({Government Analyst}) this was seen as a dilemma for the Department.

Moreover, this was happening because acute outputs were increasing. Some of this increase was because more types of service were made available by doctors (and other health professionals) because of advances in their knowledge and skills. As a result of the increase in acutes, some elective surgery was squeezed out and waiting lists increased. Furthermore, advances in knowledge relating to elective cases caused more

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5 This point was made by Hospital and Related Services Taskforce (1988) (see p. 50 of this thesis).

people to queue to obtain the benefit of these advances. In any case, no more money had been available to reward the additional effort being put in by hospitals which responded to these increases.

The Hospital Enterprise Period

The interviewees discussed several matters pertinent to the 1993 reorganisation. All of them stressed that costs and quality would be critical to the survival of the new hospital organisations, and that data about both would also be critical. {Ministry Official}, {Government Analyst} and {RHA Official R} linked these sentiments to the way the organisations would obtain money under contracts with regional health authorities. These contracts were due to replace those between hospital organisations and the Department of Health in time for the 1993-94 financial year. In addition, the Department would cease to monitor the hospital organisations, but under its new name, the Ministry of Health, it would fund and monitor the regional health authorities[6]. In turn, these authorities would monitor their contracts with hospital organisations and other providers, but entirely from a purchaser's perspective. The task of monitoring hospital organisations from an ownership perspective would fall to a new body, since named the Crown Company [Monitoring Advisory] Unit.

Changes to Basis of Contracts

It was expected that the basis of hospital organisations' contracts would change eventually from that described earlier (see pp. 168-171) to one of specified services purchased at specified prices. According to {Ministry Official}, {Government Analyst} and {RHA Official R}, the government was keen that hospital organisations be paid on a case by case basis, and this would also be attractive to the organisations themselves. But in order to limit "fiscal risk" and deter hospitals from "drumming up" business simply to maximise revenue, volume limits were essential. Though these three interviewees agreed that this change would occur, they differed over how quickly it

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[6] {Ministry Official} explained that this funding would be negotiated with each authority around the demographic characteristics of their regions and the health needs inherent in these characteristics (i.e., a population-based funding formula). Also, a framework for monitoring regional health authorities was published in 1993 (Department of Health, 1993b).

would be completed; five years was the most optimistic forecast. It was expected that for 1993-94, most existing contract arrangements and funding would have to be rolled over from 1992-93 into the hospitals and other facilities which would make up each new organisation[7]. The reason given was that hospital organisations were not in a position to price their services because they lacked the costing structures and systems. The hospital organisations were set to inherit the problems area health boards had had in the form of old but changing structures, and old but changing systems. The systems in most organisations had been moving towards better cost data, but producing anything of the type required for pricing services was expected to take some time.

In contrast, one advantage the regional health authorities were expected to have compared with Crown health enterprises was that, as new organisations, they could start with new structures and new accounting systems. But their task of purchasing would not be helped by what the Crown health enterprises, the dominant providers, were capable of in the area of costing and pricing. In particular, rolling over funding on the existing basis would lessen the scope for letting contracts to private or alternative providers because of the difficulty in making price comparisons. It was expected that few private providers would initially emerge, but were likely to do so within a year or two in some specialities. Some Crown health enterprises might wish to expand at the expense of others, and again the regional health authorities' task would be difficult if price comparisons were not available from either or both competing parties.

In any case, it was thought that fundamental issues would arise over what regional health authorities would actually purchase, and about pricing, costing, quality and value for money. Specifying services was perceived as remarkably difficult from a contracting, costing or pricing perspective, and interviewees mentioned possibilities and problems associated with using DRGs, or similar classifications of diseases or cases, in order to provide definitions of cases for which prices could then be specified. {RHA

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7 From various anecdotal evidence in 1994, the researcher obtained a similar impression about 1994-95, despite a lot of talk about identifying and trying to count and cost diagnosis related groups [DRGs] (Fetter, Shin, Freeman, Averill & Thompson, 1980).

Official R} and {Ministry Official} believed it would take time to reduce these problems. However, when clearer definitions of case types acceptable to both hospital organisations and regional health authorities were established, it was anticipated that input costs could be traced to these to calculate cost data for pricing purposes.

Open and Close Ended Contracts

{RHA Official R} and {Ministry Official} also related that in regard to fiscal risk, should contracts be open-ended on a price per episode basis, admitting patients would not only be clinically advantageous under a care ethic, it would also be financially advantageous to the hospital organisation providing the service. But the regional health authorities as purchaser organisations would have a finite amount of money available. Their problem would be to limit payments to provider organisations, and such open-ended price per episode contracts would put them at risk. The interviewees thus surmised that in order to avoid this, regional health authorities would make most contracts close-ended financially.

{Ministry Official} and {RHA Official R} explained that there were two versions of financially close-ended contracts. The first were those in which a hospital organisation agreed to treat all-comers in a particular case type for a specified period in return for a set block fee. The second were those in which a hospital organisation agreed to handle patients of a particular case type up to a set volume limit during a specified period in return for a set price for each case or batch of cases. A variation on the second kind was one in which the price per case or batch was reduced as particular volumes were exceeded until finally nothing was paid for any cases beyond a specified limit. In either case, for health professionals, and the hospitals at which they were based, the limits inherent in these contracts meant adding to the already difficult task of deciding which patients to treat, and which not, because inevitably there would be case types for which demand would exceed the volume limits. Also, limits would leave regional health authorities with the predicament of patients beyond the limits not being treated unless additional funds could be found to pay for more at a set price, and this would also be of concern to the Ministry.

{Ministry Official} and {RHA Official R} pointed out that trying to negotiate contracts under which a provider treated all-comers for a fixed total fee would be attractive to regional health authorities. But it would lead to hospital organisations facing a dilemma similar to that arising from fixed budgets. That is, increasing outputs to accommodate demand would push up costs but would leave revenue the same. Only by switching the basis of payments between purchaser and provider to service outputs would this dilemma be ameliorated for the hospital organisations. But, if hospital organisations only treated cases up to the limit for which they were receiving payment, rather than the dilemma going away, it would shift to the regional health authority in the way described above.

Clinical Assessors

{Ministry Official} mentioned an alternative to the principle of regional health authorities setting limits for the number of admissions for which they would pay. This would entail these authorities appointing their own clinical assessors (or gatekeepers) to determine each admission for which payment would be made. He doubted, however, if the government would countenance such an approach. He thought that clinically it would be both impractical and unacceptable because traditionally, doctors authorised the admittance of patients. They also supervised the way diagnoses and treatments were carried out after admission. Appointing assessors would encroach on the clinical authority of hospital-based doctors to determine how to deal with their patients.

Efficiency and Costs

{Ministry Official} and {RHA Official R} pointed out that in the health system as a whole the basic problem remained: the quantity of money was finite regardless of how high outputs could go. The difference was that under the new system it would be more transparent than in the past. Indicators such as waiting lists would show that demand was exceeding supply of services and the money available to purchase more. This greater transparency was expected to prompt a debate on whether more money should be put into regional health authorities. Between them the interviewees alluded to some of this money coming from within the system through efficiency, cost savings and cost-effectiveness gains. They related that these had been occurring for some considerable time in the form of hospital closures, changes to configurations and staffing practices

on wards and other operating units (including flexible rostering and labour usage geared to demand rather than capacity), reduced lengths of stay for patients, and contracting out of non-core activities. The interviewees felt that not only would these gains continue, but that they would be an essential part of the way hospital organisations operated. The gains made would also have to reflect financially in the prices that were included in service contracts. Obtaining these contracts in the face of competitors would be crucial to the survival of hospital organisations. This latter argument was put forward in various forms by all of the interviewees, and implicit in it was a link between prices and costs. The interviewees expected that cost-based prices were likely to prevail until market prices could be established.

{RHA Official R} indicated that his regional health authority had told hospital organisations and other potential providers that they would not be permitted to contract unless they adopted its activity-based costing methodology, or had an acceptable alternative of their own. In either case, the methods used would need to survive a certification process conducted on the authority's behalf by a "big 6" accounting firm. He explained that this step had been taken because providers in general "have had no real experience of pricing." The authority wanted to determine "the comparative value for money which each cost-based price would represent," and to avoid contracting with providers "which get their sums so wrong that they become financially unstable." In particular, the authority did not want to enter into contracts based on prices calculated either deliberately along marginal costs lines, or which unwittingly or expediently took account of only the more obvious costs and left out those tied to long term viability. In addition, the authority wished to curtail any tendency for hospital organisations to cross-subsidise.

The Development of Costing Systems

In addition to their use for pricing, service/product costing data, along with data about the volumes of cases handled, were expected to influence the manner in which hospital organisations were managed. The interviewees expected competition for contracts to arise on the basis of different kinds of patients, and the carrying out of specific procedures or activities, rather than across the board on a geographical or similar basis.

{Ministry Official} and {RHA official R} opined that secondary hospital care was about "carrying out separate procedures" that make up individual cases. In order to win contracts, hospital organisations would have to be "efficient" in carrying out each of these procedures, as well as in combining them. {RHA Official} indicated that one of the initial tasks of regional health authorities was to set "boundaries of contestability," bearing in mind the impact of contestability on various existing and potential structures. Thus people at his authority were examining how, having broken treatments or other patient episodes into procedures, these could be synthesised into discrete products, such as radiology and pathology or laboratory services, which the authority could purchase from different providers as needed. In doing so, their aims were to make structures contestable, with different players in different locations competing to supply different products in related markets; and to encourage these players to be aware of actual and potential market share.

Controlling the costs of the inputs that were consumed by procedures, and controlling the consumption of procedures by cases, was seen generally as being vital. Consequently, detailed, accurate data about costs of procedures were seen as necessary throughout hospitals. However, {RHA Official R} differentiated between developing overall costing systems for "purely pricing purposes," and fully blown systems used throughout organisations for "detailed managerial purposes." He thought given hospital organisations' poor record on systems (e.g., RUS), that it would be better to concentrate on the use of such systems for "organisation-wide pricing" for the moment. More elaborate detailed costing systems could come later, if necessary, "when implementation problems among managers are ironed out."

{RHA Official R} ascribed the apparent failure of RUS to problems among managers rather than to software problems, and indicated that the hospital organisations of the late 1980s were not ready for it "culturally, organisationally or managerially." He thought that even in 1993 "many managers see costing systems as an accounting problem which they can leave with accountants." He thought they were something which should be of much greater concern since they entail "changing how a whole place works and how people act and are controlled." He indicated that these systems could cause even simple

things to change, such as "a nurse going down town to buy nappies" because the internal transfer prices charged by the linen service were too high. These apparently minor things could accumulate into a variety of unintended, perverse incentives. Until these behavioural implications were "appreciated by senior executives," then fully fledged case-mix costing, pricing and transfer pricing systems were unlikely to work. Introducing them would "reinforce the low integrity which clinicians ascribe to data from accounting systems, and the low opinion they have of accountants and managers."

{Ministry Official} and {RHA Official R} indicated that coding of cases and of expenditures were vital elements of case-mix systems whether they were used in relation to pricing, or were more fully fledged and used in management. They felt that coding required a clinical input that in the past had been generally lacking. Instead "poorly paid staff have been left to interpret discharge letters and other prime documents" ({RHA Official R}) in order to arrive at clinical codes. Understandably then, tests of existing patient classification systems in use in some hospitals had shown that there were major coding and related inaccuracies. The acquisition of systems which could provide well-structured and accurate volume/clinical data would be "a major step for many organisations." On the expenditure side also, the problems with general ledgers would need resolving and "just getting sensible general ledgers" would be a major advance. In combination, these steps could provide "building blocks" for developing more sophisticated case-mix systems.

It was expected that while many cases would be subject to competition, there would be some in which competition was unlikely. This would arise because of a combination of high tech, high cost facilities and equipment, and sporadic or limited use of them. It was anticipated that facilities and equipment already in existence would be rationalised on economic grounds, whereas in the past there had tended to be an overabundance of some of them as one hospital, organisation or city attempted to keep up with another for prestige-related or other symbolic reasons. Once rationalisation had taken place some monopoly situations were likely to occur in relation to these facilities and cases. {Ministry Official} and {RHA Official R} anticipated that regional health authorities would need to be wary of these potential monopoly services being over-priced and used

to make excess profits by the hospital organisation which enjoyed the monopoly. These profits could also be used to cross-subsidise its other service areas in order to ward off competition there.

Service Quality

The interviewees also thought that regional health authorities would need to resolve the question of measuring and evaluating quality. {RHA Official R} indicated that the people at his authority were giving thought to a clinical audit process that should be an integral part of contracts. This process would start before contracts were let through what he dubbed "due diligence procedures". An evaluation would be made of a potential provider's clinical quality, including "its back-up and support systems," alongside its commercial and financial viability. The composition and extent of these procedures would vary according to what the authority already knew about a potential provider. In the case of Crown health enterprises, this knowledge would be more extensive than for a new private provider. Even so, the authority would want to ensure that peer review processes were in place and working alongside other more quantitative measures of quality, such as waiting list management, customer surveys, informed consent procedures and complaints procedures. Other aspects of the due diligence procedure were that a hospital organisation would develop "its ability to plan long-term and to think strategically," whereas under the area health board system these abilities had barely developed. This was especially so in the financial planning area which had been "dominated by the mentality of annual budgeting."

{RHA Official R} related that standards of peer review, quality and planning were expected to be written into contracts. These standards would include a basic level at which such things should start, and improvements which the authority would want to see from year to year. The authority's contracts would also include monetary incentives and penalties based around things which providers could control, and which add value and quality and reduce waiting times. The criteria around which incentives were based would exclude such things as holding people in hospital organisations answerable for the number of births occurring in some defined geographical or other area, "but would include how the births are dealt with."

The Effects on Doctors

A key group of people affected by the changes outlined above were expected to be doctors. This group was seen as comprising very dedicated people who had high standards. Even so, it was anticipated that the purchaser-provider arrangement would require an alteration in attitude from them. In particular, {RHA Official} thought that as individuals and teams, "they should expect to be accountable or they were likely to be without work." The reforms would mean significant changes to their work patterns and work distribution, as well as to everyone else's in hospital organisations, rather than a mere "shifting of the deck chairs [on the Titanic]." However, some changes would leave clinicians in dilemmas professionally, and it was felt that they should not have to cope with these dilemmas when in fact they were managerial or political choices. It was suggested that this could be done by establishing a barrier between clinicians providing care, and management actions and decisions.

Reporting and Evaluation

{Ministry Official} expected the reforms would, "rev up people's ideas in that they are going to be more vulnerable over their performance, and also they are going to be rewarded for behaving better." The structure was expected to separate out the responsibility of ownership of hospitals and related assets from the responsibility of purchasing healthcare on behalf of patients. The interviewees thought that in the area health period these often conflicting functions were a cause of tension within the Department and probably in the hospital organisations as well. In the hospital enterprise period they expected the Ministry to continue its interest in the purchasing side through its funding relationship with regional health authorities. These authorities would be monitored by the Ministry on a basis that was expected to include various financial and health performance indicators, and to use inter-authority comparisons as a method for evaluating the indicators.

{RHA Official R} related that the Ministry seemed keen to compare prices of similar services being obtained by each authority from various contractors. He pointed out that this would be difficult because the four authorities being established in 1993 seemed to take separate and different approaches to basic things relating to contracts, including

service definitions and pricing. The Ministry's monitoring of regional health authorities was also expected to embrace the idea of fiscal risk in a similar manner to that with which the Department monitored the hospital organisations in the pre-1993 era. Contracting terms, the existence of monopolies, and the number of contracts let through open tendering were also expected to interest the Ministry.

{RHA Official R} related that regional health authorities expected to have to report on their activities and performance under the Public Finance Act of 1989. This would make reporting more timely because of the statutory limits on publishing reports, and, as a result, better reporting was expected to occur. The regional health authorities would have to decide how much detail they intended to reveal in public documents like annual reports about their service contracts with various health providers. Coupled with this was the question of reporting on the quality of services purchased. He explained that performance measures used in annual reports of hospital organisations in the period up to 1993, and for managerial purposes within these organisations, had tended to omit quality and focus on quantity and efficiency.

{Ministry Official} and {RHA Official R} expected the Ministry's relationship with Crown health enterprises to be less bureaucratic and more at arm's length, than it had been with the area health boards. These new style hospital organisations would be monitored by the Crown Company Unit from an ownership, efficiency and successful business perspective. The information which this unit would demand of hospital organisations was expected to relate to quality, customer satisfaction, image, operational matters, financial matters, contracts and audit[8]. {RHA Official R} related that a practical approach was being taken to determine the set of information initially required in that whatever useful information was already there or easily obtainable should be of use; and information that did not come under this description should be temporarily forgotten. Among the dilemmas to be resolved was the extent to which enterprises would report their costs to the monitoring unit, because organisations would be

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[8] The basis of monitoring was announced a few months after the interview in Department of the Prime Minister and Cabinet (1993).

competing with one another and these cost data would be commercially sensitive information.

All the interviewees thought that from a public perspective hospital organisations' annual reports would be more important than in the past because they might be the only public information available. But to what extent hospital organisations would want to publish information about services, service costs, and service contracts in their annual reports or in similar documents, or the extent they would have to, remained to be seen. Senior managers were likely to ask how much they could afford to publish in the new competitive environment, and anything commercially sensitive, such as cost of services statements, was seen as "doomed" by {RHA Official R}. As with regional health authorities, the whole question of how much to publish about contracts, and contract prices and volumes, was "likely to be a tricky one." Organisations would probably prefer to publish the minimum required by statute and regulation, because of the interest of potential competitors and of regional health authorities as purchasers. {RHA Official R} pointed out, it was not usual in business for sellers to publish details of prices, nor for them to be able to find their competitors' prices without having to resort to some subterfuge. It was thought that the bare minimum to be published would be a profit and loss account, a balance sheet including details of capital structure and gearing, and a cash flow statement. Anything more would have to be "prised out" by specific statute and statutory regulation.

{RHA Official R} also pointed out that given their specific contract relations with hospital organisations, it was not expected that regional health authorities would rely on annual reports or similar published documents for information about these organisations. In order to ensure that the people at his authority "got everything" they would add a right to certain specified information into contracts with providers. Much information would be required on a frequent and timely basis about whether an organisation was "performing to contract including in the areas of quality, prices, financial viability and long term planning capability." Signs of sustainable major cost and productivity improvements would also be sought, and "a dim view" would be taken of short term expenditure deferments that would prejudice long term sustainability. There was

expected to be some overlap with the information that the Crown Company Unit would demand.

Service Developments

There was some speculation among the interviewees about how hospital organisations would fare in the future. It was expected that the location of some services would change. For example, general practitioners might take some minor surgery away from hospitals; and some primary care services might be taken on by hospitals. It was also expected that new organisations would enter certain service markets within the first two years, and that after that entering and exiting markets would be normal occurrences. {RHA Official R} related that these aspects would be monitored by regional health authorities in order that, as "providers in the last resort," Crown health enterprises would not be faced with additional costs from first losing contracts and being obliged to incur exit costs, and then regaining contracts after the withdrawal of a new contractor and incurring start up costs.

Overall, it was felt that in the face of more competition and the loss of a public sector monopoly, Crown health enterprises would handle less work, or at least would lose some of their market share, simply because more players would be involved in providing services. The people running hospital organisations, and particularly their senior managers, would need to be aware of this development and to evaluate how it would affect their revenue streams, especially as the market developed and new market entrants became established. Reductions in the capacity of hospitals and similar facilities were expected to be necessary for the foreseeable future, and implementing these would be a key factor in whether individual organisations survived as successful businesses.

Interviewees in the Community

There were seven interviewees who were in the community outside of the system and units depicted in the functions and values framework. All were visited because they received the annual report issued from SITE R (see Table 4.3). The three journalists and {Nurse Educator R} were female; the other three ({Voluntary Body Official}, {Union Official R} and {CEO Local Council R}) were male. All were located in

provincial cities and towns, and two were in the same city as the main base hospital associated with SITE R.

The job titles of the interviewees varied, as did the names and natures of the organisations in which they were employed. Apart from remembering that they had received an annual report when it was shown to them by the researcher[9], they had in common an interest in particular aspects of the SITE R hospital organisation in particular, and/or hospitals and the health system in general. These aspects related to services provided either to individuals or to communities or both, and to the effects of health system changes on services and staff.

A Local Council Official

{CEO Local Council R} was visited in his modern, well-appointed office which overlooked a base hospital. He related that:

> at the political level especially, the council is very involved and interested in what gets done in the district and its communities. . . .
>
> One scene in which this is exercised is the health scene, and at present the health reforms are of interest to the council.

He explained that a primary reason for this was that the mayor was commissioner of the SITE R area health board and had also been appointed to the board of the new SITE R Crown health enterprise. He explained that the base hospital had been the centre of a hospital board merged into SITE R. He thought that on balance:

> [at the time] people did not like the idea of going into something bigger and feared that there would be a loss of autonomy and maybe a loss of services. Probably some of that lingers today and the latest reforms have raised new fears. . . . most [of these new fears] are probably at the level of the several local communities in the area. ({CEO Local Council R})

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[9] Some could not remember what they had done with the report they received some 12 months earlier, and some were not sure what the researcher had meant by the annual report but had assembled several other health related documents in readiness for his visit.

He reported that one community, "probably anticipating undesirable changes to its small local hospital, has applied successfully to set up a community trust" ({CEO Local Council R}).

{CEO Local Council R} remembered skimming through the SITE R annual report, but did not see it "figuring in the overview concerns of the council." Information relevant to this scene "tends to happen so quickly and comes from the political level, and it is also at this level that the council usually reacts." He also related that sporadically the council received representations from people in the community wanting it to do something about health services. These were usually handled politically including organising public meetings or making the councils views known to the hospital organisation. He also opined that:

> [as far as] finding out about what dollars are being spent by the [hospital organisation], the council probably does not feel it has a lot of interest or say in the matter other than being interested in whether the district is getting its services here.

A Nurse Educator

{Nurse Educator R} indicated that her department was "intimately connected with nursing practice. . . . Most of the students work as registered nurses." Commenting on the direction of nursing she related that:

> over recent years there has been a move away from the notion of a patient as merely a biomedical problem to the wholistic theme of the complex patient. Meanwhile, the nursing profession has become more of an independent one among several interdependent professions, rather than playing a traditional and merely ancillary role.

{Nurse Educator R} also referred to the:

> considerable change that has taken place in the last few years in the role of charge nurses. In particular, whereas financial management used to be done at the centre such that nurses did what was required to be done and someone else worked out how it would be paid for, nowadays much more of this is the

> responsibility of the charge nurse. The charge nurse now has much more responsibility for managing the ward [or similar unit], and with this goes much more accountability. This change in roles has been brought in quickly and has given rise to a conflict between two value systems, one to do with care and the other to do with how it is appropriate to spend money.

{Nurse Educator R} thought that overall annual reports were quite important documents, but that the coverage given to nursing was superficial. For example, " a picture of a nurse with a high-tech machine looks good, [but] that is not what nursing is about really." She added that one would become more aware of the importance of annual reports in their absence, and that it would concern her if they did not appear. She also hoped that future reports would be more informative rather than persuasive and promotional.

{Nurse Educator R} was hopeful about the future, and did not want to see things return to the way they were before the reforms, or to repeat the change process again. She also thought that "a lot of the changes have been wasteful in human resource terms and a lot of rebuilding is needed because of the amount of expertise that has been lost."

A Trade Union Official

{Union Official R} headed the health division of his union which represented orderlies, kitchen staff and cleaning staff working at SITE R and other hospital organisations in the region, including those running private hospitals. These staff were either employees of the hospital organisations or of contractors which had been awarded hospital work. Employees of the latter used to be employed directly by the hospital organisations. {Union Official R} pointed out that unions had a wider brief than just representing their members. "Essentially the system is people and people's health, and people delivering that health. . . . Historically the unions' campaign has been to save public health in order to look after the interests of people, and to look after the carers."

{Union Official R} had studied the history of the health service and had traced the setting up of hospital boards to "the need to have free and accessible healthcare." These

organisations had grown as a result of government pouring money into them during a period when the country was relatively affluent. "The boards were basically run by doctors, and as long as people could go in and out of hospitals as necessary and the facilities were kept up with the times, there was general satisfaction with the way they were run." He thought that the "beginning of the decline" of the system "started to happen under Muldoon in the early 1980s." He related that eventually the need arose for government to stop the increase in spending on health, which "in any case had got out of hand" through managers acting irresponsibly to increase funding. The government tried to do this by creating area health boards. But previous managers, instead of "carrying the can", were given new jobs and titles in the new system.

{Union Official R} agreed with the Minister (of 1993, Simon Upton) that "just putting more money into the health system will not lead to a better service," but he also believed that "neither will what the present Minister is doing." In 1991, "the elected people were done away with leaving only people appointed by the Minister in charge." Furthermore, the system was becoming such that "people's choices are being reduced and the perception of most people is that they are receiving less in the way of healthcare." He thought that the setting up of regional health authorities was an attempt by government "to remove itself because health is politically sensitive." Also, he thought that accountability mechanisms in the form of "checks and balances in the system" were being removed, and that as healthcare became more costly to the individual so "a rich and a poor system" would emerge.

{Union Official R} indicated that managers running hospitals "in the way now required", had provoked "an equal reaction amongst the staff." He thought that:

> a lot of the goodwill has been lost over the years and as staff are the key to the delivery of health this has affected the service. . . . While it is true that the staff did need to pick up their act and to work harder, along the line somewhere the managers missed the train. . . . the experience of the staff is contrary to the ethic of New Zealand that if you work harder you get rewarded more in that though productivity in the [hospital organisation] has risen 15%, pay has gone down. . . . The unions are no longer arguing to save public health, or to promote health

> values. . . . The managers call the tune at the moment and confrontation seems to be the mood. [The staff are] being rapidly driven into the traditional style of unionism.

{Union Official R} added that:

> today's environment makes it hard which does not encourage cooperation at the workplace. Instead it encourages confrontation and this bodes poorly for health. The employer sees staff as a huge liability rather than the number one resource or asset.

A Voluntary Body Official

{Voluntary Body Official} was a branch manager of a national organisation. The branch provided residential and vocational day services for people registered with it, and also some home support and social work services. Before joining his organisation he worked at a hospital connected with SITE R.

{Voluntary Body Official} indicated that he did not see the branch "as an organisation as such; rather it is 60 people living together . . . who view hospitals and hospital care in the same way any private individual would." But he also pointed out that a number of these people used some particular hospital facilities a lot and "if [these facilities] face any funding issues that may affect the needs of these people, then the people associated with the branch would be interested."

{Voluntary Body Official} did have some interest in annual reports, but more those of the Department of Social Welfare and of his own organisation, than the annual report of SITE R. This was because he was more dependent on the first two organisations for funding and other matters. In any case, because of his own branch planning he was more interested in forward planning documents than in reports about the past. In the future he expected to take more interest in the plans and reports of the regional health authorities, because they might become a source of local funding, than of Crown health enterprises. He saw the establishment of regional health authorities as "a positive move" as he expected their focus "will be on health and wellness. This contrasts with the

vision of sickness which many people have fixed in their head when they think of hospital boards."

Three Journalists on the Health Round

A Small Town Paper

{Journalist RTR} and {Journalist RTS} worked on a paper which appeared three days a week in a town and its environs. The paper "concentrated on the community" and the stories used had to have a "local angle"; it was aimed at all age groups, though the town's population was biased towards the elderly. Both had at one stage held the "health round" concurrent with 7 other "rounds", and both had found health to be the area which generated the most stories and the most interest from readers. For example, "the paper recently ran a reader survey on what the community considered were the basic core health services and there was an incredible response to that" ({Journalist RTS}).

The stories generated on the health round varied in nature but tended to be about local services and about people. {Journalist RTR} explained that:

> the local hospital is one of the things of interest because of its significance to the paper's readers. There is a great deal of local concern and uncertainty about its future including what services it will provide, and so plans affecting it or data about it are of particular interest. The local perception is of budgets, funding, spending, resources and facilities at the hospital being cut heavily. It is seen as a very efficiently run hospital. . . . People are concerned about how the latest change is affecting services particularly as many people are relatively old. A community action group has been formed and it has about 800 members. There is public concern about more people having to travel to [cities 50 and 120 kilometres away] for services that are no longer going to be provided locally if parts of the hospital and other existing facilities are closed down. This group was formed to fight changes to the hospital and it has the backing of the hospital manager.

{Journalist RTR} also indicated that the financial component of many stories "is not very great. The kind of financial thing that makes a story tends to be about a cut in expenditure or trying to do the same job with less money. . . . Also, user charging is an issue."

Until the interview {Journalist RTR} was unaware of annual reports of hospital organisations (she was new to the job, having joined the paper after completing her formal education, and the health area was also new to her). {Journalist RTS} (the reporter on health before {Journalist RTR}) was familiar with these reports along with other official documents. Her main interest in all these had been information with "a service and local geographical orientation and a planning or future orientation. . . . The goals and strategic plan narratives have been useful in generating stories, . . . [but] there is no point in putting the balance sheet in the paper."

{Journalist RTR} indicated that she was "being bombarded with core health stuff. . . . It is not unusual to receive four or five envelopes full of material each week much of it sent in duplicate." Also, the two indicated that press releases from the SITE R hospital organisation had been common, but these had "dried up" recently and the meetings of the new Crown health enterprise board were closed to the public. But even if they were open {Journalist RTR} doubted if she could find time to attend. In any case, she had established a relationship with the local member on the Crown health enterprise board, who was an accountant and on his own admission knew very little about health either (he had told her that he had only been to a hospital twice in his life, both times when his children were born). They had got together to learn about health and try to figure out some of the issues.

A Regional Paper

{Journalist RHR} worked on an evening daily newspaper published in the city in which SITE R was located. Until a few weeks before the interview her sole responsibility had been the health round. The stories used by the paper were a combination of local, national and international. Health stories tended to appear daily and originated from doctors, the Department of Health, national and community groups, the Press

Association, and other newspaper and media sources. Also, "there were stories about people and about research." The stories prepared by the reporter were of "a local nature, and some but not all were things to do with [SITE R]."

{Journalist RHR}'s main interest was "the likely effect on readers of what was going on, and so a lot of stories were to do with services and concrete things rather than other things." The stories which seemed to generate the most public interest were those about "services and changes to services, and user part charges." Finance came into her work, but "not a great deal." She had tended to report on "things like budget overruns or underruns and whether the board was within its budget for the year. And on cost cutting in a ward or hospital and the effects on services or in terms of job losses." Things that were "not perceived as affecting people directly" did not attract much reaction from readers.

{Journalist RHR} used to attend meetings of the SITE R board, which were held almost weekly until the elected board was abolished in 1991. These regular meetings provided access to information not only about items on the agenda, but about matters mentioned during discussions. These included "projects, developments in the hospitals and anything to do with services. . . . Once the meetings stopped, information about the board was less easy to come by," and she had to rely on "contacts in the [hospital organisation] and matters brought to my attention in other ways." She did not use anything out of the 1990-91 annual report (which was still the most recent in January 1993) "because it came out six months after the time it dealt with and so in terms of news it was pretty old hat." In any case during the time to which it related, {Journalist RHR} was able to attend board meetings and "used to get monthly progress reports on the financial position." The main hospital published its own quarterly review which provided information on how many people were on waiting lists. After the elected board meetings stopped "and everything was changed around", she "was not issued with any financial reports at all."

{Journalist RHR}'s overall impression was that "the trend in the [Crown health enterprise] of giving less information is indicative of the adoption of the businesslike

practice of not giving anything out." She thought that documents like annual reports were "pretty important otherwise people will not know what is happening with money and things like that." She also thought that "the downgrading of public input and consultation to the way the service is run is a real worry."

Closing Pointers

In this chapter a thick description is drawn from the within-case analyses of the interviewees located at the central authority level of the hospital system, and of those in the community with an interest in the health and hospital systems. This description encompasses aspects (i.e., intentions, motives, meanings, work context, situations, and circumstances of action) corresponding to those dealt with in chapters 5 and 6 in relation to people at the other levels of the system. It also provides some historical perspectives of macro-matters, including tracing how the central authority level has changed in response to demands from other parts of government in New Zealand. This builds on and elaborates some of the changes outlined in chapters 2 and 3, including more detailed perspectives on the second iteration of structural changes.

The concerns at central authority level are unmistakably macro and relate to resource allocation and finance. These concerns are imparted across the system through contracting and monitoring mechanisms associated with spending, balance sheet items and activity levels. They contrast markedly with the micro and service concerns not only of people in the operating core and support services, but also of the interviewees in the community. The description pertaining to the latter contains a certain amount of exasperation and trepidation, along with hope and reflection. While the central authority interviewees grapple with resource allocation and funding issues, and with new systems and processes, the people in the community are concerned about the radical, government led reforms, including how services will change and how patients, staff and communities will be affected by the choices being made by whoever is making decisions.

This chapter and the previous two form the basis for the next chapter in which matters of orientation, control and resources are analysed to show cross-sectional differences between the central authority level and elements in other levels in the hospital system;

and to show longitudinal differences within these levels. Similarly, matters of task and resource interdependence and answerability are drawn out to show relationships between elements and levels. In addition, matters to do with the situated practice of accounting, including budgets and answerability for spending, are further thickly described and interpreted in chapters 9 to 11.

CHAPTER EIGHT
THE CONTEXT IN WHICH ACCOUNTING FUNCTIONS WITHIN HOSPITAL ORGANISATIONS AND THE HOSPITAL SYSTEM

This chapter presents a thick interpretation which takes the reader to the heart of the processes and interactions thickly described in chapters 5 to 7. The interpretation illuminates and promotes understanding of the hospital organisation and hospital system context of accounting. This is done by examining each element in the functions and values framework and the relationships between these elements.

Introduction

"It is proper to devote a portion of one's report to conjectured causes of variations so long as one clearly labels his conjectures, hypotheses or theories as being that" (Lofland quoted by Patton, p. 491). This chapter comprises some of these conjectures, including the author's "opinions and speculations, after he has struggled with the data" (p. 431).[1]. Its purpose is to bring about illumination and understanding of the hospital organisation and hospital system context of accounting processes and outcomes; and to facilitate extrapolation about the future of this context (Patton, 1990).

The contents of the chapter are derived from probing the thick descriptions in chapters 5, 6 and 7, other data from interviewees and published literature (see Eisenhardt, 1989, and Patton, 1990, on this stratagem). The contents are cross-sectional in that they consist of contextual aspects about people in the hospital system; and longitudinal in that they reveal changes in these aspects over several years. The chapter is in six sections. The first one outlines the way in which the interpretation is presented. The next four

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[1] It is recognised that the matters covered in this chapter are not "equally important or credible" (Patton, 1990, p. 431). The author was again faced with "the agony of omitting" (Lofland cited in Patton, 1990, p. 429). Despite the amount of material included in chapters 5, 6 and 7, much had to be omitted from these chapters (see pp. 35-36 of this thesis). Even so, to attempt to interpret every aspect included would detract from the focus of the Study, and so this chapter focuses on examining the heart of the processes and interactions (Denzin, 1989a).

interpret the intentions, motives, meanings, work context, situations, and circumstances of action (Denzin, 1989a, 1989b) of people in the operating core and support services, the institution level (or management zone), the central authority level, and the community, respectively. Particular note has been made in these four sections of the processes and interactions through which accounting is manifested within and between levels. This provides a foundation for the thick description of the situated practice of accounting within hospitals appearing in the next two chapters. The last section comprises a short note on the functions and values framework.

Focal Points of the Interpretation

Two sets of focal points are used to present the interpretations in the next four sections. The first comprises three characteristics induced from the within-case analyses which go to the heart of the functions and values of people within each element set out in the framework (see Figure 4.3); and the second comprises three features induced from relationships between these elements which are relevant at this stage of the analysis.

Characteristics Within Elements

The first characteristic, which will be referred to as *orientation*, refers to the direction, motivation and order of priorities derived from the beliefs, values, surroundings and/or circumstances of the people within an element. For example, individual doctors might be said to have an orientation in which diagnosing and treating individual patients are emphasised above all else. The second characteristic, which will be referred to as *control*, refers to the way controls are administered in relation to an element and whence the direction for controls derive (Dalton & Lawrence cited in Anthony & Young, 1988, p. 666). For example, individual staff in non-clinical support service departments might be said to be subject to controls administered by the departments' managers and supervisors in a mechanistic fashion. And the third, referred to as *resources*, refers to the source of the element's resources, be they inputs into an activity (e.g., a person's expertise exercised over time, materials, use of facilities), or money and/or the power to purchase. For example, wards might be said to depend for resources on allocations made to them through ward budgets.

Features Between Elements

The first feature, which will be referred to as *task interdependence*, refers to the way in which the tasks performed in one element contribute to those performed by another element to form a relationship. For example, laundered linen derived from non-clinical support services is used on wards to provide clean beds. The second feature, which will be referred to as *resource interdependence*, refers to the way in which the resources in one element derive from the resources of another element to form a relationship. For example, ward budgets are conferred on wards from the service and hospital organisation managers at the institution level. And the third feature, which will be referred to as *basis of being answerable*, refers to the way in which the actions carried out in one element have to be answered or accounted for to people from another element to form a relationship. For example, the hospital organisation managers at the institution level might be said to be answerable to the central authorities for the state of the financial structure of their enterprises as disclosed on their balance sheets.

Longitudinal Considerations

It was apparent that the composition of most of the characteristics and features were changing during the Study. In order to chart these changes, time was divided into three periods. These periods might be labelled as pre-reform, area health and hospital enterprise. The dates of these periods are approximately pre-1988, 1988-1992, and after 1992[2], respectively. It should be noted that these periods began or ended at different times for those people in different elements. For example, in the central authorities, the end of the pre-reform period might be seen as early as 1984 when the Fourth Labour Government was elected (see pp. 246-249).

The manner of focusing the interpretation, notably the sets of characteristics and features, has some similarities with the ideas underlying the derivation of the model of Becher and Kogan (1980). The characteristic *orientation* corresponds with Becher and

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[2] It is recognised that the official order change to Crown health enterprises did not occur until July 1993. However, during his visits to interviewees in late 1992 and early 1993, it was apparent to the researcher that they were gearing up for and working in "hospital enterprise mode".

Kogan's intrinsic and extrinsic values in the normative mode (see Figure 4.2). Similarly, between them *control* and *resources* correspond to the operational mode functions and the links between the normative and operational modes; *task* and *resource interdependence* correspond to relationships between levels in the operational mode; and *basis of being answerable* corresponds to the judgments between levels in the normative mode.

An Analysis of the Operating Core and Support Service Levels

This section is divided into five subsections. The first four deal in turn with the characteristics within, and the features of the relationships between, the elements at the individual level and basic unit levels which correspond with one another (e.g., doctors and clinical departments, nurses and wards). In the fifth subsection, the features of the rest of the prominent relationships between these eight elements are outlined.

Doctors and Clinical Departments

The orientation of individual doctors was a micro one in the sense of helping each individual patient to get well again or achieve a satisfactory level of comfort (Ackroyd et al., 1989; W. R. Scott, 1982). Controls of individual doctors were both self-administered and administered informally by peer groups. The bases of these controls included professional medical training, experience with previous patients, reading of published literature and interaction with colleagues and other health professionals including nurses. Junior doctors were also being guided by treatment protocols established either informally or formally by their senior departmental colleagues.

The main resource of doctors was their own labour, much of it expended while in contact with patients. Once on the staff they could make use of their time, knowledge and skills at their own discretion within the confines of clinical freedom, peer review, duty rosters for their clinical departments and the norms of the working environment in their hospitals. They also determined whether a patient should be admitted and how he or she should be diagnosed and treated. These decisions had repercussions for other people in the hospital in the form of the use of ward accommodation, the carrying out of laboratory tests, the use of operating theatres, the administering of drugs, and the use

of similar facilities and services[3]. Consumption of these resources used to be triggered free of charge when a patient was admitted, but that was changing with the introduction of costing and pricing, and internal charging. The changes to selected characteristics of doctors are depicted in Figure 8.1A.

The orientation of clinical departments derived from that of individual doctors. It was centred on ensuring that individual patients were diagnosed and treated in accordance with accepted professional practices, although it had an element of the macro in the form of developing the specialty of the department. That macro-concern was driven by the likely needs of future individual patients, often irrespective of competing needs. Each department consisted of doctors who had different interests within the same specialty, and differing opinions about diagnoses and treatments. This was seen in the culture of the medical profession as a strength. Departments had a "loosely structured order" (Cox, 1991, p. 90), which was also characteristic of the hospitals which the doctors tended to control in the pre-reform period. By the area health period, being the head of a clinical department entailed providing some administrative coordination and representing the views of doctors in the department up to whatever level of the system was necessary (e.g., the service manager, the Minister).

Doctors were the main departmental resource, and the head of department ensured that there were enough doctors to cover the work. During the area health period, departments began to be given budgets by the hospital managers. These were regarded with disdain by doctors, both in the way they were put together and for what they were supposed to mean (see pp. 282-284). Except for the doctors' salaries and related employee costs, very few if any of the costs actually caused by the decisions of the doctors appeared in these budgets. Prospects for the hospital enterprise period included a quite tentative trend towards telling individual doctors and their departments about the costs the doctors were causing.

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[3] Estimates by Gibson, Waldo and Levit, and Wilensky and Rossiter, cited in Eisenberg (1986), put the costs of services prescribed by physicians (i.e., doctors) at "as much as 80% of expenditures for medical care" (p. 3).

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
ELEMENT	Individual Level: Doctors		
ORIENTATION	Diagnosing and treating their patients severally	Diagnosing and treating their patients severally	Diagnosing and treating their patients severally
CONTROL	Professional: self, peers, treatment protocols laid down by senior doctors for junior ones	Professional: self, peers, treatment protocols laid down by senior doctors for junior ones	Professional: self, peers, treatment protocols more formal, clinical audit. Managerial: patient numbers, cost profiles
RESOURCES	Free use of own labour, free hospital facilities	Relatively free use of own labour, free hospital facilities for the most part, but some ad hoc questioning of, say, the need for lab tests, drugs, and care methods by managers of departments whose budgets affected	Measured use of own time, use of hospital facilities at a price

Figure 8.1A. Changes in three characteristics of the individual doctors element in the hospital system across three periods.

The changes in selected characteristics of clinical departments are depicted in Figure 8.1B. The changes in selected features of the relationship doctors have with their clinical departments are depicted in Figure 8.2[4]. These findings are consistent with the material related in chapter 4, particularly from W. R. Scott (1982) about autonomous professionals. They are also consistent with P. Davis (1981) who provided a much fuller insight on doctors in the New Zealand health care system, and in hospitals in particular. Citing both Davies and Salmond he argued that:

> Although some have professed to see a diminution in the authority of the doctor, with the growth in size and complexity of the hospital, there is still an undiminished core of clinical responsibility and judgement that is difficult for the administrator to bypass. More than merely expertise, the hospital doctor also has a certain administrative authority that allows him or her to invoke special clinical procedures and issue orders to subordinates. Clearly this applies more to the senior consultant than to the junior doctor, who traditionally has had to carry the burden of the unpopular medical tasks in the hospital. (P. Davis, 1981, p. 131)

It is acknowledged that P. Davis (1981) was written some time before the end of the pre-reform period, but as is shown in Figures 8.1A, 8.1B and 8.2, little change was detected in doctors or clinical departments between the pre-reform period and the area health period. It is felt that the authority of doctors is being sustained in part from the prestige ranking of doctors vis-à-vis administrators and other hospital workers[5].

The findings about doctors and their departments are also consistent with Eisenberg (1986) who looked at doctors' practice patterns from a cost perspective. This

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[4] In Figure 8.2: GP = general practitioner; RHA = regional health authority. By entering into contracts with specified providers for patients in their regions, regional health authorities were having a bigger say about which provider (and hospital doctor) a GP should refer his or her patients than seemed to be the case in the past.

[5] P. Davis (1974) studied these rankings across New Zealand society. His findings are probably out of date but basically showed that doctors ranked above administrators, who in turn were above heteronomous professionals, who in turn were above non-professional support staff.

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
ELEMENT	Basic Unit Level: Clinical departments		
ORIENTATION	Ensuring individual patients who come to the hospital now and in future can be admitted, diagnosed and treated	Ensuring individual patients who come to the hospital now and in future can be admitted, diagnosed and treated	Ensuring individual patients who come to the hospital now and in future can be admitted, diagnosed and treated
CONTROL	Very loosely structured order	Loosely structured order with some monitoring of spending mainly on remuneration	Loosely structured order within the confines of activity and cost controls on a per patient type basis
RESOURCES	Staffing establishment, rest of hospitals' resources there for the taking	Budget for staff and some materials items, rest there for the taking subject to some negotiation with managers of other departments	Budget for staff and for materials purchased including items purchased internally from other departments

Figure 8.1B. Changes in three characteristics of the clinical departments element in the hospital system across three periods.

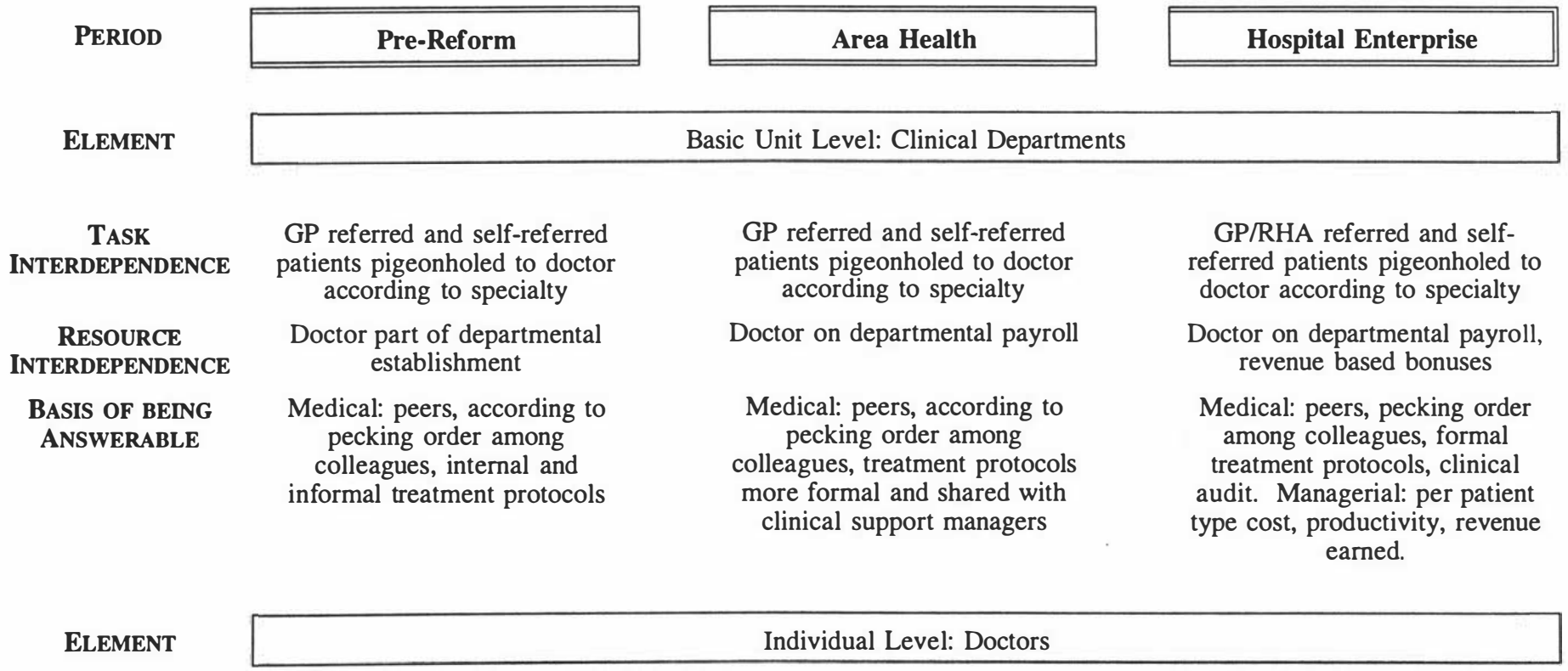

Figure 8.2. Changes in three features of the relationship between the individual doctors and clinical department elements in the hospital system across three periods.

perspective falls into what Flynn (1992) describes as "international trends towards the subjection of professional definitions of efficiency and effectiveness to managerial criteria" (p. 28). In New Zealand, this subjection was found to be a mix of indirect and prospective means. That is, the changes affecting the groups with whom doctors interacted (e.g., nurses and clinical support staff) were having a flow-on effect that influenced how diagnostic procedures were performed and how treatments were administered (e.g., aspects such as diagnostic tests, drugs and length of stay were being affected). Peer review, clinical audit, and quantitative data about how different doctors treated similar patients were mentioned by both doctors and managers as recent innovations or future possibilities. These trends are consistent with "the principle that clinicians must be made aware of the costs they generate, not least so that they might compare their productivity and 'value for money' with other colleagues, and improve their performance" (Flynn, p. 81). However, it was found that it is still the case that, "Ethically, doctors have a duty to provide the best treatment for their patients regardless of costs, and many believe that consideration of the resource effects of their decisions is irrelevant and inappropriate" (p. 81). Indeed, when managers mentioned clinical audits, it was implicit that doctors were organising this process, and to what extent the audits would be managerial rather than purely medical seemed unclear to them (see Elston, 1991, p. 75; Flynn, 1992, p. 39).

Nurses and Wards

The orientation of individual nurses on wards was also a micro one. It took the form of each nurse caring for up to as many as six patients at a time. The structure and basis of control was traditionally professional and in some senses was becoming more so ({Nurse Educator R}; Elston, 1991). But the marked change in the role of the ward charge nurse was giving rise to a mix of professional and managerial control. A nurse's main resource was his or her own labour exerted while in contact with patients. Each nurse worked according to a roster drawn up by the charge nurse, who also assigned the nurse to care for specific patients. Each patient had a "care plan" ({Charge Nurse QB}) drawn up under the direction of his or her doctor, and the nurse followed this plan exercising professional discretion, conferring with colleagues on the ward, and feeding back information to the doctor when he or she visited the patient, or at other times as

appropriate. Administering care to a patient, and doing more general work around the ward, entailed the use of other resources (e.g., drugs, linen, food). Traditionally, these resources were "free" and their consumption was triggered by the patient having been admitted. During the area health period, quantity and/or cost data were passed on to charge nurses, and in some cases, individual nurses, about some of these resources. Indeed, towards the end of this period the implementation of systems of internal transfer prices were imminent as their use would affect the ward budget, and prices and usage were even more likely to be brought to the attention of nurses by charge nurses. Prospects in the hospital enterprise period were for the identification of these costs to become more common and to be attributed to each patient and the nurse looking after that patient. The changes in selected characteristics of nurses are depicted in Figure 8.3A.

The orientation of wards and charge nurses was patient care, comfort and welfare. {Charge Nurse QB} indicated that her major job was "to give support to the ward staff in order that they can do their job." In the pre-reform period nursing administration was done at a higher level of the subsequently defunct nursing hierarchy[6]. During the area health period the wards became responsibility centres with the charge nurse as responsibility centre manager.

The relationship between the nurse and charge nurse featured the latter as hirer and firer, rosterer and determiner of pay, and supervisor and motivator, all in the managerial sense; as well as trainer, supporter, mentor and senior colleague in the professional sense. The source of ward resources was the ward budget, which gave the charge nurse the formal managerial authority to spend money on staff and on other items listed in it. The managerial role of charge nurses continued to grow as the hospital enterprise period began, as were the items included in the budget (e.g., items supplied to wards from within the organisation were about to be the subject of internal transfer charges). The prospects for the hospital enterprise period included charge nurses being redesignated

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[6] The claim by Thomson (cited in P. Davis, 1981, p. 131) about the administration component of nursing duties becoming dominant even at the ward level in the early 1970s seems to have been either premature, or not sustained for long.

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
ELEMENT	Individual Level: Nurses		
ORIENTATION	Functional caring for their individual patients a few at a time	Wholistic caring for their individual patients a few at a time	Wholistic caring for individual patients, and/or performing specified tasks for all patients on a ward
CONTROL	Professional: self, peers, senior nurse, patients' doctors. Administrative: nursing hierarchy	Professional: self, peers, charge nurse, patients' doctors. Managerial: charge nurse, duty roster based on patient numbers and acuity	Professional: self, peers, senior nurse, patients' doctors. Managerial: ward manager, duty roster based on patient numbers and acuity, cost profiles, "efficiency" constraints on caring
RESOURCES	Use of own time within confines of assigned caring and other work, free use of hospital facilities and supplies	Use of own time (some of it measured) within tighter confines of assigned caring and other work, loss of overtime work, hospital supplies obtained with restrictions, including price, hospital facilities tend to be free.	Measured use of own time within even tighter confines of assigned caring and other work, more casual employ and loss of overtime work, hospital facilities and supplies obtained at a price to the ward budget.

Figure 8.3A. Changes in three characteristics of the individual nurses element in the hospital system across three periods.

ward managers, and carrying more responsibility for patient costs. Even so, in commenting on various developments {Charge Nurse QB} expected that:

> on a typical ward the patients will continue to come in, be looked after, and then go home. . . . [even though] the way the service is organised could be quite different. [But] there will always be beds for acute admissions and for major surgery in the [public hospital] because a profit-based organisation would not want to take those sorts of things on as they are much harder to control. Perhaps beds for day patients may disappear because somebody else could very easily take this work on as it is planned and relatively uncomplicated.

The changes in selected characteristics of wards are depicted in Figure 8.3B[7]. The changes in selected features of the relationship nurses have with their wards are depicted in Figure 8.4. The findings are consistent with the material related in chapter 4, particularly from W. R. Scott (1982) about heteronomous professionals. They are also consistent with P. Davis (1981), who noted that nurses have cultivated "a special interest in caring activities" (p. 104) in an attempt to establish their independence from the medical profession. He also noted that nurses, along with other occupational groups in hospitals outside the medical profession, have found administrative imperatives harder to withstand than have the doctors, "yet it is clearly active patient care that attracts and retains nurses and sustains their morale" (Salmond cited in P. Davis, p. 131). Also, "nurses have seen advantages in clear lines of responsibility and rather hierarchical relations; they have all the trappings of professional status, but within it, the apparatus of hierarchy and bureaucratic control" (Davies and Francis cited in P. Davis, p. 132).

A major change to this apparatus which occurred at the end of the pre-reform period was the replacement of the chief nurse and nursing hierarchy by a chain of managerial command through the charge nurse to the service manager, assistant general manager and general manager (this development is discussed in the section on hospital service

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[7] In Figure 8.3B, see Anthony and Young (1994, pp. 14-15) about the idea of a fixed discretionary expense centre budget. Also, the term "bureaucratically" is used in contrast to the situation of using a market mechanism (see Bourn & Ezzamel, 1986b).

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
ELEMENT	Basic Unit Level: Wards		
ORIENTATION	Ensuring that patients on the ward are cared for in accordance with professional practice	Ensuring that patients on the ward are cared for in accordance with professional practice	Ensuring that patients on the ward are cared for in accordance with professional practice and cost limits
CONTROL	Professional nursing hierarchy	Responsibility centre within managerial hierarchy. Routine monitoring of spending within a fixed discretionary expense centre budget. Nurses collectively able to maintain professional independence	Responsibility centre within managerial hierarchy. Routine monitoring of spending within a standard expense centre budget. Attempts by nurses to maintain professional independence
RESOURCES	Staffing establishment and ward requisitions from purchasing. Other resources supplied from other departments bureaucratically	Ward budget for staff and externally sourced materials. Internally sourced resources supplied subject to negotiation with other managers	Budget covering staff and all materials whether purchased internally or externally

Figure 8.3B. Changes in three characteristics of the wards element in the hospital system across three periods.

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
ELEMENT	Basic Unit Level: Wards		
TASK INTERDEPENDENCE	Patient admitted onto ward assigned to nurse	Patient admitted onto ward assigned to nurse	Patient admitted onto ward assigned to nurse, and/or specified task(s) to be done for all patients on ward assigned to nurse
RESOURCE INTERDEPENDENCE	Nurse part of nursing establishment assigned to ward	Nurse on ward payroll	Nurse on ward payroll, or in hospital nursing pool
BASIS OF BEING ANSWERABLE	Nursing through nursing hierarchy	Nursing through charge nurse. Managerial also through charge nurse, productivity	Managerial through ward manager, cost per patient type, or cost per unit of task, productivity. Nursing through peers, senior nurses
ELEMENT	Individual Level: Nurses		

Figure 8.4. Changes in three features of the relationship between the individual nurses and wards elements in the hospital system across three periods.

managers, see pp. 232-236). But nurses retained some professional aspects by meeting together on a regular basis within the hospital to discuss professional and related matters. Items of a managerial nature were sometimes discussed at these meetings. Also, "nurses are a powerful body in the hospital because they constitute the majority of its staff" ({Charge Nurse PB})[8].

Other Health Specialist Staff and Clinical Support Service Departments

The orientation of staff within clinical support service departments was also micro, and was related to performing specialist tasks severally. In cases in which tasks involved direct dealings with patients (e.g., physiotherapy), the interpretation above relating to nurses was apt. In other cases, the staff member followed procedures and exercised discretion in keeping with professional or similar expert training and experience. In some cases specialist doctors from separate clinical departments worked alongside staff, who thus played a subordinate role. In the main, tasks were performed as a result of a doctor's decision about a patient, and tasks were assigned individually or in batches by departmental managers or supervisors. These people had a professional as well as a managerial relationship with the staff member, and although this managerial relationship seems to have been present in the past, it was becoming stronger.

The professional labour of staff members was a major resource, but in many cases (e.g., pharmacy, laboratory and radiology) materials and equipment were also major. Their usage used to be 'free', but during the area health period that was changing. The change involved reduced inventories, and the introduction of cost data about materials in an effort to promote cost awareness and change behaviour. Some of this information was passed on to doctors, particularly in the case of prescribed drugs for which cheaper alternatives were available. Prospects for the hospital enterprise period were for more costing of procedures carried out by the staff, including comparison of actual with standard for each staff member. The changes in selected characteristics of staff in clinical support service departments are depicted in Figure 8.5A.

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[8] Health Benefits Review (1986) indicated that there were more than 20,000 nurses in general and obstetric hospitals compared with less than 5,000 doctors and other health professionals.

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
ELEMENT	Individual Level: Other Health Professional and Scientific/Technical Staff		
ORIENTATION	Proficiency in carrying out specialist tasks	Proficiency in carrying out specialist tasks	Proficiency in carrying out specialist tasks
CONTROL	Professional: self, peers, doctors connected with department and patients' doctors	Professional: self, peers, doctors. Managerial: departmental manager and supervisors, cost constraints	Professional: self, peers, doctors. Managerial: departmental manager and supervisors, quality standards and standard costs for tasks
RESOURCES	Use of own time within confines of assigned tasks, free use of hospital facilities and supplies	Use of own time (some of it measured) within tighter confines of assigned tasks, hospital supplies obtained with restrictions, including price; hospital facilities free	Measured use of own time within even tighter confines of assigned tasks, hospital supplies and facilities obtained at a price charged against standard costs of tasks

Figure 8.5A. Changes in three characteristics of the other health staff element in the hospital system across three periods.

The orientation of clinical support service departments, and of their managers, was more macro than in either the wards or clinical departments. According to {Clinical Support Manager PP}, it entailed professional outcomes in the sense of compliance with ethics and statute and in "ensuring the quality of service is there for customers." And it entailed management in the sense of "ensuring cost effectiveness and value for money for the hospital and the taxpayer." In the pre-reform period, the administration of these departments came under the chief doctor, or in some instances the chief administrator. Only limited supervisory work, and resource procurement tasks such as purchase requisition requests and equipment replacement lists, had been done in the departments. In the area health period, the departments were turned into responsibility centres and their managers became constantly involved in managerial work, including giving professional advice and support as one of the senior professionals. Key aspects involved budgeting, personnel matters, costing and pricing, and promoting cost awareness among doctors and ward nursing staff.

The source of departmental resources was the departmental budget, which gave the managers the formal managerial authority to spend money on staff and on other listed items. But budgets were inadequate in the sense that while departmental staff, severally and to a lesser extent jointly, could control the costs they were incurring for each task performed, they had no control over the volume of tasks they were required to perform (see chapters 9 and 10). This volume was determined in the main by the decisions of individual doctors to admit, diagnose and treat patients; no cost data were available. During the area health period, departments started to distribute volume and cost data to doctors and charge nurses, but these data were informal, ad hoc and incomplete. Entering the hospital enterprise period, more formal, systematic and complete production of data was in prospect. These included: first, support department cost allocations to clinical departments based on what doctors in each one were prescribing, and/or to wards based on where a patient was staying and what had been prescribed for him or her; second, internal transfer charges to one or both of these same places for the services rendered on a prospective pricing basis; and third, support cost per patient type data, and individual doctor and clinical department profiles of costs by type of patient. These developments are discussed in the section above on doctors and clinical departments.

Other prospects for the hospital enterprise period were revenue from internal and external charging replacing an expense budget; competition from contracting out work, and conversely, winning contracts from outside.

The changes in selected characteristics of clinical support service departments are depicted in Figure 8.5B[9]. The changes in selected features of the relationship departmental staff have with their departments are depicted in Figure 8.6. These findings are consistent with the material related in chapter 4, particularly from W. R. Scott (1982) about heteronomous professionals. The subordination of pharmacists and radiographers to the clinical judgements of the doctors is also remarked on by P. Davis (1981, pp. 103-104).

Non-Clinical Technical and Ancillary Workers and Support Departments

The orientation of workers in non-clinical support services was also micro and task related. However, the most sophisticated of these tasks were more in the way of trades (e.g., building and plant maintenance, electrical and carpentry work) than professions. The least sophisticated were quite menial, repetitive and boring (e.g., scrubbing floors, washing dishes). The structure and basis of control was hierarchical with chargehands, foremen, supervisors, clerks and managers, and time sheets, clock cards and similar mechanistic control procedures. Labour was a major resource, and workers were assigned jobs through the hierarchy, whence also materials were requisitioned. Much of this was unchanged between the pre-reform period and the area health period, except that costs became much more important to the survival of the departments, which faced being disbanded and seeing their work contracted out. This imperative of cost reduction was being passed down the line and workers were expected to be much more cost conscious than before, and more responsive to the needs of their internal "customers".

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[9] In Figure 8.5B, see Anthony and Young (1994, pp. 14-15) about the idea of a profit centre flexible budget.

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
ELEMENT	Basic Unit Level: Clinical Support Services Departments		
ORIENTATION	Responding to professional bureaucratic demand for tasks	Responding to professional bureaucratic demand for tasks	Responding to market demand for tasks sold internally at a transfer price, plus some external sales
CONTROL	Hospital medical/administrative hierarchy	Responsibility centre within managerial hierarchy. Routine monitoring of spending within a fixed discretionary expense centre budget. Attempts by staff to maintain professional independence	Responsibility centre/business unit within managerial hierarchy. Routine monitoring of revenue and expenses within a profit centre flexible budget. Some contracting out
RESOURCES	Staffing establishment and departmental requisitions from purchasing. Other resources supplied from other departments bureaucratically	Departmental budget for staff, externally sourced materials. Internally sourced items supplied subject to negotiation with other managers	Budget, derived from transfer pricing and pricing of tasks, covering staff and all materials whether purchased internally or externally, and asset renewals

Figure 8.5B. Changes in three characteristics of the clinical support service departments element in the hospital system across three periods.

Period	Pre-Reform	Area Health	Hospital Enterprise
Element	Basic Unit Level: Clinical Support Service Departments		
Task Interdependence	Tasks assigned to staff members	Tasks assigned to staff members	Tasks assigned to staff members and private contractors
Resource Interdependence	Staff part of departmental establishment	Staff on departmental payroll	Staff on departmental payroll or working for private contractor
Basis of being Answerable	Proficiency: senior colleagues including doctors	Proficiency: departmental manager, supervisors and doctors. Managerial: departmental manager and supervisors	Managerial: departmental manager, supervisors and doctors: cost per unit of task, productivity, quality standards
Element	Individual Level: Other Health Professional and Scientific/Technical Staff		

Figure 8.6. Changes in three features of the relationship between the other health staff and clinical support service departments elements in the hospital system across three periods.

The changes in selected characteristics of workers and their non-clinical support service departments are depicted in Figures 8.7A and 8.7B[10]. The changes in selected features of the relationship which workers have with their departments are depicted in Figure 8.8. These findings are consistent with the material related in chapter 4, particularly from Mintzberg (1989) about machinelike enclaves. However, it seemed that the professional orientation of the other parts of hospitals influenced the orientation of the managers of the non-clinical support service departments. In the pre-reform period these departments came under the general administrator arm of the triumvirate. Green cited in Cox (1991, p. 92) alluded to the penchant of administrators for trying to emulate doctors and claiming to be professionals. A combination of more commercial skills, similar activities being operated in the private sector, a change in orientation in the hierarchy above them under general management, and the threat or opportunity of privatisation, seem to have brought a shift in orientation of these departments without denting the belief that they were an indispensable part of a noble and worthwhile cause (i.e., looking after sick people). The non-clinical support service departments were probably the easiest to turn into responsibility centres, and these took the form of expense centres moving quickly into profit centres (Anthony & Young, 1994). Entering the hospital enterprise period, cost allocation and transfer charging to wards and other departments was becoming normal. Indeed, some contracting out was reported before the hospital enterprise period ({Union Official R}), and several Crown health enterprises caused newspaper headlines by contracting out many services soon after being established (e.g., Ross, 1994a).

Prominent Relationships Between Basic Units

The staff in basic units organised and carried out the tasks for which the institution was responsible in the official order (see pp. 238, 240-241). According to {Doctor QP}, "It is necessary for all of these staff to interface extremely cleverly to make sure all of the respective jobs get done in the way that is most beneficial to each patient." Potentially tens of thousands of these interfaces were possible because they occurred between individuals informally and in a spirit of cooperation. In the triumvirate structure of the

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[10] In Figure 8.7B, see Anthony and Young (1994, pp. 14-15) about the idea of a desired return on investment within an investment centre.

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
ELEMENT	Individual Level: Non-Clinical Technical and Ancillary Workers		
ORIENTATION	Carrying out assigned tasks ranging from menial to sub-professional	Carrying out assigned tasks efficiently ranging from menial to sub-professional	Carrying out assigned tasks efficiently and competitively ranging from menial to sub-professional
CONTROL	Administrative: self, supervisors, captured task recipients	Managerial: departmental manager and supervisors, cost constraints, task recipients as clients with rights, less secure jobs	Managerial: departmental manager and supervisors, cost constraints, task recipients as purchasers, quality standards and standard costs or quotations for tasks, even less secure jobs
RESOURCES	Use of own supervised time within confines of assigned tasks, free use of hospital facilities and supplies	Use of own supervised and measured time within tighter confines of assigned tasks, hospital supplies obtained with restrictions, including price, hospital facilities tend to be free	Use of own supervised and measured time within even tighter confines of assigned tasks, hospital supplies and facilities obtained at a price charged against standard costs or quotation for tasks

Figure 8.7A. Changes in three characteristics of the non-clinical technical and ancillary workers element in the hospital system across three periods.

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
ELEMENT	Basic Unit Level: Non-Clinical Support Service Departments		
ORIENTATION	Responding to professional bureaucratic demand for tasks	Responding to professional bureaucratic demand for tasks	Responding to market demand for tasks sold at a transfer price. Survival in face of contracting out
CONTROL	Administrative hierarchy	Responsibility centre within managerial hierarchy. Routine monitoring of spending within a fixed discretionary expense centre budget. Cost cuts in face of potential external competition	Responsibility centre/business unit within managerial hierarchy. Routine monitoring of revenue and expenses within a profit centre flexible budget, or within an investment centre desired return on investment. Widespread contracting out
RESOURCES	Staffing establishment and departmental requisitions from purchasing. Other resources supplied from other departments bureaucratically	Departmental budget for workers and externally sourced materials. Internally sourced resources supplied subject to negotiation with other managers	Budget, derived from transfer pricing of tasks, covering workers and all materials whether purchased internally or externally, and asset renewals

Figure 8.7B. Changes in three characteristics of the non-clinical support service departments element in the hospital system across three periods.

Period	Pre-Reform	Area Health	Hospital Enterprise
Element	Basic Unit Level: Non-Clinical Support Service Departments		
Task Interdependence	Tasks assigned to workers	Tasks assigned to workers and private contractors	Tasks assigned to workers and private contractors
Resource Interdependence	Workers part of departmental establishment	Workers on departmental payroll or working for private contractor	Workers on departmental payroll or working for private contractor
Basis of being Answerable	Administrative: task completion, immediate supervisor and above	Managerial: efficient task completion, departmental manager and supervisors	Managerial: departmental manager and supervisors, cost per unit of task or job cost, productivity, quality standards
Element	Individual Level: Non-Clinical Technical and Ancillary Workers		

Figure 8.8. Changes in three features of the relationship between the non-clinical technical and ancillary workers and non-clinical support service departments elements in the hospital system across three periods.

pre-reform period there was a pecking order between and within the three arms of the triumvirate. This appears to have been on the basis of professional seniority and the relative prestige attaching to an occupational group (P. Davis, 1981). The management structures of the area health and hospital enterprise periods were superimposed on this traditional order, and caused relations to vary somewhat but without altering the fundamentals within basic units. The new managerial hierarchy, however, caused an increase in formal vertical chains of command, and this in turn caused some interference to traditional horizontal relationships between people and departments at the basic unit level. Some of the latter also became more formal: sharing was replaced by exchange because of the development of internal markets and transfer pricing. There were three pairs of relationships between basic units which were prominent enough to warrant discussion.

Clinical Departments and Wards

Doctors and nurses are the stuff of traditional children's games and television drama. Their and their departments' interdependence, as far as tasks were concerned, was centred on admitting, diagnosing, treating and caring for patients. In this joint effort the doctors were traditionally seen as taking the clinical decision-making role (and holding wards clinically answerable), as well as carrying out some of the tasks involved. Eisenberg likened them to the player-manager of an athletic team both calling the plays and working with others to carry them out (1986, p. 3). However, it seems that the nurses were no longer just handmaidens, if indeed they ever were:

> Another group who have been moved off their pedestal a bit are the doctors. The charge nurses are now managing the wards and in some ways that includes managing the doctors. They are bound to come up against some stroppy doctors occasionally, but the old notion of the doctor waving the big stick and making demands to which the nurses jump has gone; so too has the metaphor of nurses being doctors' handmaidens. ({Non-clinical Support Manager PH})

Some of this change in relations might be due to the nursing profession gaining more independence of the medical profession through concentrating on caring (Elston, 1991), but some of it was also due to awareness among charge nurses in particular about

variations in doctors' practice patterns and the cost implications of these for the ward budget in terms of nursing costs in particular. Future prospects were for doctors' decisions to impact on ward budgets even more. This would happen as more items were added to these budgets and spending became more dependent on the treatments which patients received and their length of stay. The changes in selected features of the relationship between clinical departments and wards are depicted in Figure 8.9.

Clinical Departments (and Wards) and Clinical Support Service Departments

Doctors and the staff of clinical support service departments were interdependent as far as tasks were concerned in that doctors' diagnostic and treatment decisions gave rise to the tasks done in these departments. For example, these decisions caused laboratory tests to be done, x-rays to be carried out, and drugs to be dispensed by other health professionals. These activities caused resources to be used by these departments which, in the area health period, appeared in departmental discretionary expense budgets. The tradition was for doctors to be able to hold clinical support departments clinically answerable for the tasks they performed. These relations were changing because of the managerial authority vested in departmental managers, who, faced with orders for expensive tasks, were querying some of these with individual doctors and querying treatment protocols with senior doctors. The prospects for the future were for departments to be responsible only for the cost of each task performed, and for the volume of tasks performed to be a matter for doctors and their clinical departments.

The relationship between doctors and clinical support services might in some ways be seen as a three-way relationship in that it was the ward nursing staff who acted as a go-between between the doctor's patient and the clinical support department. That is, the ward staff ensured that the patient or the patient's samples reached the clinical support department, and that the results were reported to the doctor on his or her rounds or at other appropriate times. There was also the prospect of clinical support services being charged to wards on the basis of the patients staying on them. The changes in selected features of this relationship are depicted in Figure 8.10.

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
ELEMENT	Basic Unit Level: Clinical Departments		
TASK INTERDEPENDENCE	Doctors making decisions in respect of patients cared for on wards	Doctors making decisions in respect of patients cared for on wards	Doctors making decisions in respect of patients cared for on wards
RESOURCE INTERDEPENDENCE	Apart from use of own labour, resources free; no charge to clinical department	Apart from use of own labour, and some ward costs, resources free; no charge to clinical department	Clinical department and ward costs to be attributed to patients for comparison with standard cost for patient type and revenue per patient type
BASIS OF BEING ANSWERABLE	Patient recovery or comfort up to time of discharge or death	Patient recovery or comfort up to time of discharge or death	Patient recovery or comfort, and no unplanned readmittance, within cost limit
ELEMENT	Basic Unit Level: Wards		

Figure 8.9. Changes in three features of the relationship between the clinical departments and wards elements in the hospital system across three periods.

Period	Pre-Reform	Area Health	Hospital Enterprise
Element	Basic Unit Level: Clinical Departments		
Task Interdependence	Staff of support departments carry out orders made by doctors in relation to patient diagnosis and treatment	Staff of support departments carry out orders made by doctors in relation to patient diagnosis and treatment	Staff of support departments carry out orders made by doctors in relation to patient diagnosis and treatment
Resource Interdependence	Staff of support department assigned to tasks, other resources free; free to clinical department	Staff of support department assigned to tasks, other resources met from department budget; free to clinical department	Staff of support department assigned to tasks, other resources met from department budget, revenue obtained by charging clinical department or ward budget for task at prospective price
Basis of being Answerable	Doctor satisfaction with individual task	Doctor satisfaction with individual task	Doctor satisfaction with individual task. Clinical department satisfaction with price; external competition
Element	Basic Unit Level: Clinical Support Service Departments		

Figure 8.10. Changes in three features of the relationship between the clinical departments and clinical support service elements in the hospital system across three periods.

Wards and Non-Clinical Support Service Departments

Though non-clinical support service departments no doubt interacted with all other parties (e.g., from repainting the office of the general manager[11] to making sure anyone could get a cup of tea), their relationships with wards probably accounted for most of their activities, and typified the relationships they had with other elements in the basic unit and individual levels. Non-clinical support service department tasks were carried out for patients (e.g., supplying bed linen, an orderly taking them to the operating theatre), for nurses (e.g., supplying and laundering uniforms), and for wards (e.g., providing building and plant maintenance, switching external telephone calls). All this activity contributed to the smooth running of the wards, and allowed nurses to perform their tasks in relation to patient care.

The resources supplied by non-clinical support services to wards used to be "free", but in the area health period, some cost allocations were being made, and entering the hospital enterprise period, internal charging at prospective transfer prices was being introduced. At the same time, some services were being contracted out and these external charges were to be allocated to ward budgets on the basis of use. With charging, more formality was entering into the way services were ordered and paid for, including the facility for charge nurses to question the quality of work, the prices at which jobs were being charged per unit, and the total cost billed for each job. There was also the prospect of wards choosing whether to have a service done or not, the method by which it was done, including frequency, and who should do it. In the area health period, however, charge nurses still faced a monopoly supplier, but there was a less indifferent attitude on the part of the poorer support departments because of the prospect of competition. The changes in selected features of this relationship are depicted in Figure 8.11.

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[11] Now known as chief executive (Ministry of Health, 1993b, p. 37).

Period	Pre-Reform	Area Health	Hospital Enterprise
Element	Basic Unit Level: Wards		
Task Interdependence	Department/staff supply ward, or patients on ward, with goods or services	Department/staff supply ward, or patients on ward, with goods or services	Department/staff supply ward, or patients on ward, with goods or services to order
Resource Interdependence	Use of staff time, free materials and facilities; no charge to patient or ward	Use of staff time, and materials met from department budget, free facilities; cost allocation to patient or ward in isolated cases	Ward is charged against its budget; and department revenue matched against cost of labour, materials and facilities
Basis of being Answerable	Task completed to satisfaction of charge nurse (weak)	Task completed to satisfaction of charge nurse (stronger)	Task completed to satisfaction of charge nurse (very strong), and price accepted; External competition
Element	Basic Unit Level: Non-Clinical Support Service Departments		

Figure 8.11. Changes in three features of the relationship between the wards and non-clinical support service departments in the hospital system across three periods.

An Analysis of the Institution Level

Hospital Service Managers and Support Staff

Service managers were a new breed developed in the area health period at the hospital or hospital district level. Their development can be attributed to a combination of four ideas. First, that they already existed to some extent under the general administrator arm of the triumvirate. Second, that they filled a vacuum created by the disappearance of the nursing hierarchy. Third, that under general management, responsibility, authority and accountability should be vested in one manager for each service created as part of the switch from the functional orientation of hospital institutions to a health services orientation. And fourth, that they filled the need for management control (Anthony & Young, 1994) absent in the pre-reform days, and which was seen by government and people of a businesslike ilk to be the solution to perceived problems of inefficiency, ineffectiveness and over spending in the hospital system[12]. The orientation of these managers was managerial and more macro than staff in the basic units. They tended to see nursing and clinical support staff, and their wards and departments, as being under them in the managerial hierarchies that emerged, entering the area health period. By contrast, they were inclined to respect the doctors for their expertise and hard working attitudes, and to leave them alone to get on with their important work. Thus the researcher encountered two structure and control phenomena which Covaleski and Dirsmith (1983) have discussed.

Parallel Hierarchies

The first was the notion of parallel hierarchies. That is, "democratic and bottom-up for the professionals, and . . . machine bureaucratic and top-down for the [non-clinical] support staff" (Mintzberg cited in Covaleski & Dirsmith, 1983, p. 326). Both on the wards and in the clinical support services area, this operated in the following manner:

> downwardly directed control is exerted on this area from higher levels and this control orientation is expected to be passed on to subordinates by the [charge

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[12] Both Mintzberg (1989) and Meyer and Rowan (cited in Covaleski & Dirsmith, 1983) refer to the idea of organisations being expected by powerful external parties to employ management control (albeit in a ritualistic or symbolic manner) even when their task technology is proficiency driven.

> nurse or clinical support service department manager]. These [people], however, perceive themselves as being professionals and are seeking to develop a bottom-up dialogue in order to legitimize the nursing services [or clinical support service] area and establish some measure of bureaucratic autonomy. (p. 326)

Loosely Coupled Systems

The second phenomenon was the notion of loosely coupled systems (Meyer & Rowan, and Ouchi, cited in Covaleski & Dirsmith, 1983, p. 333). This notion was applied among the service managers as follows: Faced with the disparity between the expectations of more senior managers and the central authorities for the adoption of management control devices, and the coordination and control strategies suggested by the task technology in much of the basic units area (see pp. 89-95 of this thesis), at least some of them operated their areas as loosely coupled systems. That is, "they decoupled the formal image structure that the organization presents to its environment from its technical structure" (Covaleski & Dirsmith, p. 333). According to Weick; Pondy and Mitroff; March and Simon (all cited in Covaleski & Dirsmith), this would give them two advantages:

> (1) the presumption that the formal image structure really works is insulated from the anomalies and unstandardized processes peculiar to its technical work processes; and (2) conflicts among subunits and between subunits and the institutional level of the organization are minimized and the organization can better mobilize its personnel to appear to conform to the formal structure while still preserving subunit autonomy and the ability to be responsive to a loosely coupled world. (p. 334)

The five interviewees at hospital service manager and support staff level can be used to illustrate this phenomenon. The ones at SITE P seemed to be true to situation. First, the circumstances of {Service Manager PC} vis-à-vis the responsibility centre managers in her area (e.g., {Clinical Support Manager PL} and {Clinical Support Manager PP}) made loose coupling appropriate, and seemed to be in place. Second, and similarly, {Nurse Manager PS} and {Nurse Manager PM} were mediating between their managerially oriented service managers and their responsibility centre managers, who

were virtually charge nurses[13]. Third, the responsibility centres in {Service Manager PB}'s area (e.g., those managed by {Clinical Support Manager PD}, {Non-clinical Support Manager PH}, {Non-clinical Support Manager PE}) were performing more mechanistic and less ambiguous tasks, and were not in need of a loosely coupled system. As {Site Coordinator P} pointed out, this suited the style of {Service Manager PB}, but would have been less suited in the clinical areas.

{Service Manager QS} might be described as the exception which proves the rule. He appeared to have the greatest difficulty balancing his position between a management control hierarchy and nurses and doctors wanting to maintain their professional autonomy. He did express the idea of merely "facilitating the process" by which these professionals "delivered the services in which they had actually been trained." But he still seemed intent on imposing more management control than other service and nurse managers working in similar clinical areas. Nevertheless, he had noble intentions to do with quality and value for money within the hospital as an institution. These intentions sum up the orientation of the other service managers and support staff as well, except for {Nurse Manager PM} who was in a community oriented service. She was committed to quality and value for money, but felt that much higher priority was due to primary health care in the hospital district vis-à-vis institutionalised care.

The basis of control exercised by the service managers and their support staff in dealing with basic unit people varied, as outlined above. In dealing with people above them, they reported on what was happening in their services to the next person up the hierarchy. This seemed to be on a joint and several basis with their peers, and a consensus basis with their superior. However, as in many of the superior-subordinate relationships in the new managerial hierarchies, one suspects that much depended on the personality and style of the respective district general manager or assistant general

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[13] The doctors who headed six clinical departments related to {Nurse Manager PS}'s area did not seem to recognise the hierarchical structure shown in the formal organisation chart, although unlike most of his colleagues {Chairman P} did try to participate in the budget process (see chapter 9).

manager. The service managers also acted as advocates for their services within the hierarchy, particularly in terms of resources.

The source of resources in the area health period was the aggregate of the responsibility centre budgets within their services. The authority to manipulate these within each service lay with the service manager, and this was done in negotiation with the responsibility centre managers. In order to obtain more resources for the service as a whole, and to retain those which had been in the budget for the service the previous year, service managers had to negotiate among their peers, and with people higher up the managerial hierarchy. This was not easily done in a time of cuts, restraints, clawbacks and other descriptions of lower rates of funding by the central authorities. But some areas seemed to be able to get away with overspending on grounds of more acute patients being admitted than in the past, or on grounds that similar numbers were admitted previously and the overspending which had occurred then had not prompted an increase in the budget. People in other services understood and empathised with this overspending, and the hospital organisation and central authority people appeared not to challenge it unless there was no compensating underspending to balance things out.

Prospects in the hospital enterprise period were mixed. At SITE P there was excitement at the prospect of the hospital obtaining greater autonomy with the disbanding of the area health board corporate headquarters and the devolving of its functions to the institution. {Service Manager PC} expected service managers at the institution level would take on a greater coordinating role. {Service Manager QS} mentioned the prospect of middle management tiers being rationalised, which he thought was for the greater good even though he might be adversely affected. At both sites, it was expected that some support services would either be put on profit centre bases, or be contracted out entirely, but with some internal management mechanism remaining to monitor contracts. In either case, it was expected that the environment would be more competitive, and in order to win contracts from regional health authorities, more units of service would have to be provided for less cost.

The four financial support people seemed to view the new period as yet another one of opportunities to assist service managers and basic units by improving systems, reporting, data availability and skills and understanding. The prospect for more support staff of this kind being recruited were referred to by {Cost Accountant Q}, {Financial Controller P} and {Central HQ Manager RF}. The changes in selected characteristics of service managers and their support staff are depicted in Figure 8.12.

Hospital Organisation Managers and Support Staff

Though they were not a completely new breed, hospital organisation managers and support staff were very different from their predecessors by the end of the area health period. They grew out of the board-office based general administration arm of the triumvirate structure of the pre-reform period. They were the product of general management, and started early in the period to develop a management control framework in their organisations. By the end, their composition and structure were still changing so that their organisations could operate as successful businesses (Health and Disability Services Act of 1993) in the hospital enterprise period. Jointly, their orientation was macro and strategic, and included dealing with contracting and funding. Severally, they headed various parts of the managerial hierarchy and fulfilled management control functions to do with programming, budget setting, reporting and evaluation (Anthony & Young, 1994). Some of them had hospital service managers reporting to them; others dealt directly with responsibility centre managers. These arrangements varied according to organisational size and structural choices.

Compared with service managers, and people in the basic units, they seemed more inclined to see the organisation from a unitary perspective. They also seemed not too concerned about the notion of professional independence, but were not dealing with doctors, nurses and other health professionals as frequently or as directly as the service managers. They saw ultimate responsibility for the performance of the organisation resting with them, and were cognisant of how that responsibility was growing. They were also cognisant of that responsibility shifting as the funding and contracting mechanisms changed, including the emergence of regional health authorities as the other contracting party. While the managers who had experience on the clinical side saw the

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
LEVEL	Institution: Hospital Service Managers and Support Staff		
ORIENTATION	Not in existence; some duties subsumed by triumvirate members, others disregarded or not contemplated as being appropriate	Managing a service on a quality and value for money basis, cooperating with people in other services	Managing a service on a quality and value for money basis, or managing a group of successful business units; coordinating the business enterprise
CONTROL	-	Managerial - downward: responsibility centres, spending vs fixed budgets, projected outturn, nothing has gone/will go wrong. Clinical areas: loose coupling; non-clinical areas: mechanistic. Upward: senior manager, keeping on budget, no surprises, scandals	Managerial - downward: responsibility centres/business units, revenue and expenses vs flexible budgets, quality standards. Clinical areas: loose coupling; non-clinical areas: competition. Upward: business oriented institutional senior manager, successful business
RESOURCES	-	Service expenditure budget, fixed amount, allocated across responsibility centres	Service revenue and expense budget, flexible according to RHA contracts or revenue earned from transfer prices, analysed between responsibility centres/business units

Figure 8.12. Changes in three characteristics of the hospital service managers and support staff element in the hospital system across three periods.

organisation as first and foremost concerned with healthcare and patients, the others had a tendency to talk about the organisation "as a set of commodities (staff, equipment, plant) to be rationalised in order to achieve" (Cousins cited in Flynn, 1992, p. 67) some required outcome measured by profit and loss accounts, balance sheets and returns on investment. The changes in selected characteristics of hospital organisations managers and their support staff are depicted in Figure 8.13.

The Distinction Between Hospital Organisation Managers and Service Managers

The distinction between hospital service and organisation managers was strongest in the operating core areas compared with the non-clinical support services. It derived from the traditional distinction of the base hospital from the board office. It was likely to decline in significance with hospital organisations becoming smaller in the hospital enterprise period[14], and the way in which all elements in the hospitals were moving towards a more managerial outlook. But within the hospital enterprise period, a dual role was likely to persist whereby each institution level manager would have a separate set of management control responsibilities for groups of responsibility centres, and joint strategic responsibilities as part of the organisational executive team.

Institutions and Basic Units

Interdependence between the institution and basic unit levels derived from the people in basic units arranging for the implementation of tasks for which the institution was formally responsible; and the people at institution level looking after coordinating type activities. Each kind of basic unit contributed to this process. The doctors determined who would be admitted and how they would be diagnosed and treated, and the others joined with the doctors in making direct and indirect contributions to implementing these decisions. People at institution level (formerly administrators, more recently managers) both provided support and imposed limitations on these decisions and their

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[14] There are two data from which this inference can be drawn. First, in the 1993 restructuring 23 organisations replaced 14. And second, "the [Crown health enterprises] will be the losers in the new market set up in that the amount of business they get and their market share will decrease compared to what it has been" ({RHA Official R}).

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
LEVEL	Institution: Hospital Organisation Managers and Support Staff		
ORIENTATION	Traditional administrative style based on consensus within triumvirate, institutional orientation	More purposeful management with more community orientation, and more financial orientation; one year time horizon	Managing integrated institution oriented organisation pursuing corporate goals of financial kind; successful business; longer horizon
CONTROL	Elected board (low poll elections) bureaucratic, uniform structures and procedures, no consensus to change, loosely structured order through influence of doctors	Elected board, later commissioner, corporate management structure and process, annual plans and budgets, monthly reports, emphasis policing expenditures and keeping on budgets	Appointed board, business people, business unit management structure, core business, contracting non-core activities, emphasis winning contracts and delivering contracted volumes at under planned costs
RESOURCES	Funding from government, population based funding formula, adjusted upwards if overspending occurred; capital separate and free once obtained	Funding from government, contract for way population based grant allocated between broad categories of services. Capital merged with operating grant	Services defined by DRG or similar classification sold via contracts to regional health authorities

Figure 8.13. Changes in three characteristics of the hospital organisation managers and support staff element in the hospital system across three periods.

implementation. Their method changed in character from period to period: from being administrative and passive, to becoming more managerial and directive, and financial.

The allocation of responsibilities, duties and resources had been bureaucratic. Money was not used as a basis of authorising or of answerability. That changed during the area health period and continued to do so entering the hospital enterprise period. Internal and external market forces came to play a bigger role. Responsibility centres were created and developed at the behest of institution level managers. These started as discretionary expense centres with fixed budgets covering direct controllable and non-controllable expenditures. In the hospital enterprise period there was every probability that they would, according to circumstance, become standard expense, profit and investment centres. These centres would have cost-volume based flexible budgets covering an extensive range of direct and indirect items which could be controlled by the person or group comprising the respective responsibility centres. In any case, the budgets of these centres were determined at the institution level, with varying degrees of participation at basic unit and individual levels. The allocation of indirect costs in budgets was introduced in the area health period, and, entering the hospital enterprise period, this had been or was about to be superseded by internal transfer pricing in many areas.

Together with changes to the way responsibility for money in particular was rolled down to basic unit level, there were changes to answerability for managerial matters from basic units to the institution level. During the area health period, this was dominated by answerability on the part of responsibility centre managers to service managers for spending compared with the budget according to monthly general ledger reports. Relations between the people from each level were convivial and empathetic when much actual contact was involved, but there was some antagonism from the basic unit level towards other people at both the institution and central authority levels (see Flynn, 1992, p. 74 on a similar development in the British national health service under general management). Logan (1993) has elaborated on the relations between clinicians and managers from a clinician/manager perspective, including "clashes of clinicians' deontological attitudes and the much wider utilitarian views of management" (p. 304); and "many clinicians fail[ing] to accept organisational accountability consistent with

their status" (p. 304). The prospects for the hospital enterprise period were for more comprehensive criteria and measurement to be used, including service volumes, standard and actual cost comparisons, and measures of quality and responsiveness. In contrast, Logan, calling for increased cooperation between clinicians and managers, expected that "control exerted by managers through resource restriction should diminish with the advent of the purchaser provider split" (p. 304).

It remained to be seen whether this would happen, but in terms of controlling activity levels, spending and revenue in the area health period, a major problem was that institution level managers were reluctant to be responsible for individual admissions. In leaving this to doctors (aided by charge nurses and other basic unit level staff), these managers avoided the ethical dilemma of refusing admission on financial grounds. Although doctors circumvented this dilemma in non-acute cases through mechanisms such as waiting lists, in acute cases there was no question of patients either being turned away by clinical staff, or of getting less than the full treatment once admitted, regardless of how much money there was in the budget ({Doctor QP} and {Doctor RP}; {Charge Nurse PA}, {Charge Nurse PB}, {Charge Nurse QA}, {Charge Nurse QB} and {Charge Nurse QP}). How service managers and responsibility centre managers coped with these problems was part of loose coupling discussed above. The changes in selected features of the relationships between the institution level and the four kinds of basic units are depicted in Figures 8.14A, 8.14B, 8.14C and 8.14D.

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
ELEMENT	Basic Unit Level: Clinical Departments		
TASK INTER-DEPENDENCE	Doctors as institutional gatekeepers determine diagnostic procedures and treatment. Administrators look after administrative consequences of doctors actions	Doctors as institutional gatekeepers determine diagnostic procedures and treatment. Managers attempt to manage managerial consequences of doctors actions	Doctors as institutional gatekeepers subject to contract limits; determine diagnostic procedures and treatment within standards. Managers intervene in doctors actions to manage managerial consequences
RESOURCE INTER-DEPENDENCE	Administrators provide environment for doctors to work relatively free of concerns about scarce resources	Managers create responsibility centre structure, clinical departments and budgets. Doctors expect managers to find money needed to do what has to be done for patients	Managers expect doctors to work within tighter resources, standard treatment costs, limits on patient volumes according to institution-regional health authority contracts
BASIS OF BEING ANSWERABLE	Doctors answerable to peers and ultimately to chief doctor. Chief administrator and chief doctor of equal formal status each responsible for their staff	Managers hope (in vain) that clinical departments will conform to managerial structure imposed on other types of basic units	Managers expect doctors to set up management control structures within profession, peer review and clinical audit, and use cost profiles, etc. about comparative procedure/treatment costs
LEVEL	Institution		

Figure 8.14A. Changes in three features of the relationship between the clinical departments element and institution level in the hospital system across three periods.

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
LEVEL	Institution		
TASK INTER-DEPENDENCE	Nurses follow doctors decisions about patients and decisions within nursing hierarchy about implementation. Administrative consequences of nurses actions looked after by administrators	Nurses follow doctors decisions and decisions of ward hierarchy about implementation. Institution managers monitor ward resources in terms of consequences for institution	Nurses and wards act within task performance standards and budgets laid down by institution managers according to contract limits, and subject to doctors' decisions
RESOURCE INTER-DEPENDENCE	Nursing hierarchy provides an environment for nurses on wards to work which is relatively free of concerns about scarce resources	Institution managers create responsibility centre structure, wards and budgets. Wards shifted from nursing hierarchy to managerial one. Authority for spending devolved to wards	Wards given standard expense centre budgets by institution and expected to work within tighter resources, including standard treatment costs, and limits on patient volumes in institution-regional authority contracts
BASIS OF BEING ANSWERABLE	Nursing of patients in accordance with policies and procedures of nursing hierarchy.	Charge nurses answer to service managers (or nominees) mainly for budget and spending as shown in general ledger	Ward managers answer to service managers on flexible budgets according to actual volume and case mix, and on quality aspects
ELEMENT	Basic Unit Level: Wards		

Figure 8.14B. Changes in three features of the relationship between the wards element and institution level in the hospital system across three periods.

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
LEVEL	Institution		
TASK INTER-DEPENDENCE	Staff follow doctors' decisions about patients and decisions within professional group about implementation. Administrative consequences of staff actions looked after at institution level by administrators	Staff carry out doctors requests with some circumspection from a resources perspective within departmental guidelines. Institution level managers monitor departmental resources in terms of overall consequences for institution	Staff and departments act within task performance standards and budgets laid down by institution managers according to contract limits, and subject to influence of doctors' decisions
RESOURCE INTER-DEPENDENCE	Administrative hierarchy provides an environment for staff to work which is relatively free of concerns about scarce resources	Institution managers create responsibility centre structure, departments and budgets. Departments come within managerial hierarchy. Authority for spending devolved to departments	Departments given profit centre budgets by institution managers, and expected to work within tighter resources, including standard treatment costs, limits on task volumes according to institution-regional health authority contracts
BASIS OF BEING ANSWERABLE	Carrying out tasks in accordance with policies and procedures of professional group. No answerability for resources	Responsibility centre managers answer to service managers mainly for budget and spending as shown in general ledger	Business unit managers answer to business managers on profit centre budgets according to revenue, actual volume and task mix, and on quality
ELEMENT	Basic Unit Level: Clinical Support Service Departments		

Figure 8.14C. Changes in three features of the relationship between the clinical support service departments element and institution level in the hospital system across three periods.

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
LEVEL	Institution		
TASK INTER-DEPENDENCE	Staff, departments perform routine tasks to traditional custom and practice within directions from institution administrators who look after the administrative consequences of staff actions	Staff, departments respond to requests for tasks to be done as notified by service managers and other basic units explicitly or implicitly. Institution level managers monitor departmental resources in terms of overall consequences for institution	Staff, departments act within task performance, cost standards and budgets laid down by institution managers according to contract limits. Much work contracted out
RESOURCE INTER-DEPENDENCE	Administrative hierarchy provides environment for staff to work which is relatively free of concerns about scarce resources	Institution managers create responsibility centre structure, departments and budgets. Admin hierarchy replaced by managerial one. Authority for spending devolved to departments	Departments given profit centre (or investment centre) budgets by institution managers, and expected to work within tighter resources, including standard task costs and limits on task volumes
BASIS OF BEING ANSWERABLE	Carrying out tasks within policies and procedures of administrative hierarchy. No answerability for costs	Responsibility centre managers answer to service managers mainly for budget and spending as shown in general ledger. External competition	Business unit managers answer to business managers on profit centre budgets according to revenue, actual volume and task mix, and on quality. External competition
ELEMENT	Basic Unit Level: Non-Clinical Support Service Departments		

Figure 8.14D. Changes in three features of the relationship between the non-clinical support service departments element and institution level in the hospital system across three periods.

An Analysis of the Central Authority Level

Within the Central Authority Level

The basic orientation of the central authority level has always been macro. It has comprised monitoring the health status of New Zealanders, developing health policy, advocating the allocation of resources to healthcare, and determining the process and structure of the health system. Within this basic orientation there have been shifts of emphasis from time to time (see Department of Health, 1969; "A Health Service," 1975; Ministry of Health, 1993a, 1993b). Over the three periods being examined it has become:

(a) less administrative and bureaucratic overall;

(b) less regulatory and interventionist over health/treatment at the operational level;

(b) more strategic, contractual and market based; and

(d) more concerned with spending staying within capped funding and with net assets not being run down in a way prejudicial to providing future services.

These shifts stem from broader reforms in the economy and in the public sector. A combination of economic necessity and ideological zest led to far reaching economic reforms after the fall of Muldoon in 1984. There was a fundamental change from neo-Keynesian style intervention to reduced intervention under Monetarist and New Right philosophies dubbed *Rogernomics* (Boston et al., 1991; Munro, 1994b). This was operationalised at government department level with more formal lines of responsibility and accountability for outputs, revenues, expenses, and balance sheet items (Treasury, 1989, 1990). The Department of Health was affected by these changes, and also implemented them in the hospital system between the pre-reform period and the area health period (Department of Health, 1991b). Implementing the changes between the area health period and the hospital enterprise period was shared between the Department of the Prime Minister and Cabinet and the Department. The Department was formally disbanded in 1993 after more than 90 years (Department of Health, 1993a), and its functions in relation to health policy and funding the hospital system (or purchasing health outputs) were taken over by the Ministry of Health and the regional health

authorities. Its functions in relation to regulating and monitoring hospital organisations were removed a year or so earlier and vested in a wing of the Department of the Prime Minister and Cabinet which eventually became known as the Crown Company Monitoring Advisory Unit. The section looking after hospital organisations was called the Crown Health Enterprises Monitoring Unit, and the wing had two other sections looking after state-owned enterprises and Crown research institutes, respectively.

Naturally, the changes that were made at political and bureaucratic level of government were not as a result of any detailed master plan. Instead, several general principles were used as a broad guide to action. It was left to many people in different locations and at different times during the period of reform to interpret these principles, and embellish them when opportune. In regard to changes to organisational process and structure these principles were a mix of business management, market mechanisms, corporatisation and privatisation (Boston, 1991). For citizens, the principles adopted included making direct taxes less progressive, and using indirect taxes to obtain a higher proportion of tax revenue[15]. The principle of user pays was also introduced, along with making welfare less universal and more "targeted" to those who met specified criteria and were willing to be tested on them. More people were expected to "stand on their own feet", in a shift from collective societal responsibility and intervention, to individualism and *laissez faire.*

In the late 1980s the government began to find out how much it was spending on a business basis, and what its assets and liabilities were. To carry out this task, professional accountants were employed in greater numbers and in more places across the public sector than formerly. Accounting concepts and standards applying to financial reporting were given greater force by legislation and ministerial regulation. The prime movers appear to have been the Treasury and the Audit Office (Coy, Tower & Dixon, 1994; Hay, 1992; McCulloch & Ball, 1992; Pallot, 1991a, 1991b). Switching accounting to a business basis was in keeping with the notion of running the government

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15 'Public Accounts for' (1987) showed direct taxes for 1986 at $10.6bn and indirect taxes at $3.2bn. The corresponding figures for 1993 in 'Financial Statements of' (1993) were $16.2bn and $9.8bn.

like a business, and eventually being able to laud the whole enterprise being turned around to make a surplus (Munro, 1994a; Dominion, 1994).

Despite the apparent harmony and unambiguity that often comes with rationalising after the event, reality was different. At the political level, the fundamental changes in economic policy did not sit well among the Labour traditions of many government MPs, and had a mixed reception from voters in traditional Labour constituencies in the 1987 election. Also, by 1988, the two leading members of the government, Finance Minister Roger Douglas and Prime Minister David Lange, fell out, and probably precipitated each other's resignation in 1988 and 1989 respectively (see Munro, 1994b). This in turn contributed to Labour's loss of the 1990 general election. But the policies of the National government on the economy (presided over by Ruth Richardson as Minister of Finance 1990-1993), and on public sector restructuring, were remarkably similar to Labour's. Treasury and the Reserve Bank remained in the ascendancy on the bureaucratic side. The dynamism of change at central authority level was reinforced by high turnover of both politicians[16] and bureaucrats/managers, just as the dynamism within the hospital system was also spurred by frequent personnel changes.

Naturally, the reforms to the public sector affected hospital organisations and hospitals in several ways; as one of government's biggest spending areas it could hardly have been otherwise. The 1989 restructuring was implemented after the government made a choice between two models for a restructured system. Health Benefits Review (1986) discussed six options, and for the then immediate future supported an area health board model. Hospital and Related Services Taskforce (1988) advocated a purchaser-provider model. The time taken before the government made an announcement after the publication of these reports indicates heated debate in Cabinet over this choice (see Palmer quoted in Munro, 1994b, p. 9). The area health board model was chosen

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[16] Politicians have turned over quite quickly including Prime Ministers Muldoon, Lange, Palmer, Moore and Bolger; Finance Ministers "Rogernomics" Douglas, Caygill, Richardson and Birch; and Health Ministers Caygill, Clarke, Upton, Birch and Shipley.

(Caygill, 1988; Clark 1989)[17], despite the more market orientation of the other choice, which would have been more in keeping with reform principles applied in the rest of government. The reason may well have been the demise of Roger Douglas, and the start of Labour's change of course on social and welfare issues in response to public opinion. Health and hospitals evoked strong emotive constraints because of the reliance placed on the public system by most New Zealanders.

The restructured hospital organisations, with their newly elected and ministerially appointed members, were in place by 1989. When National came to power in 1990, however, it was not long before the hospital system was reorganised a second time. On this occasion, the purchaser-provider model was adopted, probably because it was more consistent with reforms in other parts of government. The implementation of the second restructuring started in 1991 (Upton, 1991), and led to hospital organisations being set up as business enterprises within the umbrella of the public sector, but with some speculation that they would be privatised eventually[18]. The changes in selected characteristics of central authorities are depicted in Figure 8.15.

Central Authorities and Institutions

The central authority and institution levels were interdependent in that the former had a responsibility to society and to individuals to ensure that healthcare services and facilities were available, and the latter provided most of the care available at the secondary level, particularly that deemed medically acute, together with some primary care. There were other providers of both sorts of care, and primary care in particular

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17 Some people may prefer to say that the choice of the area health board model was reaffirmed because legislation was enacted for its introduction as early as 1983 (i.e., Area Health Boards Act of 1983). The significant changes in policy were over implementation being compulsory within a set time limit, and with area boundaries being imposed. Previously implementation was reliant on local initiatives among hospital boards most of whom cherished their independence and the primacy of the hospital institution.

18 Very few interviewees even mentioned this possibility, and those that did (e.g., {Service Manager QS}) saw it as a long way into the future. In contrast, the hiving off of particular organisational units (e.g., non-clinical support services) was regarded as already happening.

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
LEVEL	Central Authorities		
ORIENTATION	Health status of New Zealanders, health policy, obtaining and allocating resources for healthcare	Health status of New Zealanders, health policy, changing the health system, allocating and monitoring hospital organisation spending	Health policy, 'owner' of hospital organisations, health status of New Zealanders in each region, purchasing products of health providers
CONTROL	Department (of Health) as administrative and bureaucratic centre of the health system process and structure, regulatory and interventionist	Department as bureaucratic centre of health system process and structure, contracting for services in capped funding, power over operations devolved, monitoring monthly spending	Ministry as strategic bureaucratic centre of health system; Crown Company Unit monitoring government investment in hospital organisations; RHAs negotiating and monitoring contracts with hospital organisations and others for the purchase of health commodities
RESOURCES	Obtained from Vote Health and distributed on basis of population	Obtained from Vote Health on basis of outputs pledged to Parliament, distributed on basis of population, contractual agreements, spending caps	Obtained by Ministry from Vote Health, distributed on basis of population to regional health authorities which make purchases

Figure 8.15. Changes in three characteristics of the central authorities level in the hospital system across three periods.

was provided outside institutions for the most part. The prospect in the hospital enterprise period was for more care to be provided by alternative providers.

Resource interdependency kept step with task interdependency. In the early days of public hospital services, funding came from voluntary subscriptions and patient fees, local councils and government, with government providing subsidies and meeting deficits. "The Social Security Act 1938 required public hospital treatment to be given free of charge to patients" (Department of Health, 1969, p. 10). Levies on local authorities ceased in 1957-58, after which "hospital maintenance expenditure became entirely a Government responsibility" (p. 10), but earlier legislation which stabilised the hospital rate "radically altered [the] outlook on the part of many Hospital Board (sic), there ensuring a demand for buildings, equipment and additional staff which would have remained considerably more modest if the previous rating system had continued" (p. 15). According to the Advisory Committee on Hospital Board Funding (1980), expenditure by boards escalated apparently unchecked from 1946 until 1967-68, when the government instituted a system of allocations within which boards had to operate strictly. For the 15 following years, grants by the central authorities were made annually using the previous year's grant as a base, and making various ad hoc and across the board adjustments (see Advisory Committee on Hospital Board Funding, 1980, pp. 110-120 for a year by year description). In 1983 a population-based funding formula was introduced (Advisory Committee on Hospital Board Funding, 1980; Health Benefits Review, 1986) in an effort to bring about a more equitable distribution of the total funding given to hospital boards by central authorities.

This formula has persisted, with modifications. It was a key aspect of the relationship between the government and the hospital organisations in the mid-1980s when funds were advanced according to annual allocations, but with the possibility of additional allocations being made if necessary. This latter arrangement became less acceptable to government as spending was tightened under the political and economic changes outlined above. It was clearly signalled in 1989 when the government's demand for hospital organisations to stay within cash allocations went unheeded by the biggest hospital organisation (i.e., Auckland Area Health Board). The Minister took the

unprecedented step of dismissing the elected board and appointing a commissioner, who, in keeping with the increased use of business parlance, was dubbed by some circles as a "receiver".

Entering the area health period, central authorities introduced a contracting process in which the population-based grant to hospital organisations was linked to service targets (Minister of Health, 1989). Institutions were under the impression that total funding was reducing absolutely, and not keeping pace with service demand, despite efficiencies or savings in providing services. In the hospital enterprise period, the population-based grant was paid to the regional health authorities ({Ministry Official R}) who in turn were expected to spend it in accordance with government policy guidelines (e.g., Minister of Health, 1992), and on the basis of cases treated under contractual agreements with public hospital organisations and other providers. Initially this spending took the form of distributions to hospital enterprises, similar to the contracting process that had existed between institutions and the Department up to 1992-93. However, regional health authorities were eventually expected to enter into agreements to purchase services from hospital enterprises and other providers on a competitive basis, giving rise to markets. In these markets, patients would be classified into product types, and hospital organisations would become multi-product firms (see Chua, 1995) competing for the custom of health commodity oriented (Cousins in Flynn, 1992) regional health authorities.

Another noteworthy aspect on task and resource interdependence between the central authority and institution levels was that, during what has been a history of expansion of the health service, there were regular attempts by the central authorities to rationalise the system and the number of hospitals (by closure) and hospital organisations (by restructuring, merger and takeover). It was reported in Department of Health (1969) that as long ago as the 1880s attempts were being made to "rationalise the hospital system" (p. 9). "A Health Service" (1975) reports further attempts at reform along these lines in 1909 (p. 26), 1921 (p. 29), 1937-38 (p. 61), 1953 (p. 62), and 1970 (pp. 68-69; see also Department of Health, 1969); and it too made reorganisation proposals. The possibility of closing some hospitals, and downgrading the level of work done in others,

has been subsumed by the changes in central authority-institution level relations from period to period, and the prospect in the hospital enterprise period was for hospitals which were not awarded regional health authority contracts to fail financially as business units, and be closed. However, despite this according with the economic and other general concerns of government, there is a propensity for the political party in power to intervene to keep a hospital from closing in response to timely community action[19].

The basis of institutions being answerable shifted as part of the tightening of money. Many detailed controls, which were characteristic of a system becoming more centrally oriented (see "A Health Service," 1975, pp. 60-73) until the mid-1980s, were brushed aside as part of the reform philosophy. On the financial side, instead of being concerned primarily with the probity of individual transactions and cash spent, central authority monitoring during the area health period focused on overall spending of each hospital organisation within its capped funding amount. Indeed, this concern over spending appeared to come to the fore as the basis of institutions being answerable to the central authorities; the main demand on the health side was "no surprises and no scandals" (Central HQ Manager RG). Entering the hospital enterprise period, there was another shift which comprised two aspects. First, the Department of the Prime Minister and Cabinet began to focus on the value and risk attached to the government's investment in each hospital organisation. This has since moved to monitoring performance of the organisations using criteria appropriate to the legislative requirement for their being successful businesses (Health and Disability Services Act of 1993; Department of the Prime Minister and Cabinet, 1993). Second, the regional health authorities began to focus on the specific treatments they were purchasing from organisations, including quality, price, and the ability of these organisations to continue providing those treatments in the longer term ({RHA Official R}). The changes in selected features of the relationship between central authorities and institutions are depicted in Figure 8.16.

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[19] In the run up to the 1993 general election the Minister directed one hospital organisation not to close Balclutha Hospital. In the critical Selwyn by-election of 1994, in which the National Government might have been brought down, the prospect of closing two hospitals in the constituency, and other hospitals in the South Island, were a prominent issue in the campaign (see also p. 152).

An Analysis of People in the Community

It was implicit in the previous section that politicians and officials, ideologies, policies and government departments outside the health system had influenced the direction of change in the system by intervening at the central authority level. Another set of people from outside the system were the seven interviewed in connection with SITE R (see Table 4.3). Their orientation was quite different from the people who intervened through the central authority level and reflected their communities and constituencies (e.g., individuals, community groups and whole communities, nurses, non-clinical support staff). This was a concern about access to health services, maintenance and development of services, use of staff in more productive ways to meet patient demand, and maintenance of the number and pay of the staff providing services. On balance, there was more emphasis on tackling ill-health using curative medicine, and seeing the hospital as a symbol of help for those afflicted (see P. Davis, 1981, pp. 96-99).

As far as controls were concerned, people outside the funding-contracting-management arrangements knew less about what was happening in the hospital enterprise period than they had in the area health period. The channels by which they received information had been impeded by the dismantling of democratic structures and processes[20], by reductions in professional autonomy, and through institutions withholding information which they labelled *commercially sensitive* in terms of the trading which had commenced in health commodities. The areas in which external interviewees had the greatest concern about poor information were those involving planned reductions,

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[20] Elected area health boards were abolished in 1991 because "the Government does not want to put board members in the unenviable position of having to respond to the communities which elected them while also having to follow Government directives on reform" (Upton, 1991, p. 128). It was also pointed out that:

> when [elected] boards attempt to make major strategic decisions, they are hampered by the politicisation of the decision-making process. . . .
>
> At present, when an [elected] board decides, for instance, to move resources out into the community and close all or part of a big hospital, it is almost sure to face public opposition and hostility. (p. 9)

Ironically, an accounting consultant who wished to remain anonymous related that one problem the government was having with the Crown health enterprise board members which it had appointed from mainly local businessmen was that they were acting too parochially in relation to rationalising service provision (personal communication, 17 March 1994).

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
LEVEL	Central Authorities		
TASK INTER-DEPENDENCE	Institutions cope with operationalisation of state's role to provide free treatment and care for all	Institutions cope with operationalisation of state's role to provide free treatment and care for all	Institutions deal with patients within categories for which contracts exist with regional authorities up to volume limits, and other patients at the discretion of doctors, etc. involved in admissions
RESOURCE INTER-DEPENDENCE	Population-based funding formula, historical funding according to facilities in existence, not related to patient numbers or mix	Funding formula, contracts for broad service categories but not related to patient numbers or mix, agreed budget allocations between service categories	Contracts for particular treatments and services, prospective prices according to diagnosis related groups, pre-determined service volume limits
BASIS OF BEING ANSWERABLE	Compliance with administrative procedures and probity of transactions, spending limits easily transgressed, funds not spent are lost and danger arises of reduced funding in future	Annual contract negotiation monthly general managers' reports; annual budget, overspendings and projected outturns, spending limits rigid, unspent funds carried forward but constant threat of reduced funding	Regional health authorities: contract negotiations on volume, quality, price, viability, monthly reports on progress with contracts, competition from alternative contractors. To Crown company: quality customer service, public opinion, operating measures, financial performance and viability, contracts
LEVEL	Institution		

Figure 8.16. Changes in three features of the relationship between the central authorities and institution levels in the hospital system across three periods.

rationalisations and changes of access to services. These were the very areas which interested them most (e.g., "CHE Business Plans," 1994; Kilroy, 1994; "Midcentral Considers Hospital," 1994; Ross, 1993, 1994a, 1994b, 1994c). The interviewees from outside the system were concerned about politicians and managers not being accountable for health services and hospitals. There was also concern among these people, and among professionals, that the information withheld was pertinent to improving professional practices, irrespective of its commercial use for financial gain. The changes in selected characteristics of people outside the framework are depicted in Figure 8.17.

A Note on the Function and Values Framework

Until this chapter the reader has been asked to take on trust that the function and values framework (Figure 4.3) is not merely a matter of administrative definition. By comparing the Figures in this chapter relating to each element (i.e., Figures 8.1 A & B, 8.3 A & B, 8.5 A & B, 8.7 A & B, 8.12, 8.13, 8.15), it can be seen that values and functions were quite distinct between people at each of the levels, regardless of changes from period to period. In essence, as one moves across the framework, the values and functions move from micro to macro, and from diagnosis, treatment and care to financial risk. Indeed, there are clinical parallels with Becher and Kogan's observation that "the freedom of the basic unit is a dominant . . . norm" (1980, p. 27); and there are political and administrative parallels with their observation that "the central authorities influence the . . . system so as to make its norms compatible with the needs of society which nourishes and sanctions it" (p. 27). Another parallel which came through the within-case analyses was with Becher and Kogan's observation that:

> although [the system] has changed in response to the social expectations authoritatively placed by government and others on it, it has also persistently demonstrated a contra-functionalism, a different view of society and its needs, embodied in the obstinacies of the [medical] way of life. (p. 27)

This reference to contra-functionalism relates to knowledge and (alternative) opinions practised in providing personal care in one-on-one encounters with patients. This is at variance with managerialism which "equates professional conduct with an efficient use of people and resources" (Chua & Clegg, 1989, p. 106). Encounters with patients used

PERIOD	Pre-Reform	Area Health	Hospital Enterprise
EXTERNAL GROUP	Community Based People		
ORIENTATION	Quality, quantity of services (emphasis on curative), service changes, retention of hospitals as community symbols; needs and experiences of individuals	Quality, quantity of services (emphasis on curative), service changes, retention of hospitals as community symbols, resisting cuts; needs and experiences of individuals	Quality, quantity of services (emphasis on curative), service changes, retention of hospitals as community symbols, resisting cuts; needs and experiences of individuals
CONTROL	National culture, equality, fairness. Elections of government, Mps, boards, other political/democratic processes; public opinion	Political/democratic processes, publicity, public opinion	Political processes, publicity, protests, whistle blowing, strikes, public opinion
RESOURCES	Voting, lobbying, press and media publicity, community action, the will of the people, strength of health professions, public information flows	Voting, lobbying, press and media, community action, hospital closure protests, government Mps in marginal electorates. Public information flows, plans, budget and annual reports. Strength of medical profession, strikes	Community orientation of board members, press and media, whistle blowing, community action, hospital closure protests, government Mps in marginal constituencies. Strength of medical profession, strikes, general election

Figure 8.18. Changes in three characteristics of the people in the hospital system environment across three periods.

to be free of any thoughts of economising on resources to keep costs down, or of notions of rationing (see p. 476 of this thesis). Controls on individuals and basic units were altering this, as is evident in the relevant Figures above. A major source of these controls were accountants and accounting techniques.

Closing Pointers

The interpretation presented in this chapter serves to elaborate the functions and values framework of the hospital system, and so illuminate the context in which accounting is practised. The numerous Figures presented attest to the dynamic state of normative and operational modes in all elements at all levels of the system from 1984 to 1994. However, one particular trend stands out. The central authorities have been much affected by business-related ideas of rational management and market mechanisms, and the changes in this area have flowed across to other levels. Some levels and elements have been completely engulfed, in particular administration with the emergence of the management zone. While others, particularly where doctors are involved, have not been as affected, they have been affected. Also, ideas to do with accounting, including budgets, costing and pricing, responsibility centres and answerability for spending have emerged as part of this flow. These ideas are described and interpreted in chapters 9 to 11; and the flow of these ideas from the central authority level towards the individual level of the system, and the changes emanating from them, is a central plank in the theory-in-use articulated in chapter 12.

PART III: DESCRIBING AND INTERPRETING THE SITUATED PRACTICE OF ACCOUNTING WITHIN NEW ZEALAND HOSPITALS

CHAPTER NINE
A THICK DESCRIPTION OF THE BUDGET CYCLE AND PREPARATION OF THE BUDGET

The chapter provides a thick description of the situated practice of accounting in hospitals in 1992-93, focusing on the budget cycle, and the budget setting phase of that cycle among responsibility centre managers, and service managers and their support staff. This phase is covered in linear fashion from the start of budget preparation until a budget is formally approved, which usually happens part way through the financial year.

A Signpost

The Primacy of Monitoring Spending and Budgeting

In designing the Study, and in choosing sites, processes, procedures, activities and documents about which to ask questions, the researcher tried to survey the practice of accounting from many angles. Whichever way he approached the object of his Study, the accounting process which occurred most frequently and took most time in the operating core and support services of hospital organisations in 1992-93 was the monitoring of spending against budgets. This process also involved service managers and their support staff and other managers and accountants further up the managerial hierarchy. In addition, managers of basic units participated alongside these management zone people in preparing the budgets of hospital organisations for the 1992-93 financial year. This started in the autumn of 1992 and continued until the budgets were set in the spring of 1993. Budget preparation was more intensive than monitoring because it took up a substantial amount of time for a short period. The primacy of these interrelated processes is evident in the situated practice of accounting within hospital organisations.

Sequence of Reporting the Situated Practice of Accounting

The situated practice of accounting in hospital organisations is the subject of chapters 9, 10 and 11. The first two are thick descriptions of the processes and interactions associated with this practice, and chapter 11 is a thick interpretation of them. The thick descriptions are derived primarily from within-case analyses of the basic unit level and the hospital service manager and support staff element of the functions and values framework. In compiling the chapters, the researcher has made a conscious effort to report faithfully what was told him by the interviewees. Much of the text is derived from words and phrases used by individual interviewees. In particular, the opinions expressed and "the meanings persons bring to their experiences" (Denzin, 1989b, p. 159), are those of the interviewees.

The thick descriptions demonstrate initially the cyclical nature of the budget. They then proceed chronologically beginning with the budget preparation process in this chapter, and moving onto the monitoring of spending and answerability in chapter 10. Note, however, that this is not how the processes actually developed. The tendency has been for people in the management zone to impose spending control from above before involving operating core staff in the preparation of budgets which then become the basis of that control.

The Budget Cycle and Its Hospital Based Participants

Many interviewees alluded to the cyclical nature of the budget. {Service Manager QS} described how the budget process started a few months before the financial year began and continued until after it ended. A business plan and budget were produced around the start of the year, and monthly budget reports[1] were generated by the general ledger

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[1] The interviewees had various names for these reports such as *the monthly budget report*, *the monthly expenditure print-out*, *the general ledger report*, *the variance report*, *the financials* and *these sheets* (the latter with a slightly derisive intonation). These names are used variously in this chapter, and indeed they have appeared in earlier chapters. Despite the variety of names, the reports were very similar wherever one went. Typically they consisted of a single sheet for each responsibility centre, and the data on them were listed under columns headed *annual budget*, *current month* and *year-to-date*. The last two of these

(continued...)

system for its duration. These reports were disseminated to managers in the various programmes and services. In what was a "trial run" for the hospital enterprise period ahead, a split was made in the 1992-93 business plan between a purchaser (i.e., the board office) and providers (e.g., the S Service which {Service Manager QS} managed) which contracted with the purchaser to provide services in return for funds. But {Service Manager QS} felt this had not made "any real difference to the financial side of the planning process as far as I was concerned." In practical terms:

> the process essentially followed the tradition of previous years in as much as the Board was working primarily on the basis of the separate and finite annual chunk of cash it was expecting to receive [from the Department] in 1992-93. . . . This is how the allocation of funds seems to come to the Board and this dictates its approach to planning.

{Service Manager QS} also noted that though the organisation was supposedly using accrual accounting, it was "a misnomer to describe either the accounting, or the budgeting, systems as accrual based. To all intents and purposes they are still cash based."

Service Managers and Support Staff

The ten service managers and support staff who were interviewed were all involved with money, managing resources, financial management, expenditure reports and similar matters. Typically, they were finding the budget and related matters "pretty important", "challenging and exciting", and "interesting and stimulating." For example, {Nurse Manager PM} described the budget as "something practical to be used to provide services. . . . There are competing needs for money, and so it has to be allocated according to priorities, although this can sometimes cut across other considerations." She saw her job as being "to move money round the service, redeploy resources according to priorities, and integrate the services." She described herself as "into cost

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[1](...continued)

> were subdivided into three further columns headed *budget*, *expenditure* and *difference* or *variance*. The classes of items in the budget were listed row by row, and data in dollars appeared in the cells where rows and columns intersected.

efficiencies" and "quite rational when it comes to the use of money. . . . I hate money to be wasted." She did not believe in "trying to increase the amount of money available to the service for the sake of it," although she perceived that this was "what some people used to do and probably still are in a few cases."

Doctors Doing Managerial Work

{Doctor QC} and {Chairman P} had some budgeting responsibilities. For {Doctor QC} these consisted only of a budget for surgical items, and not for staff or other costs associated with a department. {Chairman P}, on the other hand, was head of his clinical department which was classed as a responsibility centre. The budget set the financial limits within which he was expected to run the department vis-à-vis the hospital. He perceived the budget as an allocation of staff which he would do his "damnedest [i.e., utmost] to stay within." He stated that "staying within the allocation on the staffing side is important because it means that the department is left alone to get on with its job. . . . Correcting inaccuracies in what is a wretched financial system can be important because they can tip the department over its staff spending allocation." He raised several criticisms of the budgeting process, and these are reported later. Both he and {Doctor QC} were positive about being involved in allocating and managing resources, but pointed out that this was not a view shared by many doctors, including some in whom some managerial responsibilities had recently been vested.

Charge Nurses

A significant portion of the new managerial tasks, paperwork and data in which charge nurses were involved had to do with the money which was spent by wards, and that meant budgeting. The situation before these changes started were summed up by {Charge Nurse QP}:

> Neither the charge nurse nor the nurses in general ever had to worry about how much money was being spent on managing patient welfare and providing care. For all of us, the money was just always there as if it came from a bottomless pit.

With more data available, the charge nurses were finding out how much total spending was linked to their wards via general ledger systems. But they perceived the main reason for their being given these data was that their wards were expected to live with progressively less money. Similarly, they saw managerial tasks and paperwork as being about spending less. For example, commenting on preparing estimates of his ward spending for 1992-93, {Charge Nurse QP} stated:

> These estimates were based on how the ward intended to do business in the year ahead and whether there was anything about the patients we were expecting to admit which meant that they could be dealt with differently compared with the past in order to shorten their stay or make it cheaper.

He guessed that the rationale for charge nurses and other departmental heads being made responsible for the money spent was that "we will apply more critical thinking on how we conduct our business." He thought that the intention of these changes was "to bring about a more businesslike approach to what we all do." But he perceived that a conflict could arise between this approach and the basic reasons for everyone being at the hospital which "are founded on providing the best quality care and similar medical principles. . . . [and] that care cannot be provided without incurring costs." Notwithstanding, he felt that it was possible for him and his colleagues to change the way they thought and behaved without compromising the care given, or offending other principles. He stated that he and others were now thinking in terms of how much it was going to cost to do things, and whether there might be a better way of doing them.

While charge nurses became more involved in monitoring their ward budgets from 1991, none of those interviewed had been involved directly in setting these budgets before the 1992-93 budget. Also, the degree to which they were consulted in the exercise for that year varied both between and within sites. {Charge Nurse QA} indicated that her ward budget was done by "someone unknown," and the first time she saw it was when it "appeared on the monthly budget report" for the ward. This left her with "no choice other than to accept it." Notwithstanding this and similar instances, the general rule in relation to preparing the 1992-93 budget seems to have been one of charge nurses being consulted by service managers. At SITE P, staff were appointed during 1991-92 in the

service managers' offices (e.g., {Nurse Manager PS} and {Nurse Manager PM}) to act as intermediaries between the charge nurses and service managers.

For the future, there were expectations of more direct involvement in budget setting by both the charge nurses themselves and their service managers. While some charge nurses were averse to this prospect, all of them felt that they should be involved in this exercise because "it is hard to measure up to a budget which you have not set yourself" ({Charge Nurse PA}). At the very least they should like to be consulted "by whoever puts the budget together for the ward," and have it explained "when it is being put together." This would help both to increase their general awareness of things that were being planned, and to carry out the managing and monitoring they had to do once a new budget year was under way.

Clinical Support Service Managers

Between them, the clinical support service managers indicated that during the period after about 1990 the money they were authorised to spend came primarily in the form of their departmental expenditure budgets. The tasks relating to budgeting and spending evolved quickly after their inception, and further changes were in prospect which would lead to these budgets being replaced by revenue from internal charges and sales to external parties as the source of their money. Notwithstanding, in 1992-93 expenditure budgets represented the most significant managerial constraint within which these managers had to work. They were seen as the means by which the dollars available to their respective hospital organisations and hospitals were shared out. They were also seen as the means by which the ultimate authority of the general manager was delegated or devolved to responsibility centre managers. Budgets gave these managers responsibility for spending decisions and made them answerable for keeping spending within set limits. The clinical support service managers were supposed to ensure that the people in their departments operated within this constraint, and they were answerable on this matter to their service managers.

The clinical support service managers regarded their departmental budgets dichotomously. On the one hand, they were a source of greater freedom or discretion

than existed previously. "There is more challenge and flexibility coming my way as bureaucracy is reducing. . . . It's my budget, I live within it and exercise discretion" ({Clinical Support Manager PL}). They could get on with running their services without, for example, being "queried about every large purchase order" they wanted to place. On the other hand, the budgets meant that a money constraint was being imposed on total purchases, regardless of the demands placed, particularly by doctors, on the professionals comprising each department.

Non-clinical Support Service Managers

The non-clinical support service managers were all involved in budget setting and monitoring. These and related matters were a significant part of their jobs. They saw the budget as a key attribute of the relatively new responsibility centre structure through which they were supposed to control the money being spent. For {Non-clinical Support Manager PH}, who had been doing the same type of job since the 1970s, budget setting and monitoring were new and he had had to do "quite a bit of learning." However, the others had been involved in such matters in previous jobs[2]. They had also taken an interest in estimating costs and controlling expenditures in their present jobs before these tasks were established in a more formal way by hospital management in about 1990. According to {Non-clinical Support Manager PH}:

> Before the responsibility centre managers became involved with budgets, the hospital manager was responsible for them all. I had never seen any budgets and did not know what money was going anywhere, or indeed what the hospital manager was doing with it all. All of a sudden, when it became apparent that responsibility centre managers were needed to take control of their own services and become accountable, the finance department had to devolve out of this massive hospital manager's budget all of the things into the areas in which they were wanted.

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[2] For example, {Non-clinical Support Manager QT} used to work as a *budget officer* at the site in the pre-reform period. This entailed acting as an intermediary between the manual general ledger and commitment accounting record systems and various clinical departments.

> At this stage the responsibility centre managers did not have any input into doing the budget, but they did have to run the budget. Each of us was given lump sums of money to cover various expenditure items. . . . We were told that traditionally each sum had been used to pay for these items and that the sums given were all we were going to get. Most people felt that the sums given were less than what was needed but we were just expected to do the best we could with them.

He added that if the money was insufficient in a responsibility centre, the manager had to find savings. This process began to instill the concept of looking for savings and of gradually introducing changes to realise these.

Budget Preparation: Experience at SITE Q

{Service Manager QS} related that in carrying through the planning process for his service in 1992-93, "account was taken of the sort of money we had got available." This was based on "the budget for the previous year, taking account of the fact that overspending occurred in some services, mainly through faulty budgeting; and what we wanted to do in terms of service delivery and everything else." From these two positions, he had "worked back until I got a fit between the service outputs we wanted to achieve and the financial resources available to do that." The preparation of the budget was "retained" by {Service Manager QS} at his level because he perceived that "the heads of departments were not yet ready to prepare budgets for their departments on their own." This applied in particular to "charge nurses[3] and senior medical officers."

This situation was mirrored among responsibility centre managers in other services. {Clinical Support Manager QP} reported that she was only involved in budget setting in the 1992-93 round through being "consulted by [my service manager] about the budget he intended submitting for the services provided by [her department]." {Non-

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[3] One of these, {Charge Nurse QA}, was quoted above as saying that her ward budget was done by "someone unknown," and the first time she saw it was when it "appeared on the monthly budget report" for the ward.

clinical Support Manager QL} and {Non-clinical Support Manager QT} described how in both the 1991-92 and 1992-93 budget setting rounds, they prepared detailed estimates of staffing, operating and capital item expenditures using their own technical and financial data, and submitted these to their service manager. But not much consultation took place after that in either round. Their estimates were used to derive fixed block budget allocations for their departments, but they were not sure how this was done, nor even by whom. This limited involvement caused them some frustration. They also made the point that the allocations made to them were not based on projections from the data available about actual use.

{Charge Nurse QP} indicated that "preparing estimates for salaries and capital works for the 1992-93 year was the first time we had to project future spending." He based these estimates on current salary scales, and what was spent on major and minor capital items in the 1990-91 year "coupled with a costed out capital items shopping list for 1992-93. . . . the ward put forward a figure which was passed to someone above me, who in turn passed it to finance to be put through the books." In September 1992 approval of this figure was being held up because the current wage round had not been settled. {Charge Nurse QP} regarded this hold-up as "inevitable because the question of how much money goes into salaries has an impact on how much money is freed up by the people at Board level for minor and major capital works." Also, he had already had "to go over the department's estimates in order to cream more money back out of them." He was asked to do this because it was felt that "there would not be enough money in the organisation to spread out over everything."

Further insights into the budget setting process were provided by {Doctor QP}. He indicated that in his specialty the amount of resources available and their use, were based on two things. First, the historical approach taken to providing care in the region served by SITE Q; and second, the annual modifications which he and his colleagues made to this allocation in consultation with other staff, including the relevant service manager. Each year, this service manager organised the development of the business plan. {Doctor QP} stated that "the idea is to see which areas are being covered and which areas need to be covered, and whether resources can be shifted in any way to

improve one of these, acknowledging that it will have to be at the expense of the others." He added that there were not many decisions to be made about how to spend the allocation, as most of the costs were fixed. In particular, salaries and related employee costs took up about 80% of the allocation and "there is little leverage in these. Such leverage as is possible in the whole allocation is done by the charge nurse on the ward" where most of {Doctor QP}'s patients were cared for. Neither {Doctor QP}, nor his colleagues, had any direct say in how this was done, particularly as concerned nursing salaries. In terms of the other salaries, there were three other professional staff and "their costs are relatively fixed in that there is not much leeway unless they were to be sacked. The same applies to the three doctors' salaries."

Budget Preparation: Experience at SITE P

By contrast with SITE Q, the participation of responsibility centre managers at SITE P in budget setting was more overt by the 1992-93 round, and this had come about over the previous two or three years. For both 1991-92 and 1992-93 the budget was compiled for the entire hospital organisation using OPIS[4]. This process included compiling outputs and making spending allocations to responsibility centres. The outputs were used, among other things, to meet the requirements for the annual contracts by which the organisation obtained its annual funding from the Department of Health.

Both {OPIS Support Person P} and {Financial Controller P} worked at the hospital organisation's central headquarters in 1990. They recalled that OPIS had replaced a paper system which was used by the hospital organisation for the 1990-91 budget round. {Financial Controller P} reported that "the stack of paper accumulated by [the paper]

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[4] OPIS, or the operational planning input system, was promoted by Deloitte Ross Tohmatsu as providing:

> a very cost effective way of capturing and manipulating data and ensure that this is done in a consistent manner, across the [organisation]. It will allow a much more responsive and interactive planning and budgeting interface between the operational units and the corporate office. (in-house operating plan guide)

This source also tried to show how business planning and OPIS fitted into the government's financial management reforms, and with notions of effectiveness, efficiency, performance measurement and accountability.

system was about five or six metres high by the time it reached the management accounting office at headquarters." He described the organisation of this mountain of paper into the budget as "atrocious and an abomination. . . . It took months and months and the noise it raised in complaints was huge." This prompted the introduction of OPIS for the 1991-92 budget round, and this led to most of the paper being replaced with computer discs. The discs contained a series of standard computerised forms which had to be completed for each responsibility centre.

{Financial Controller P} also related that in the previous system, little account had been taken of input-output relationships between responsibility centres (e.g., linen from the laundry service being used on the wards), either within the same hospital, or between the different hospitals that comprised the hospital organisation (i.e. the area health board). "All it had been concerned with was giving everyone a dollop of money and that was it." By contrast, OPIS required staff to enter onto discs data about the projected outputs of their organisational units. This led to many of the key links between resources and outputs being recognised from responsibility level upwards for the first time. "Making this association was a huge step for the organisation especially for people at the grass roots." However, despite this change, {Financial Controller P} still considered that "the approach for both 1991-92 and 1992-93 was a top down one" in which the hospital district, along with other parts of the hospital organisation, were "given a dollop of money by the [central headquarters] and told to spread it around." The people at headquarters also took "a top down approach in regard to projected outputs." They told everyone that for 1992-93 they were "not allowed to reduce their outputs compared with what was actually happening in 1991-92. This had to be adhered to regardless of whether the funding they were to receive was reduced compared with 1991-92."

{Service Manager PB} said that budget setting, OPIS and other developments of a resource rationing nature had "trickled down the organisation since 1990, rather than introduced everywhere all at once." He attributed this trickle down effect to the need for people at one level "to understand what a change is all about before that change happens and is passed to the next level down." He had perceived that "as people at each

level got comfortable with each change they got their people involved." Thus, the changes in the budget preparation process had occurred at different rates in different parts of the hospital organisation and its hospitals, and at any particular time similar problems were being tackled in different ways by different managers.

The 1991-92 Budget

{Site Coordinator P} stated that much of the financial part of the budget for 1991-92, was compiled by staff in the hospital's financial services division, including herself. The hospital district was given a total amount of money within which to work. This was combined with previous data held by the division in order to "hand down" budgets to service managers for the first time. These budgets comprised "total dollars which could be spent." She thought that what service managers did next differed from service to service.

One version of events was provided by {Nurse Manager PS}. She and the service manager "took the total amount [of money] for our service, and determined the financial budget, expenditure item by expenditure item, for each responsibility centre." In doing so, they consulted the service's responsibility centre managers. More specifically, each charge nurse sat next to {Nurse Manager PS} while she worked on their ward budgets at a PC. During these times, the charge nurses also "worked out the output side" of their budgets with her assistance. In the course of this budget preparation work, several difficulties were encountered by {Nurse Manager PS}. For example, the documentation that came with the system was voluminous and it was "difficult to learn about the system in the time available." It was also "difficult to interpret what OPIS wanted to know."

These problems were experienced by the hospital as a whole, and {Service Manager PB} discussed the problem with central headquarters in quite strong terms (see p. 69). He related that people at central headquarters were trying "to expand OPIS into a gigantic or enormous tool," and he wrote to them saying that the hospital could not support such a move. He suggested that they "try to settle the thing down, and also use it as a tool in developing inter-service linkages." He felt that to attempt much more than

that would have taken OPIS, and the headquarters people, "out of their depth given what the software was originally designed to do." This view was accepted after some argument, during which "solid support" came from service and responsibility centre managers throughout the district. These people had "a fair number of problems initially with OPIS, but because of the time and effort they were willing to put into the system, the thing began to work."

The 1992-93 Budget

These representations to central headquarters provoked several changes in time for the 1992-93 budget round. {Site Coordinator P} was again responsible for overseeing the whole budget preparation process in this second round. She was regarded by {Nurse Manager PM} as "the central person in the whole OPIS exercise as far as the hospital is concerned." This entailed everything from "making sure that the service people received the publicity materials about the budget . . . to ensuring that the proposed budget submitted to [central headquarters] was balanced" ({Site Coordinator P}). In 1991 she received training about budget preparation, and was made responsible for ensuring that similar training was provided to facilitators in each service (e.g., {Nurse Manager PS}, {Nurse Manager PM}). Up to the start of the 1992-93 budget process, she conducted about 40 staff training sessions to groups of one or two, and arranged for some staff to do training modules on budgets and reports. These were organised by the hospital organisation's in-service training department as part of its management training programme.

{Site Coordinator P} described how at the start of the 1992-93 budget preparation process, the people at central headquarters notified the hospital district of a total dollar allocation within which its budget submission had to come. "This allocation was calculated from the budget for 1991-92 up to period 6 [i.e., the first six months of the year], and then annualised." Also, adjustments were made for anything which was due to happen in the remainder of 1991-92 "provided that they had been authorised by central headquarters. . . . Actual expenditure to period 6 was not taken into account

directly in this calculation[5]." {Site Coordinator P} indicated that she had "to scrutinise this calculation carefully to ensure that the way in which adjustments were annualised overall did not disadvantage the hospital district." She came across "a variety of errors and omissions in the budget adjustment calculations." But she "did not take the matter up because overall they seemed to be in our favour."

{Service Manager PC} commented on the way the amount of funds were allocated to the hospital district by the hospital organisation in more general terms. The annual allocations were "the result of a bargaining or fighting process. Over the years the hospital has had to fight for every extra penny, despite its comparatively poor funding position and the situation of the district in general practitioner terms[6]." Similarly, {Nurse Manager PM} stated that it was the view of many staff that the hospital had not had its rightful share of resources compared with other hospitals controlled by the hospital organisation. The hospital had "a reputation of providing more with less," and this was something which had "shown up in surveys of various services, such as radiology, medical records and nursing care," in the hospitals concerned. Moreover, {Financial Controller P} claimed to have:

> enough raw indicators to show that [the hospital district] is far and away the cost leader in terms of what happens in [the area covered by the hospital organisation]. For example, the hospital has fewer anaesthetists, who between them are doing more sessions, and are getting paid less than at [a neighbouring hospital of similar size]. Also, the laboratory technicians in [that neighbouring

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5 {Central HQ PA} related that the start of the budgeting process for him and his colleagues at the central headquarters was the half-yearly accounts for 1991-92. He stated that after this:

> units [(e.g., the SITE P hospital district)] were sent details of the expenditure of their departments for the first six or seven months of 1991-92. This was accompanied by a summary of the [hospital organisation]'s overall strategy. . . . From the expenditure data they were given, units were expected to calculate their year's expenditure by a process of extrapolation, give or take some variables. . . . The projected expenditure so calculated constituted the basis of the units' budgets for 1992-93.

6 The district was served by fewer general medical practitioners than other districts in the hospital organisation's area.

> hospital] do 10% more tests, but there is something like 190 of them compared with 75 at [SITE P hospital].

{Chairman P} was also concerned about the district's allocation. He pointed out that "resources are allocated historically and a comparison of budgets from year to year shows that these have not been changing according to need or demand across the hospitals in [the hospital organisation]." He also related that the principle which underlay allocations of resources to hospital organisations, as well as individual hospitals and related facilities, was one of giving each a slice of the total resource cake in order to provide everything necessary for the people in its geographical area. He opined that despite the frequent use of formulae in such systems, hospitals in politically articulate areas, and ones whose establishment or development were politically inspired, "have tended to get bigger slices of the cake than the rest, regardless of throughput." The biggest problem facing SITE P was that under these funding systems it had always been underfunded by comparison with many similar institutions. Thus, under the present population based funding system SITE P had suffered on two fronts. First, the region in which it was located was underfunded as measured on a per capita basis compared with the national average; and second, of the major hospitals in the region, it was the worst off for funding, given the throughputs of these hospitals. {Chairman P} attributed this to the electorate being "comparatively inarticulate politically," and having other "social, cultural, ethnic and racial disadvantages."

The Allocation Process and the Role of Financial Services

For the 1992-93 budget preparation process, the financial services division asked services to take on more work than they had in relation to the 1991-92 budget. But because the district had been given a fixed allocation, it was considered:

> pointless to take an open ended approach in the sense of preparing a budget for the level of service which was likely to be wanted. . . . [Also,] the people in the services expected the division to say where their budgeting should start from in terms of what their total allocations should be right down to responsibility centre level. ({Site Coordinator P})

Thus, calculations were done in the division based on the total hospital district allocation, and each service was given an allocation for the entire service, broken down by each responsibility centre. The result was a distribution of funds based primarily on the "previous year's use, though some funds were distributed to special areas and projects which were being pushed among the district management team" ({Service Manager PC}). {Site Coordinator P} distributed this information to service managers along with an OPIS disc for each responsibility centre manager, and other materials. These included a copy of the standard training booklets issued by the central headquarters[7]; and some material which she had prepared herself. The latter consisted of "information and practical type guidelines and forms which would be easier to follow than those from headquarters." The information included submission deadlines and "guidelines on the proper way for services and responsibility centres to do the capital part of their budgets, including ranking their proposals." {Site Coordinator P} also conveyed an invitation for people to come and seek help at the financial services division.

{Nurse Manager PM} related that her service was told that it should budget on the basis of getting the same amount of money as in the 1991-92 budget, regardless of increase in demand leading to increases in activities and costs, new facilities being opened, and productivity or price changes. She also stated:

> the link between output volumes and total dollar budgets is an authoritarian one with the [central headquarters] dictating that like everybody else the service will

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7 {OPIS Support Person P} stated that this information package was intended for distribution to various people including service and responsibility centre managers. However, "in a lot of cases some of the strategic guidelines and so on did not get past the unit general managers, nor did these managers give their troops a strategic statement for their units." {Central HQ PA} explained that "unit managers and finance managers reckoned that the initial batch of materials that went with OPIS disks would have had the effect of swamping responsibility centre managers and some service managers." Consequently, not many people received information like the hospital organisation's overall strategy document and other details, "but instead were given a summary prepared at the unit level. Perhaps . . . responsibility and service managers missed out on receiving a total [hospital organisation] picture."

> do more outputs with less money. There is no rational tie up of budgeted fixed and variable costs with target volumes.

What happened in preparing budgets and completing OPIS discs from service to service could have varied. However, all service and nurse managers interviewed regarded the allocations as both the starting point for drawing up their services' budgets, and the "total dollar amount to which the budgets of responsibility centres within [the service] should balance in total" ({Nurse Manager PS}) at the end. Furthermore, some interpreted the break downs of their allocations between responsibility centres as "the amount of dollars which would be available" to each responsibility manager, who should then "work out the amount of service which could be performed to fit within this dollar amount." ({Nurse Manager PS}). By contrast, {Nurse Manager PM} indicated that she discussed with each responsibility centre manager how their budget could be varied. "Those with too much money for what they had planned would have money cut and redistributed to other responsibility centres." {Service Manager PC} also indicated that some redistribution of funds was possible compared with the previous year's budget, provided that it was within the total hospital allocation. She stated that:

> Though this distribution is organised at a district management level, the first stage in any redistribution of the funds compared with the previous year's budget happens within each service. Thus, in [Service C], if I feel that [a department] needs a few hundred thousand dollars and I can find that amount within my service, then I can just transfer it as long as the service as a whole can meet the needs of the various clinical services. Outside of that kind of redistribution within a service, I would have to go to the management team for any other additional funds and make a case based on the levels of service that they might want the service to achieve.

Most interviewees thought that most, if not all, responsibility centre managers in the hospital were involved in putting together the 1992-93 budget[8]. Even so, it was the

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[8] {OPIS Support Person P}, from his vantage point at central headquarters when the 1992-93 budget process was in progress, stated that:

(continued...)

service managers who were formally responsible for providing the information to the financial services division. {Site Coordinator P} related that it seemed to her that service managers chose to have different levels of involvement in putting their services' budgets together. Overall:

> they did not seem to spend as much time as the responsibility centre managers on the technical aspects. . . . [Nevertheless,] all of them seemed to perceive the process as being important, and they acted as arbitrators between and within responsibility centres. . . . [In particular,] services were able to move money around their various responsibility centres, as long as the results balanced back to the overall allocation for the service. The responsibility for ensuring that this balance was achieved lay with the individual service managers. . . . [Similarly,] it was a service manager's decision if money was taken off one responsibility centre within the service and given to another. . . . This was also true of the district general manager, and he acted as arbitrator when it came to issues between services later in the process.

{Site Coordinator P} reported that while putting their budgets onto discs, "a lot of responsibility centre people took up the offer to visit the financial services division for help," and also she was "running around to anyone who wanted help." She operated "a very open door policy so that people would wander in at any time to ask about anything," and thought that this policy was important in a big organisation, especially during a period "when people were learning to understand things." She saw what she was doing as being "supportive of their activities." Also, because of the number of people with whom she was dealing, she tended "to have a good idea of what was going on overall." She found that most of the issues raised by responsibility managers were technical ones with which she could deal, but occasionally the issues were matters of

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[8](...continued)

> how people at the various units actually went through the [budget] exercise did vary a great deal. . . . While most of the units devolved the exercise of compiling OPIS data all the way down to responsibility centre level, this did not happen as much as was intended in some places and some responsibility centre mangers never really had a great input into the process. . . . [For example,] there was one institution at which the whole OPIS exercise was all done by one of the finance managers.

service policy, in which case she suggested they should ask their service managers for answers.

Experiences of Participants

Nurse Managers

{Nurse Manager PM} indicated that in her service the task of putting the budget together fell to her, and in the meantime, her service manager assumed the role of approving and agreeing to items which she "sorted out" with the responsibility centre managers. Thus, {Nurse Manager PM} found that compiling the budget was a "huge task" for her personally. This portrayal was echoed by {Nurse Manager PC} who also felt that:

> As this was really the first time that I had done this task, despite last year's initial experience, I had feelings of limited knowledge and limited guidance. . . . I was fearful, especially given the amount of money involved; $22,000,000 was a much bigger number than the 400 FTEs by which I had previously measured the service. This new size was pretty scary and stressful given the accompanying responsibility of coordinating the actions of responsibility centre managers [14 charge nurses and six doctors] within [Service S].

Both nurse managers found the time limits allowed for each stage of the budget preparation process a problem. Although they had been notified that the process would begin in December 1991 with the distribution of a preliminary outline of the process, this outline did not arrive until March 1992 and left them with less than 30 days to act. {Nurse Manager PS} described "the resulting mad rush" as "ridiculous," and this was "made worse because during the budget period various people were on leave for parts of the time."

At the start of the process, {Nurse Manager PS} attended a short training and briefing session, and then had to advise her 20 responsibility centre managers. It had been 12 months since she had last used the OPIS programme, so she had to relearn it. She contrasted the budget preparation process with the rest of her work, and that of the responsibility centre managers. She noted that most of their tasks occupied them

throughout the year, whereas preparing budgets took place for "a few intense weeks only once a year." In addition, she found the programme had been modified since the 1991-92 round. For a time she felt that help was not easy to obtain. She perceived the staff in the financial services division as being "pushed for time" and so she felt reluctant to use them. A member of central headquarters happened to be working in her vicinity and helped her for a short time, but what she "really needed [was for] someone to sit down with me to spend more time going through the steps [in the programme]." Eventually, the financial services division provided someone to do this.

{Nurse Manager PM} reported receiving "huge masses of stuff, including discs and documentation for each responsibility centre manager." This documentation included a background document with details of all the hospital organisation's outputs and what had been achieved in the past year. The output categories had been predetermined at central headquarters, but responsibility centre managers from her service had some input into this determination[9]. She invited {Site Coordinator P} to organise a training session for her 18 responsibility centre managers and also she took them through the computer programme. The budget process documentation included an operating manual for OPIS, but it "would have taken ages to read through." She thought that people really needed a screen to work on while reading the manual, and so she encouraged them to do this.

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[9] {OPIS Support Person P} indicated that a major exercise about stipulating outputs was carried out in relation to the Department of Health, senior organisation management, and service and responsibility centre managers in the districts. The service and responsibility centre managers were told what the Department and senior management wanted, and were asked what else they might want. He related that this resulted in "pages and pages and pages of outputs from many different sources right across the various hospitals and other units. Not surprisingly all these outputs were defined in different ways." He and his colleagues tried to reduce these by blending those which had enough in common and looking at the whole issue from an organisation-wide perspective. Once this was done they "ended up with a whole range of defined output items which were available for everyone to use." {Nurse Manager PM} related that she and her colleagues had submitted their input into this exercise through a meeting at central headquarters in September 1991. Following that, participants had had until November 1991 to make written submissions, and she reported that by and large the submissions that she and her colleagues had made were accepted.

{Nurse Manager PM} saw "no reason to rely on [the hospital organisation]'s portrayal of costs based on historically based budgets, and on target outputs which are not really based on current events." Thus she had her managers draw up service plans for their responsibility centres and set some objectives. She helped each of them work out what outputs it was intended would be achieved, and for how much money. She obtained some statistics from the patient management system which were used for this task. She also maintained some financial records of her own on a spreadsheet. These showed both "the official version of events and the reality of who was overspent and underspent." These records enabled her to calculate costs for different responsibility centres, including cost per patient on each ward. Other data for the exercise included items from the previous year's plan, including the budget, and some work on outputs being developed by one of the doctors among the responsibility centres managers. Also, volumes actually occurring in March 1992 (i.e., when the budget was being drawn up) were used to estimate future trends.

After an initial round of discussions on these matters, each responsibility centre manager prepared a budget. These budgets were submitted to {Nurse Manager PM}, who compared each one with both the official records and her own. This comparison provided a basis for a second discussion phase, after which {Nurse Manager PM} "decided on the totals for each responsibility centre budget," and the responsibility centre managers put the data onto the OPIS discs. She pointed out that these data included operating outputs and costs, and also requests for capital items. For the latter the responsibility centre managers "literally put in everything they could envisage costing over $1000."

By contrast, {Nurse Manager PS} approached the 1992-93 budget from the perspective of previous years' spending experiences. However, she found it "difficult to breakdown the budget between the responsibility centres because of lack of knowledge about their individual total spending in past years." Similarly, there was "insufficient historical data about the make up of each responsibility centre's expenditure and so it was difficult to divide each of their budgets between expenditure categories such as salaries, supplies and so on." She also had problems of a similar nature "in formulating the output side

of the responsibility centre budgets as only a year or two's trend data were available." This was because in the past "responsibility for output had not accompanied spending responsibility and so the two had not been tracked in parallel." She related that this was changing "making it easier to explain what was causing spending patterns to happen." She stated that the form of the hospital organisation's "contract with the Department of Health had influenced this change to output and cost data being linked." But it was still "difficult to predict usage of supplies."

{Nurse Manager PS} also found that in arriving at responsibility centre allocations there was "little room to move things around." During 1991-92, everyone had been "pushed to the limit, or even overspent, so changes in allocations because of underspending were not possible." She made adjustments for salary increments and staff turnover, and this confirmed her impression that "absorbing automatic movements up salary scales when there is little staff turnover was a problem." She believed that the total dollars allocated "not enough because of the high cost nature of the service," including equipment, supplies and experienced nurses, and "the effect of changing foreign exchange rates. . . . It was difficult to contain everything."

In order to enter data onto discs, the responsibility centre managers came to {Nurse Manager PM} because she kept them. Although she had taken the responsibility centre managers through the OPIS programme the previous year, their proficiency varied in such basic things as keyboard skills and the ability to move around the programme, and so she helped each responsibility centre manager as necessary. Similarly, {Nurse Manager PS} described how she helped responsibility managers enter the data. Two personal computers were located in a room set aside in the suite of offices occupied by the manager of Service S and his support staff. Each responsibility centre manager was expected to visit this location and enter data. In a reversal from preparing the 1991-92 budget, the charge nurses carried out the entry procedures with {Nurse Manager PS} watching. The room was spacious "to spread out various papers containing information that were needed to be able to enter data onto the discs."

{Nurse Manager PS} related that data about the transfer of outputs of linen, dietary items and other support services to wards and other services were among those entered on the discs. These data came from the managers of the support departments. She did not check that they corresponded with her own services' planned output levels, and surmised that "the huge task of sorting out data discrepancies in [these] inter-departmental transfers was done by [{Site Coordinator P}]."

{Nurse Manager PM} felt that she had "a reasonable expertise in being able to analyse costs" and found that "people in similar roles possessed comparable knowledge." However, this was not generally the case with the responsibility centre managers (charge nurses and doctors) in her service. {Nurse Manager PM} stated that the reasons for the nurses' lack of skills were related to "the traditional philosophy of nursing," which included a rejection of the notion that money should impact on clinical matters. She also pointed out that, merely because they did not use an analytical approach to managing costs, it was wrong to think that they were not trying to make their wards work efficiently.

According to {Nurse Manager PS}, charge nurses were keen to be involved, and she attributed this to the ease with which these nurses related to her, and vice-versa, because of her own nursing background. With charge nurses becoming increasingly involved in budget preparation, she saw her role as one of providing guidance to them so that they would become competent. She also mentioned that the new systems were placing an additional work burden on charge nurses and that she was able to alleviate some of this burden and at the same time ease people into the system.

By contrast to what she was encountering among charge nurses, {Nurse Manager PS} found the attitudes to be more mixed among the six doctors who were responsibility centre managers in Service S. Three of them proved "particularly unenthusiastic" about being involved in the budget process. She attributed this to their part-time medical staff status, and related that she "ended up having to prepare their budgets." She based these on their 1991-92 budgets, and sent them copies. When she was interviewed in August 1992, she had not received any response from any of these three doctors, and was

unsure about what they did with the information she had sent them[10]. This contrasted with the other three doctors who were clinical department managers in the S Service and who had participated fully in the budget process. One of these was {Chairman P}.

A Chairman of a Clinical Department

{Chairman P} saw the budget process as "the major part in a public relations exercise designed to fool staff." He related that from reading the documentation associated with OPIS:

> it sounds extremely good and extremely sensible. Departments and other centres of responsibility are supposed to predict their workloads and communicate with each other about the impacts of these on one another. From this exchange of information, the centres are asked to calculate their staffing and other inputs in money terms and to put these calculations in their OPIS budget to show how much things are going to cost. Tasks, activities and so on are then supposed to be prioritised at various decision making levels based on these data.

By contrast, he perceived that what had actually happened was quite different in both the 1991-92 and 1992-93 budget rounds. He related that "things have tended to start off in the way outlined in the documentation." For instance, the first thing that he and his department did in putting the 1992-93 budget together was:

> to look at what work it was actually doing. Having quantified this workload, the staff resources needed to do the work were calculated. For this department, this is a fairly simple exercise in that one doctor is needed for every case. Also, it is reasonably easy to work out other costs of dealing with cases by referring to historical data of consumable materials usage and case mix. However, if someone would tell the department what the case mix is likely to be in the year for which the budget is being prepared, these workings could be done a lot more accurately.

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[10] It also proved impossible for the researcher to speak with any of the three in order to try and arrange an interview.

He explained that in spite of this possibility, such forecasts were not given to the department "by anyone who might have them." In the absence of case mix forecasts, {Chairman P} worked on the basis of "what it has cost to do the average case in the past few months." He had used that cost to project the costs of doing the number of cases which he forecasted from trends in 1991-1992.

{Chairman P} described how various people in the hospital "spent hours predicting workloads and working out costs for 1992-93 . . . painstakingly," only to be informed by the people at central headquarters that "these figures were not to be used." The people at headquarters had derived dollar figures of their own from 1991-92 data and used the authority they had over budget allocation to instruct him and his fellow managers to substitute these figures for those which had been derived in the hospital. {Chairman P}'s view was that:

> these figures were obtained without any consideration for reality. . . . Over the year on which the figures were based, there was a 25% increase in surgical throughput. This trend was not taken into account and this made a nonsense of the data that the headquarters people insisted we use.

He described how after the budget setting process was completed, it transpired that actual spending in the hospital for 1991-92 was slightly above the budget allocation, but there were underspendings in other district services. Overall, the actual spending was virtually equal to the allocation. But:

> in spite of the intention to carry on with more or less the same overall distribution of services which produced the pattern of spending shown in the 1991-92 actuals, the way in which the allocation in the 1992-93 budget was spread around the hospital and district was not altered. ({Chairman P})

{Chairman P} pointed out that the items in his departmental budget were determined by someone else's decisions. He described how situations in which many departments and individuals responded to requests for services within the hospital rendered the system of budgeting absurd in various ways. For example, the patients dealt with by his department arose from contacts between these patients and doctors who were not in his

department. He also pointed out that drugs and gases costing about $750,000, and used intensively by doctors in his department, were in the pharmacy and engineer's departmental budgets respectively, "even though they were some of the few things over which we have some control." {Chairman P} felt that these budgetary arrangements were "a great illogicality" because the biggest way in which his department could save money "is to cut down on drugs." But, "because of them being paid for out of someone else's pocket, there is no incentive to do this." He also related that he would "hate to be trying to put together a budget for pharmacy, because they have no control over drug dispensing and changes in dispensing behaviour, but have to account for them all."

{Chairman P} also indicated that the figures he had to calculate did not include equipment depreciation and replacement. Although he lobbied for a systematic approach to this issue, he stated that "no one seems to have taken much notice. Given that there is about $1m worth of equipment relating to this department's activities floating around the place, the way in which replacement is dealt with is very simplistic and ineffective." Similarly, there was no requirement in the budget exercise to take into account the cost of space which the department was using, including utilities and other services provided to that space.

Charge Nurses

Between them {Charge Nurse PA} and {Charge Nurse PB} related that budgets for their wards were prepared and set for 1992-93 during the last few months of 1991-92. They perceived that these budgets were set primarily on the basis that they must manage with less money than they had in the ward budget for the old year. This derived from an underlying presumption that hospital organisations were receiving progressively less money from the government from year to year. They also suspected that while the 1991-92 budget provided a general starting point, data on actual spending in 1990-91 and in the 1991-92 year-to-date were used to judge how much less a ward might be able to manage with in 1992-93. Meanwhile, they were bemused, and thought it ridiculous, that the money they were being allocated via their budgets was not set according to expected patient numbers. This was particularly galling because they were helping in the collection of monthly data on actual patient volumes and similar data using OPIS.

These data were used, *inter alia*, to prepare forecasts and targets of patient numbers and similar service volume measures, but were not used to calculate budget amounts. That patient number factors were not taken into account in the way budgets were set was, they believed, because:

> the budget has not been set realistically in the first place in terms of meeting the needs of the service the ward is providing. . . . The number of patients admitted to the ward are controlled depending on bed occupancy and the number of spare beds available. However, this control is oriented towards accommodating more patients, and there is no question of turning patients away simply to keep the ward within budget. {Charge Nurse PA}

The charge nurses were more concerned about this aspect of their budgets from a monitoring perspective. The budget amount which was used alongside actual spending each month was not adjusted to reflect variations in patient mixes or, higher or lower patient volumes than those implied, but not articulated, in original budgets. The only concession to this concern was talk about *flexing the budget* month by month to take account of seasonal or other fluctuations. Even so, the notion of having a fixed budget for the year would still prevail. These circumstances led the charge nurses to attribute a lot of overspendings to the budget setting process, rather than to problems on the spending side[11].

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[11] A contrasting view to this was provided from SITE Q by {Charge Nurse QP}. He stated:

> The moment a patient steps, or is wheeled, in the door then the dollars are being spent straightaway. Having a total fixed budget does not worry me at all. . . . because although the ward has no choice in the matter of admissions, the number of patients coming onto the ward is constrained by medical limits. There is a physical limit on the number of patients any one doctor can operate on in a given period, and the amount of theatre space available to take these patients is also limited. . . . I cannot see how the [ward] can be flooded with booked surgery which among other more important things might have implications of spending increasing over the budget. However, if this situation changed, . . . the issue would have to be discussed in a round table fashion among the parties concerned. As discussions of this kind on issues generally are common, and quite a lot of talking takes place already, this would not be a problem.

Clinical Support Service Managers

The three clinical support service managers interviewed described how in 1991-92 and 1992-93 they were responsible for devising their departments' budgets and submitting them to their service manager and other management staff in the hospital. They viewed OPIS as a potential managerial tool for addressing issues like efficiency. Their actual experience of it, however, was mixed. On the one hand, they found that participation in budget setting was in keeping with the hospital's way of working as a team. On the other, the approach which the hospital organisation's remote central headquarters took meant that the process became a means for people in the services and departments to retain the money they had received in previous iterations of the budget. Thus: "budgeting is not really an operational management tool tying volumes to costs, and planning in those terms. Though that is what OPIS purports to be, it has not as yet been used as such" ({Clinical Support Manager PD}). Instead it was seen as an electronic means of collecting data, and thence aggregating them, and it was serving this purpose "very well", ensuring "discipline" and "documentation." Previously, there had been "inconsistency", "clutter" and an "abysmal lack of documentation".

The clinical support service managers described how they received a budget package, or "great thick folder" ({Clinical Support Manager PL}). The contents of these varied, depending on which one of two service managers had sent them the packages. However, the sorts of items present were a computer disc for their responsibility centre(s)[12], instructions on how to use the discs, guidelines on budget assumptions, throughput/output data about the organisation and its services, and spending data on the year-to-date for their departments. Through talking to other recipients of the budget packages at SITE P and other hospitals, {Clinical Support Manager PL} knew that the actual contents of the packages received by different responsibility centre managers varied with items either being added, or removed from the packs, on their way from corporate headquarters (see footnote 7 on p. 274). While he felt that some items were removed with the best of intentions, -- not wanting to frighten or confuse inexperienced

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[12] {Clinical Support Manager PL}'s department was actually divided into four responsibility centres and each one had a budget, and so he looked after four budgets.

responsibility centre managers, nevertheless, it was "potentially frustrating" not to receive general policy, or information about developments in services supported by clinical support departments. In practice the removal of these items was not too important: in common with other managers at their level, the clinical support service managers had "grapevine" contacts of their own, and knew that the trend in work was an upward one.

The primary instruction which clinical support service managers received about preparing their 1992-93 budgets was that the total amount should not be more than that in 1991-92 budget(s). The only exception was that an allowance was stipulated for major changes, such as the opening of a new facility, but even then the amounts were regarded by the affected managers as "inadequate." Although the managers felt obliged to comply with this instruction, it caused some misgivings. They sensed that it was becoming a tradition for budgets to be set according to the previous year. In terms of money, this satisfied {Clinical Support Manager PD} who thought that her budget was at a satisfactory level. But it left the others shrugging their shoulders (during the interviews) and pointing to the "ridiculous"ness of the situation. Notwithstanding, all three felt that this imposition was undermining the budgeting process, and they found it unsatisfactory and frustrating. It meant that existing inconsistencies in budget allocations within their hospitals were reiterated, and so reinforced. Underspending and/or over-resourced areas had no incentives to revise their budgets downwards, and the other areas continued overspending because they could do nothing about most items in their budgets (e.g., costs of drugs and tests being prescribed by doctors). It also meant that similar inconsistencies between hospitals were being reinforced (see p. 272-273).

Despite these criticisms, all three clinical support service managers were glad of the opportunity to review the allocation of their total budget between classes of expenditure items, because before 1991-92 this allocation was imposed by someone else. Also, allocating a predetermined total between expenditure classes was a relatively easy job. {Clinical Support Manager PP} stated that setting the budget for her department was a matter of:

> fiddling around with the figures in order to get what hopefully is a more accurate representation of what the [department] is spending[13]. Although this approach sounds ridiculous, it fits in with the format which the budget takes and seems the only way of assessing what is going to happen. This fiddling with the apportionment of the total budget . . . makes the budget look more accurate by the end of the year than it would if the apportionment was left the same from year to year. However, as the [department's] actual spending is going over its budget[14] . . . what I expect to end up with [tongue in cheek] is that each budget item will be overspent by the same proportionate amount.

The clinical support service managers saw themselves as making great efforts to derive accurate forecasts, including estimating demand for different services, and the inputs and costs involved. They had tended to maintain their own data on actual outputs, throughputs and inputs since about 1991, and used these in their forecasting. They were also using their monthly expenditure reports to construct expenditure profiles on the items in their budgets. By combining these analyses with information from their staff and their hospital contacts about trends, they could anticipate the effects of likely future activities and changes to activities. This approach derived from professional pride, and an appreciation that a more realistic version of what the year ahead entailed would help to explain overspending. They also believed that the present process was only an interim step towards a more elaborate process in the hospital enterprise environment in which doing this task comprehensively would be crucial to the survival and development of their services. For the time being, however, they were restricted in the amounts they could put into their OPIS budgets.

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13 {Clinical Support Manager PP} explained that she had joined the hospital since the 1991-92 budget was prepared, and that this budget had been "put together between the clinical support services manager and people from financial services" because her predecessor "did not want to get involved. While my boss and the finance people had done the best they could to correct the numbers which went into that budget there were inaccuracies in it because of a lack of [departmental] involvement."

14 {Clinical Support Manager PP} attributed this "tradition" of being overspent to doctors seeing more patients, and prescribing items that were more expensive, than were implicit in the budget.

By contrast, the clinical support service managers thought that people at corporate headquarters did not want to know about planning and budgeting based on demand for services, and what it would cost to meet this demand. They also felt that these people were not concerned about how the people in the operating core made use of money, as long as there were "no outrageous catastrophes which cause anyone to scream" ({Clinical Support Manager PD}). The clinical support service managers perceived that the headquarters people's focus was on sharing the amount of money which was expected from the central authorities. They would have been satisfied had the hospital's budgets were prepared by doubling spending in the first half 1991-92[15]. The clinical support service managers knew this method was crude because expenditure reports were invariably incorrect and incomplete, seasonal variations and random past occurrences would be ignored, and the future would not be the same as the past.

Another criticism raised by the clinical support service managers referred to the standard categories of expenditures and outputs which OPIS required them to use. The output categories were the result of consultation with the support services in all hospitals affected (see p. 278). But in some services there was little commonality between hospitals, and different equipment and demands on services. The categories devised for these services by corporate headquarters did not suit any of the departments that contributed the data. Moreover, the categories were such that there was plenty of scope for ambiguity when different people interpreted the category descriptions. In any case, the clinical support service managers had major reservations about entering forecast output data onto the OPIS discs because these would tie up only by chance with the

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15 {Central HQ PA} stated that "units were sent details of the expenditure of their departments for the first six or seven months of 1991-92. . . . From the expenditure data they were given, units were expected to calculate their year's expenditure by a process of extrapolation, give or take some variables." He indicated that as part of this extrapolation "some attempt was made to distinguish between fixed and variable costs, and to apply this knowledge in order to link the budget to trends affecting projected outputs." This was done by distinguishing between direct and indirect costs and using these to project expenditure from projected outputs. This projection constituted the basis of the units' budgets for 1992-93 and they were expected to complete their OPIS discs putting in both dollar budgets and projected outputs for each responsibility centre.

equivalent input data entered for wards and other departments consuming these outputs. They believed that the costs of the inputs needed to produce the forecast outputs were not reflected in the OPIS budgets.

Non-clinical Support Service Managers

The two non-clinical support service managers were first asked to prepare annual budgets for the 1991-92 year, and the task was repeated again in relation to 1992-93. The description given above relating to clinical support service managers applied for the most part. {Non-clinical Support Manager PE} indicated that he found OPIS to be similar to other systems he had experienced in the private sector in that "it attempts to plan around production capacity, production volumes, and manpower usage." He also noted that because "most patient admissions are non-discretionary in nature, there is a major difference between planning in typical businesses and planning in hospitals." The main difference was that instead of planning on the basis of patient job mixes elected by the hospital, planning was done on the basis of forecast activity levels: "These forecasts are based on measuring underlying long term and seasonal trends in activities using such data as bed-occupancy rates."

The two interviewees described how OPIS was used to collect data from responsibility centre managers on "estimated outputs, inputs and money to pay for inputs." These data were useful to know although the budget was "constrained by a limit on the total amount of money, regardless of activity levels." However, they were expected to become "more important" as funding moved towards being output based under the regional health authorities and hospital enterprises system. {Non-clinical Support Manager PH} related that in the meantime it was a matter of responsibility centre managers "coming up with these data within the limit of money available," and this forced them to think about each of these things and how they were linked. The process of budget setting or estimating helped them "visualise what lies ahead and identify areas where money is needed or not needed." The basic aim in preparing their budgets was to achieve consistency between the expected service outputs and the money available. They were expected to prepare their budgets under the basic assumption that the amount of money they proposed to spend in 1992-93 was the same or less than their 1991-92 budget. As individual over-

and underspending did matter "in terms of answerability when the budget is under way," it was felt "important to be accurate about what is going to happen." Thus, a good deal of "juggling things around" went into preparing budgets.

The data which the two managers were maintaining about their services[16] helped a great deal. They tended to work on the assumption that patterns and trends of the immediate past were a reliable guide to the future. In addition, they had to anticipate growth or expansion in services which were likely to occur as a result of new projects being set up elsewhere in the hospital district. These caused total variable costs to increase, and sometimes meant that a service's operating capacity had to be expanded. But none of this growth was bound to lead to the annual budget allocation being increased at all, let alone by an amount which was considered adequate. The two non-clinical support service managers recognised that this would lead to overspending in some areas if nothing was done, and so tried to make reductions or savings elsewhere.

Other than being constrained in the amount of money they could propose to spend, the feeling of the two non-clinical support service managers was that they had the freedom to strike their own budgets. In addition, {Non-clinical Support Manager PH} had scope "to play around with" the money allocated between his six responsibility centres as long as it "came back to the same total amount at the end." Both indicated feeling more positive about budget setting since they had become more involved in it. However, they pointed out that the process had not been without its problems, particularly in the first year when "there were quite a lot of mistakes made" ({Non-clinical Support Manager PH}) by everyone involved. {Non-clinical Support Manager PE} attributed some of these to OPIS being:

> a more formal system than what people in the [hospital organisation] and at the hospital were used to in previous years, and so is a first for many people in the hospital. As a budgeting tool OPIS is a reasonable initial attempt in its present

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16 {Non-clinical Support Manager PH} described how he kept expenditure profiles for items in each of the six responsibility centres he looked after. Also, {Non-clinical Support Manager PE} related that his department used a system called works information management system [WIMS] to keep track of building and plant maintenance jobs and costs.

> form, and it can be refined as the need arises. One of the most important things it does is to make people sit down and think about their outputs compared to their use of labour. From that point of view it has been a success as a budgeting tool. . . .
>
> In contrast, OPIS has had a lot of bad publicity out of the way it is used to deal with both outputs and departmental input-output links. The idea or concept of trying to address these aspects of the hospital is good. At present, quite a few service and responsibility centre managers . . . do not make the decisions which drive their costs. For example, the clinical services manager, laboratory manager and pharmacy manager are not the ones ordering the tests or prescribing the drugs which are paid for out of their budgets.

He added that he was unsure about how successful OPIS had been in terms of measuring how many clinical outputs were being carried out, or "the equally intricate internal transfers that take place" ({Non-clinical Support Manager PE}). He felt that OPIS might be too crude a tool for this purpose, and stated that a lot of dissatisfaction had arisen from inconsistencies over outputs, input-output internal interlinks, and basic questions over who was driving costs.

{Non-clinical Support Manager PH} felt that the change between merely being given a budget by the finance people and being largely responsible for allocating money within his own responsibility centres' budgets, had been a significant step for him and the other managers. He related that 1992-93 was the first year that he had felt in control of the department's money and accountable for it:

> The budget in previous years was somebody else's which I have not always understood, agreed with or accepted accountability for, but even so I was held answerable for it. Now, I am responsible for the budget that is submitted, and if it goes wrong in any way, I have to answer for it.

He added that the several supervisors who were responsible to him were not involved in setting the 1992-93 budgets, and when he raised matters of overspending with them they did not seem to feel accountable.

Coordinating and Synthesising the Completed Discs

The responsibility centre managers sent their completed OPIS discs to {Site Coordinator P}, but those interviewed were not altogether clear about the steps in the budgeting process after this. {Clinical Support Manager PD} exclaimed that the discs "just disappeared!" {Nurse Manager PS} supposed that there were "a few administrative checks" made of the discs by the financial services division staff, and reported that she was asked to agree to a few alterations being made to the output data in order that the discs were consistent. As far as she knew, the division had been happy that the total dollars included on her service's discs agreed with the financial parameters within which were she was expected to work.

By contrast, {Site Coordinator P} indicated that by the time she had finished balancing and aggregating the discs, she would probably have "checked virtually all of the data put on the discs" by the service people. The task involved down loading the data from the discs and checking them, primarily to ensure that "they were reasonable, that things had not been missed, and that the budgets were spread, or flexed, over the year as they should be." In order to do this, she had to ask service and responsibility centre managers for copies of their working papers, "because the information on the discs about calculations was inadequate." She asked services to amend data as necessary.

On completion of these amendments, the discs came back to {Site Coordinator P} and she "started balancing individual services and the whole district against allocations." This was done to ensure that the total amount for each service equalled the combined total of the allocations made to the responsibility centres. When she found allocations which had been exceeded, she went back to whoever was responsible to find out what they wanted to do about it. This involved liaising with managers both within and between services, in an effort to cover excesses by reducing budget proposals somewhere else. Within a service she would "only arrange for transfers between responsibility centres on the say so of the service manager; and for transfers between responsibility centres in different services, both service managers had to agree to the transfer." In addition, the district general manager was asked for approval when, because of changes taking place in particular services, proposed budgets were in excess

of initial allocations. {Site Coordinator P} explained that "the focus during this phase was balancing the unders and overs over all the district; some people contributed to the unders and others to the overs."

{Site Coordinator P} indicated that coordinating and synthesising the data on the discs about the "capital side" was another aspect to the above task. Proposals from each responsibility centre were ranked by their managers using such descriptions as "essential to maintain the volume of service" and "nice to have." Having used the discs to generate written lists of these for each service, {Site Coordinator P} asked each service manager "to do some more ranking on these lists. After that, the general manager was asked to do some overall ranking between services for the whole district."

Only some responsibility centre managers were involved in refining their budgets during this coordinating and synthesising phase. For example, in the non-clinical support area some refinements had to be made to what was put forward. {Service Manager PB} involved the non-clinical support service managers by negotiating changes with them. He left it to them to finalise the discs for their departments before they were sent back to the financial services division for onward submission to central headquarters. The non-clinical support service managers felt that this involvement reinforced the idea of having some freedom and autonomy to allocate the money in their budgets. By contrast, the other six responsibility centre managers interviewed came under different service managers and had very little involvement in this or the subsequent stages of the process. They surmised that at some stage their budgets were incorporated into material that went to the central authorities in Wellington. Notwithstanding, they were aware of the significance of this step in that virtually all the money received by their hospital organisation, hospital and departments derived from annual government grants.

Progress of the Budget Outside the Hospital[17]

A view of the above proceedings from the headquarters' perspective was provided by {Central HQ PA}. He described how the hospital organisation was notified by the

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[17] The reader is alerted to the situation that the interviews took place while the events described in this subsection were occurring.

Minister of Health of the amount of grant it was to receive from the government. On receipt of this notification, {Central HQ PA} and his colleagues derived "a funding allocation for each unit [e.g., SITE P hospital district] for 1992-93 by taking the total amount of money in the grant and dividing it up between units based on historical information." After this, "each unit was told how much it was likely to be getting." He related that:

> once the diskettes were completed by the various people responsible throughout a unit, they were given to the finance manager of the unit in probably every case. That person's job was to review the data on the diskettes and then consolidate them for the unit. This task gave rise to a final consolidation of the unit's budget, and this consolidated unit budget was passed to [central headquarters] in diskette form. . . . each unit [also] came in with its projected outputs.

{Site Coordinator P} related that when the budget for the hospital district was completed, in about April or May 1992, the OPIS discs were submitted to the people responsible at central headquarters. It appeared to her that about a month was spent checking budget proposals to ensure they balanced with the figures originally notified to the hospital. These checks led to questions in the tone: "This does not seem to balance. What are you going to do about it?" She described how these checks were not only of overall proposals, but also related to specific expenditure classes across all services. Thus:

> questions were raised about proposals in the 1992-93 budget in cases of a big account code item, say surgical implants, being 20% or so up or down compared to the 1991-92 budget. This kind of control was focused on the overall proposed spending by the district as a whole, rather than the detail of particular services and responsibility centres. It did not present a problem for the district.

{Central HQ PA} described how "as part of its clinical planning and review task the [hospital organisation]'s purchaser division reviewed the outputs." On the financial side, {Central HQ PA} and his colleagues at various times discussed the issues involved with unit staff. These issues often revolved around variances between a unit's allocation and

its budget proposals. He recalled that two rounds of meetings took place, both interesting. In the first round:

> units took one of two approaches to what were negotiations about what should and should not be in the budget. The first approach involved a unit coming in with its base budget, plus, say, a 20-page document. The latter covered the many other things which the unit had not included in its base budget but which its staff reckoned they also needed to carry out and for which they wanted funding. The second approach consisted of a unit presenting a budget into which was built everything it wanted to do. Obviously, the budgets produced based on this latter approach did not meet the target funding allocation of the units concerned and so the meetings became a matter of arguing the point of whether various proposals should be in or out of the budget in order to come back to the allocation which the unit had been given.

{Central HQ PA} described how following on from this first round of negotiations, second meetings were held with each unit about a fortnight later. "The aim of these meetings was to review each unit's situation. In the meantime, the unit people had been back to their units where they had adjusted the budgets so that the unit would come in at the target funding allocation." This was done on the diskettes and {Central HQ PA} surmised that these were passed back to responsibility centre and service managers who were asked to revise the budgets at these levels. In any case, "the diskettes were completed by each unit such that they got back to the target funding allocation," and then were sent back to the central headquarters. At the second meetings the two groups compared notes. The headquarters people "basically looked at the budget and if the target funding agreed with the budget we were satisfied that a major goal had been achieved."

{Nurse Manager PM} reported on two events which she found significant at this time. First, the district management team were notified of the way the hospital organisation's total capital would be split between the districts. The team then collated the various service requests from the data in OPIS, and asked each service for these items to be categorised according to perceived importance, A, B, C, etc (see p. 294). After this, a

meeting was held, "but instead of considering the merits of all the A requests, then the B requests and so on, it turned out more like an auction." {Nurse Manager PM} complained that "some arbitrary allocations were handed out by the leader of the meeting [who came from headquarters], and no consideration was given to the relative merits of individual items on the various service lists."

Second, there was a meeting of district service managers with headquarters' people about a new facility in the district which had only been operational for a few months. In essence, "higher outputs than either budgeted or previously achieved were demanded [by the headquarters' people] for the same amount of money. They also offered a second choice of the same outputs for less money." {Nurse Manager PM} described the attitude which she encountered as being:

> founded on a narrow-minded accounting equation which said that there is such a thing as a base budget. In order to arrive at this base amount the [headquarters'] people had simply annualised the 1991-92 budget up to period 6 [see pp. 271-272]. This budget was calculated from a mix of the part year expenditures on both the old, less costly facility, which was replaced, and the new facility. The people from [headquarters] were not open to a change of mind even in the face of simple accounting arguments about output and fixed and variable cost behaviour patterns in the take off phase of a new facility. And they wouldn't listen to service arguments about having to perform non-discretionary procedures, such as attending to births.

{Nurse Manager PM} came away with the belief that headquarters' people "basically did not care." She saw the only way forward as being "to carry out the services and force the [hospital organisation] to match costs incurred with a budget reallocated from other parts of [the area served by the hospital organisation]," which she perceived as being better off. She received the impression that other people in her service "came away believing that it was not a good idea to open new facilities, except at the start of a new budget year [i.e., on 1 July], because of the method they [i.e., the people from headquarters] used to calculate budgets."

{Central HQ PA} related that when all these meetings were completed and the units' budgets finalised, "the information from the diskettes was up-loaded into the budget field on the [hospital organisation]'s general ledger system." He and his colleagues then "went through the information looking for areas which were over or under funded, or for which internal adjustments needed to be made." They also:

> took account of the capital component of the budget. These adjustments and considerations involved many kinds of issues all of which had to be addressed. Having the budget in the system made it easy to make the budget transfers that were necessary to get the budget to balance again. Having done this, the budget was considered to be complete, and the information was sent to the Department of Health to form the basis of the [hospital organisation]'s contract with the Minister.

For his part, the Minister wanted to know:

> how the organisation intended to spend its base grant allocation and what outputs it intended to produce. Once these things were agreed between the Department and the [hospital organisation] the Minister would sign the contract, but as always this took time because of the negotiation involved and the problem the Department has in reconciling its own budget with those of the all the boards and the other expenditures financed from Vote Health. . . . The process of obtaining Ministerial approval for the contract is not a rubber stamp by any means. ({Central HQ PA})

{Government Analyst} indicated that each hospital organisation's annual budget was submitted to the Department of Health as part of their operating plan for 1992-93[18]. The submissions were made in July 1992 and followed on from the boards having been advised of their funding allocations by the Minister from the government's own budget. Each organisation's budget was analysed to see that it made sense from a Crown ownership perspective, and that the various statements interrelated correctly. This included looking through the budget to assess whether income and expenditure were

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[18] This material has been set out in detail on pp. 168-171.

reasonable from the Department's point of view. Carrying out this assessment entailed the analysis of movements in income and expenditure year-on-year, including comparing them directly to information about the 1991-92 year.

He added that the findings for each budget were given to the Department's contract team in time for the contract negotiations with the organisation. These negotiations led to an agreement being reached on the broad composition of the budget and the overall costs, and on keeping the organisation's outputs "up" in accordance with the Department's aims. Agreement usually took several weeks, followed by the Minister's signature, and so the date on which agreements came into force varied between September and February depending on the organisation. {Government Analyst} explained that there was a higher level of scrutiny of operating plans and budgets in 1992-93 compared with previous years, particularly in projecting the year-end position. There was, also, a large focus on capital plans as some proposals had increased above what previous trends indicated might be reasonable. This accounted for some of the delay in signing contracts. In addition, delays were caused by disruption in the hospital organisations due to the arrival and departure of staff as part of the reforms.

"Working in a Sort of Limbo"

{Site Coordinator P} had a rough idea of the proceedings described by {Central HQ PA}. She presumed that once the checking process between the headquarters and the hospital was completed, the district budget was incorporated into that for the whole organisation and went to the government for approval. When interviewed at the end of August 1992, she indicated that central headquarters and the hospital were "still waiting to hear what the government are going to approve." She also intimated that the budgets which appeared on the July 1992-93 monthly budget reports, which came out in August, were generally those submitted by the responsibility centre managers and service managers (see pp. 315-316).

{Nurse Manager PM} indicated in August 1992 that although she was still waiting the final outcome of her service's budgets for 1992-93, she believed, from indications given to her at the meetings she attended with headquarters' people, that the original budget

amounts would stand. However, this pair and most other interviewees generally expected that "nothing official" would emerge until October or November (i.e., three or four months into the financial year) when everything was finalised with Wellington, and during this time they were aware that there was still a possibility of change. They indicated that all they could do was pick up "titbits" and "rumours" on the "grapevine" about what might be happening, and these were usually to the effect that "restrictions", or cuts, were in the offing.

The nurse and responsibility centre managers had a variety of feelings about the period between the dispatch of their discs and the indication of official approval. These ranged from grin and bear it and general empathy for those involved at hospital management and corporate headquarters levels, to a resignation that poor communication was the norm and little could be done. All they could do was to carry on "working in a sort of limbo; that is, on an unapproved budget" ({Non-clinical Support Manager PE}) as if nothing would change, unless and until they heard something to the contrary. But "if the Minister were to say that he wanted a reduction in the budget then all hell would be let loose to effect that reduction. This is crazy and not the way I would run a business."

The service managers were the main official points of reference for the responsibility centre managers, but information was intermittent. Those responsibility centre managers who were kept as informed as possible by their service managers clearly felt more motivated. In particular, the two non-clinical support service managers described how {Service Manager PB} discussed the implications of what was happening for their departments. They found this was very apt in relation to 1992-93 because of the impending break up of the hospital organisation in July 1993. They saw the negotiations between the hospital and the central headquarters as being critical to the amount of money that would be allocated to the new organisation for 1993-94.

{Service Manager PB} and {Service Manager PC} also indicated that once the discs had left the hospital, they could only wait. Occasionally the hospital district general manager or someone else would pass on intelligence heard from corporate headquarters or elsewhere. {Site Coordinator P} related that the district general manager attempted

to inform service managers of any approval of the 1992-93 budget at regularly held district management team meetings.

"All Hell Breaking Loose"

When interviewed in November 1992, {Chairman P}, having put his budget together and dispatched it around April 1992, had still not heard official approval. In the meantime, he was working with the budget which was submitted for approval. Earlier that day he heard on the grapevine that the hospital had just been told by the hospital organisation commissioner to save $1m from the budget that it had submitted. He expected that for the hospital as a whole, this would mean major adjustment, including how to deal with its increasing throughput. For his department he expected the cut would mean losing two or three staff by non-replacement. However, he thought that despite reduced funds, his department would be expected to provide exactly the same standard and quantity of service.

When interviewed in December 1992, {Financial Controller P} confirmed that the district had "got hit by" a $1m cost saving programme because the amount approved by the Minister for the hospital organisation in the spring of 1992[19] was less than expected. He described how this information did not reach the hospital until three or four months into the financial year. He felt that:

> no business can sustain this sort of thing. . . . It did not amount to spreading a saving of $1m over a year in a manageable fashion and adjusting output accordingly. Instead, it was a case of 'Bang!' Save a $1m after the first quarter has gone, and do not reduce outputs.

He added that "this cost saving programme hit the responsibility centre and service managers after a period of six months of virtual silence since they had submitted their budgets" ({Financial Controller P}). Having worked previously at the central headquarters, he attributed this silence to a reluctance to tell people anything very

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[19] Recollections of when the Minister actually informed the hospital organisation varied between late August 1992 ({Financial Controller P} and November 1992 ({Central HQ PA}).

definite until approval was announced from Wellington. This reluctance came from "the uncertainty of the period since 1988, during which time budgets have been cut regularly. With the likelihood of this happening again, the people at [headquarters] are not keen to tell people anything which might not be fulfilled." He could appreciate this dilemma among people at headquarters, but tended to believe that "people at the operational level should be given some information about what is happening with the necessary caveats about the possibility of change. This would be more satisfactory than just letting the submission die."

Other Criticisms of the Budget Setting Process

{Financial Controller P} raised several other criticisms of the budget process, including those that had been told to him by other people[20]. He described how, "on the whole, people seem to find the 1992-93 budget construction process pretty good and the OPIS tool was starting to work better for them." Even so, some people "still complained about OPIS a lot", but they were mollified when he suggested that they put these problems and shortcomings into perspective "by considering where the budget process had come from in the previous two years." In particular, it had been important for "managing the annual budgeting process" and in "establishing the link between inputs and outputs." {Financial Controller P} thought that from an accounting point of view the system was "brilliant because of using discs and having the facility to load them down." Compared with the manual system, there was "a lot less keying" and the process of reconciling the data across the hospital and hospital organisation was "not horrendous, nor did it take the five or so weeks that the manual system used to do."

According to {Financial Controller P} the four problems which most troubled people were as follows. First, there were problems relating to the time frame which had been set down by people at central headquarters for the actual process of constructing the budget:

> It seemed that they had laid down deadlines for the completion of work without reflecting on the kind of work which people at the hospital were having to do

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20 {Financial Controller P} did not actually arrive at SITE P until just after the 1992-93 budget submission was sent to central headquarters.

> routinely. They seemed unaware of the effect of imposing a major exercise with tight deadlines on the day to day operating environment of the hospital. Above all else, patients coming in the door wanting treatment had to be looked after in the normal way, regardless of any budgeting exercise which staff might be working on.

{Nurse Manager PS} perceived that during this time the clinical work of responsibility centre managers was "pushed aside" because of this new "business management process." The other matter which the timetable seemed to ignore was that the process occurred when traditionally "staff go on leave" (see also p. 277). One activity in particular for which there was not enough time allowed, was the "huge task" of sorting out data discrepancies in inter-departmental transfers (see also p. 281). {Nurse Manager PS} stated that:

> although there was some getting together of the parties involved in the transfers, there was not enough time for this activity. More time is needed to be able to work things out between the individual departments involved producing and receiving services in order to get agreement of the numbers. For the 1992-93 budget, part of the problem was that each service was allowed to approach OPIS as they wanted to. More coordination is needed perhaps at hospital level . . . . This coordination could include instructions, guidelines and a timetable. Also, the scene could be set for the budget up at the top and a person in each service should be designated as responsible for sorting out inter-service transfers with their opposite numbers in the other services.

The second problem reported by {Financial Controller P} was that too much of the process was under the control of people at central headquarters. The staff at various levels felt that as well as centrally imposed deadlines, they had "dictums coming down at them" which made for great inflexibility. {Chairman P} believed that if things were done in the way stated in the OPIS documentation, then much less centralised bureaucracy would be needed and "the result might make sense." Other interviewees also attributed many of the problems with the process to it being centralised. This criticism extended beyond the budget. It included the report formats used, budget

transfers and similar data entry, and data access. Headquarters staff were linked to much tighter money in hospitals and departments, and were believed to be suffering from a preoccupation with short term spending reduction. They were not held in high regard by several of the hospital-based interviewees. {Site Coordinator P} also noted that they seemed remote from the detailed level to which she and the service managers were working. She related that at hospital level, "even a $1,000 allocation is important and worth chasing, whereas the people at headquarters tend to round things up a lot more."

The third criticism raised by {Financial Controller P} was echoed widely among the interviewees. It was that too much reliability was being placed by central headquarters people on the 1991-92 budgets in working out targets for 1992-93. Consequently, not enough use was being made of patterns of actual spending and volumes of services in order to estimate the costs of the possible range of volumes which could arise in the next financial period. {Chairman P} found the budget and financial system frustrating because people like himself, who knew what was happening, were not allowed to provide accurate information:

> The system is frustrated all the way down the line because the information that goes in is garbage. The system itself then becomes garbage because nobody can make an intelligent decision based on the inaccurate information that has been put into it.

He saw OPIS as being somewhat ritualistic in that "it serves a cosmetic or public relations purpose both within the organisation and to the outside world" {Chairman P}. He charged that:

> By causing the budget to be done in the way it is, and exercising overriding authority about which figures to use, the central finance office in particular, and [central headquarters]'s officials in general, maintain total central control of the organisation. It does not matter that the exercise ends up producing nonsense figures and has also wasted a lot of people's time. In this way and despite some appearances to the contrary, there has been no devolution of budgeting and such like.

The fourth criticism reported by {Financial Controller P} was that services and responsibility centres were seen to receive the same amount of money regardless of whether they provided higher or lower outputs than expected, or were efficient or not. Also, as far as incentives were concerned much depended on what the service managers did. In this regard, {Site Coordinator P} said she had noticed "a variation in outlook and approach among the different services. Some services promoted forward thinking, responsibility, risk taking and those sorts of things, whereas others were very control oriented." She thought that "funding should be allocated on the basis of volumes of outputs to be done, at the unit cost calculated for particular outputs." She believed that "the present historically-based allocation system . . . [in which] the calculation of the responsibility centre and service budget commences from the previous year's budget, is unfair and not good because it perpetuates existing practices regardless of whether the respective managers are efficient or otherwise."

{Service Manager PC} felt that the basic approach taken to budgeting (i.e., of starting by limiting the dollars and working out what can be done for them) was "the wrong way round, or at least quite unique." She felt that "no real business has a fixed revenue," and that, "in commercial situations, most people plan to do as much as they can and then work out what it is going to cost." Along with many other people in the hospital, she was finding "this non-commercial budgeting approach, which the hospital is obliged to use," to be very frustrating. Instead, she would have preferred to do the task "the commercial way round."

{Chairman P} also felt that what had been happening was "the wrong way around." He pointed out that although OPIS featured an output focus, choices were determined by what the departments wanted to buy in order to provide their services, not what services were needed by the community. Thus, the budget started from each department's indication that a specialty service could be provided at the hospital for so many dollars. By contrast, {Chairman P} believed that in order to prepare their budget he and his department should calculate the cost of dealing with individual types of patients, and include some allowance for space and equipment. This data should then be incorporated into the budget for the surgical or other services which his department supported, along

with forecast numbers of patient volumes. Similarly, when work was being done, the department should bill the holders of these budgets for this work based on the budgeted costs for individual cases. {Chairman P} believed that in this way, the people responsible for surgical and similar services would be able to see how much the support of doctors from the department was costing them, and if they could "find anyone who is able to do the work cheaper, good on them." His view was that this:

> is too hard for the people at [corporate headquarters level]. . . . These people know that by allocating so much money in the past the hospital has managed more or less to do the work which has come its way. They then assume that repeating the allocation from year to year will be enough or more than enough. This allocation is spread around the hospital in the form of the budget. The fact that the way the money is actually being spent does not coincide with what is portrayed in the budget does not matter very much to the people at [headquarters]. What does matter to them is, first, that the hospital does not exceed its total allocation in any one year and that enough work will actually get done. And second, that from one year to the next, the allocation made to the hospital can be reduced resulting in savings in [the hospital organisation]. To actually make a real budget is hard work and incidental to these concerns.

{Chairman P} also argued that "the budget should be starting from the question, 'Are the surgical services which are being provided at present really needed?'" He felt that the budget should be put together "by someone who is deciding what is of value to the community and where the resource should be spent." After the areas in which to spend the resource were decided, then the people in these areas "could draw up the budget for their area." He had a basic concern that although services were generally seen by people in the hospital as necessary, because of the pain and suffering a lack of such services would cause, "in the wider economic scheme of things a lot of these services are probably less valuable than other things into which the resource could be put." (see pp. 122-123)

{Nurse Manager PM} felt that the budget process was perpetuating the view among some of her responsibility centre managers that they should "build up a budget and hang

onto it," regardless of the priority of competing needs in other responsibility centres. She described how she had come into her job "believing that things could be approached logically or rationally, and equitably." She had anticipated that services and service levels could be decided in conjunction with the standard fixed and variable costs of providing particular service volumes, and that resources could be allocated accordingly, both between services and overall. She had become "disillusioned," and could see that budget setting and resource allocation were part of "a political process." She also believed that inequities prevailed both between districts and within districts. It was her contention that:

> budget allocations across the [hospital organisation,] and within the hospital, are based on historical patterns and on time periods, rather than on outputs. [What is more,] there is very little redistribution of resources in response to changing output volumes, or achievements. Cuts are the norm, and these are imposed on the basis of a flat percentage across all existing allocations.

She added that these policies had adversely affected the hospital district, whose population was generally regarded as having greater needs than the hospital organisation's other districts based on its socioeconomic status. Despite the intention that the new hospital enterprises would operate on the basis of payment for performance, she could not see this occurring for some time after the Crown health enterprises and regional health authority were established, and certainly not in 1993-94. This view was shared by {Financial Controller P}. Along with his financial service division colleagues, he expected the regional health authority to roll existing contracts and 1992-93 funding for the district into 1993-94. Because they felt that the district was underfunded (see also pp. 273-274) none of them were particularly happy with the arrangement.

A fifth problem was alluded to by {Chairman P}. He related that OPIS was only one of several competing systems within the hospital organisation, and was sponsored by one faction. He claimed that another faction was pushing for a patient-based information system and the two systems were mutually contradictory systems:

> Originally, OPIS was a broad paint brush system, but has since been stretched with the intention of covering fine detail. However, it does not do this because

> it is being frustrated [in various ways]. Nonetheless, this stretching is being pushed by the vested interests which sponsored OPIS in the first place, just as other factions have pushed their systems beyond system capabilities for their own interests.

By contrast with the problems described above, {OPIS Support Person P} attributed certain problems with budgeting process to the hospitals rather than to central headquarters. He claimed that in some cases:

> units interested themselves solely or mainly in the dollar side of the exercise. These units seemed not particularly interested in defining what they were going to produce and all they wanted to do was record how much money they wanted. . . . [This was] a hangover from the way the [hospital organisation] used to operate, with money being allocated out from the centre on the basis of historical allocations and with little regard to outputs.

Some responsibility centre managers were "given a total amount within which to devise their budget, again representing a continuation of previous practices" {OPIS Support Person P}. He also felt that variations in how people went through and completed the OPIS exercise tended to impair the quality of the aggregated data. Nevertheless:

> some units put a lot of work into the budget process exercise. For example, they established quite clearly defined outputs, and they devised a process by which to relate a dollar budget to the quantity and quality of what they were going to produce.

He had also noticed that:

> on the output side most of the best input was coming from the line staff who are actually doing the work. However, when the responsibility centre managers passed their information up the line for aggregation, say at hospital level, some of the people doing the local aggregating started to interfere with the information and the measures. ({OPIS Support Person P})

He presumed that this was because they did not like something which particular responsibility managers had done. This troubled him because it meant that, "having designed a system essentially with which responsibility managers could build a budget, their base data was being interfered with at the various points of aggregation before it came back to [central headquarters]" ({OPIS Support Person P}).

Budgeting Preparation and the Ability and Attitude of Staff

At both SITE P and SITE Q, virtually all the hospital based interviewees referred to the learning entailed for themselves and other people during the developments in the budget preparation processes described above. From his hospital organisation vantage point, {Central HQ PA} observed that "the skills in this area were woeful at first but after the initial effort in 1991-92 things were much improved in relation to the 1992-93 budget."

Interviewees at SITE P felt that some responsibility centre managers came into the OPIS exercise well prepared, but most were not and their involvement was constrained by their inexperience of business management. {Site Coordinator P} described how she encountered expertise among service and responsibility centre managers and support people ranging from "very poor, to very, very good." She detected "a definite dividing line" between people who had "both clinical or technical, and management degrees or qualifications of some sort," and those who were "really struggling, such as charge nurses." She attributed the latter to the study of nursing not including any management topics, and management education only being available for them "by going outside the organisation in their own time." Notwithstanding, she thought that many people did very well in 1992-93 compared with the previous year. This applied both to the people who were involved in the training which she had provided since OPIS was introduced, and to other people. She felt that the latter had been "treated unfairly" in 1991-92 by their service managers in that they were "given their OPIS discs and told to get on with it." Although these people had struggled then, it seemed that "they benefited from the experience and did really well in 1992-93."

{Site Coordinator P} felt that more people had become familiar with "using past data, playing around with working papers, and evaluating their OPIS data," whereas in

relation to 1991-92 "they did not have adequate data or expertise to be able to do this." She was "amazed at just how much change has taken place in two years, [especially] the average charge nurse who had an $800,000 budget, and very little training on how to handle it." She was looking forward to conducting more training of people during 1992-93 so that they would become "self-sufficient in their budgeting" and "would make time to do financials in among the clinical load." Similarly, {Service Manager PB} felt that there was a greater understanding occurring each year of the budgeting process, particularly of the relationship between inputs and outputs, and the interrelationships or links between different services. Even so, he thought that understanding of these links was probably still in the embryonic stage and far from perfect. He anticipated that "by devolving the actual effects of linkages on the front line services, a clearer picture would emerge of what is really going on." For the time being, the most common occurrence was for people supplying support services to check with the service people being supplied whether they were "aware of some of the costs which they were running up." This was a relatively new phenomenon, and he saw it becoming more explicit as budgets became devolved.

{Service Manager PB} also related that people were "beginning to make the connection between their anticipated actions and the budget numbers, and learning that the budget is not just a set of numbers submitted to comply with the requirement to have a budget." He described how "applications of costing," and of "the broader concept of rationing resources," were developing at different rates in different parts of the hospital. He attributed the slowness in clinical areas to "the mind set of doctors as derived from the Hippocratic Oath." He explained that the oath meant individual doctors doing their "best for all people at all times," and was contrary to:

> the notion of a doctor cast in the role of a rationer of resources who is asked to establish an order of priority by deciding which patients will receive what level of treatment, if any, because there is not enough money to pay for everybody receiving the best treatment.

{Service Manager PB} also thought that some problems arose from doctors not being trained to be managers able "to get more from less," seeking continuous improvements,

looking at new ways of doing things, "embedding the right management structures to make the thing happen," or having "the right corporate culture so that everybody in the team is looking for new ways of carrying out tasks" whether they are medical or administrative. He believed that in the hospital's support services "millions of dollars have been driven out by the application of these techniques and philosophies." He thought that it was unfair to expect doctors, nurses and other clinical people to become brilliant managers quickly even with training, but felt that that training had to be available in order that they could become managers. He also wanted certain jobs to be renamed to reflect what they entailed. For example, he thought that "ward manager is a more suitable title than charge nurse. . . . This reinforces the culture change which is being sought. Without these kind of moves, the changes expected are not going to happen."

{Service Manager QS} described how he intended extending the budget preparation process downwards and indicated that he had "taken the approach of feeding responsibility centre managers with bits of information and responsibility from time to time, in order that they could get used to things like budgets." He perceived that this needed to be "a slow process backed by appropriate support," rather than one of "dumping things on them all at once," because this might "freak them out." He believed that this approach had "avoided the problems of trying to force change through," and instead, their jobs "are evolving, and the managerial things are less threatening and less of a mystery." They were:

> becoming accustomed to information and understanding it. . . it is working its way into the way they do their jobs, and at the end of the day they will adopt responsibility for things like budgets knowing that they are deriving benefits as individuals, and for their patients, from having this sort of control.

He felt that although charge nurses seemed to accept and like additional clinical management duties, "they probably would baulk at doing managerial things like budgets, over and above what they are already doing" ({Service Manager QS}). He saw them as needing time to develop their jobs, and to decide which tasks to keep doing themselves and which to pass to their staff. In the case of the senior medical officers,

"they have not had any exposure to any sort of [managerial] information at all." He described how there was "a drive", beginning in 1992, to make medical staff "very much more accountable for their requisition of services, including laboratory, x-ray, surgery and drugs, and also for the timing of discharges." However, he felt that the easiest way to antagonise or discourage doctors was to demand total management instantly. The response he anticipated was a refusal, on the grounds of their being doctors and not managers, and as a result this was not the strategy he believed should be taken. Instead, he believed in:

> weaning the doctors onto the basic ideas by feeding them information in a non-threatening way. In this way, doctors will become aware of the costs that they are actually incurring and will come to understand slowly that they have got some latitude within the general concept of accountability. From this they would appreciate that this idea was not a big stick, or any other kind of threat.

{Service Manager QS} added that "having got used to the idea, the doctors will start making decisions about different types of dressings, and different types of treatment, and will be able to see the benefits of new technology and all those sorts of things." He also thought that it was unreasonable to expect too much because both the senior doctors, and the charge nurses, already had a full workload.

{Service Manager PC} related that the responsibility centre managers in her service (who were largely health professionals, but neither nurses nor doctors) had coped with the 1992-93 OPIS exercise "quite well" and "most had been quite sensible about it." She was pleasantly surprised about the skill with which budgets were put together, but:

> some difficulties occurred in working out service outputs because of the lack of computers and the poor quality of the available information. . . . a lot of the outputs were based on guesstimates, but because the people in the major areas were all fairly seasoned, . . . they were pretty good at making these judgments.

By contrast, she felt that project planning had been difficult for responsibility managers to cope with, because "their knowledge of health economics is limited" ({Service Manager PC}). Consequently, they were unable to carry out "the quite complex cost-

benefit analyses" arising from large capital expenditures and expensive services, and "the number and range of options" from which a choice had to be made. Thus, she did the cost-benefit analyses and found that her combined economics, business and nursing background fitted her well for this task. She also noted a similar shortage of project planning skills among the service managers, and despite some "making quite good attempts at economic analyses, the lack of an academic background in this area showed." She described how the problems posed were fairly complex and she felt that a few more health economists were needed in the nearby university, to help hospitals to cope.

Strategic or long term thinking and planning was a subject also raised by {RHA Official R}. He related that traditionally the ability of hospitals to plan long term and think strategically, and particularly the ability to plan long term financially and make "asset decisions", had been "absolutely atrocious," and thinking was in terms of budgets for one year after another. He thought that:

> the big area the [hospital enterprises] need to think through in the long term is what basically will be the form of their organisation in five years. They need to show that at least they can plan. . . . The linking of short term changes at operational unit levels with changes of a long term strategic cost nature depends on a lead from the top management.

Closing Pointers

This chapter unites the threads included in chapters 5 to 8 in relation to compiling budgets, and traces the development of processes and interactions that are emerging as budget preparation and setting permeates through the management zone into the operating core and support services. It shows how this aspect of accounting has figured in the dynamics of hospitals, hospital organisations and the hospital system in a vertical fashion both reflectively and constitutively (see Burchell et al., 1985; Chua, 1995; Loft, 1986; Roberts & Scapens, 1985). People in different elements of the functions and values framework see budget preparation and setting having different roles. They have different feelings about its efficacy, the way it affects them and how they should approach it as a task. These feelings are changing as they become more familiar with handling the budget and with how it affects them. Much of the effect of budgets stems

from the way things proceed as the financial year gets under way. This is thickly described in the next chapter with particular emphasis on the 1992-93 year.

CHAPTER TEN
A THICK DESCRIPTION OF CONTROLLING, MONITORING AND ANSWERING FOR SPENDING

The chapter provides a thick description of the situated practice of accounting in hospitals in 1992-93, focusing on spending control, monitoring and answerability among responsibility centre managers, and service managers and their support staff. In the course of this description, other accounting processes are implicated, including internal charging, output reporting, case mix costing and annual reporting. The thick description proceeds chronologically from the start of the financial year until after it has been completed.

Introduction

At both SITES P and Q the processes of spending control, monitoring and answerability went hand in hand for the years 1991-92 and 1992-93. Detailed monitoring of expenditure against budgets was begun by responsibility centre managers as soon as the new financial year started and continued until the year was completed. To a lesser degree outputs were also monitored. The responsibility centre managers were aided in the task by service managers and their support staff, to whom they were obliged to supply answers and explanations for overspendings and other variations. A similar pattern ensued across the hospital system ultimately finishing with the central authorities (e.g., see pp. 142, 153, 161, 171-174). As budgets were not finally approved at either site until a few months into a new financial year, provisional budgets were used for monitoring during the first few months. These were based on the hospital organisations'

submissions to the Ministry[1] (see pp. 294-300). Provisional budgets were substituted by approved budgets once they became available.

Experiences Among Hospital Participants

Financial Support Staff

SITE P

The financial services division was involved in monitoring the hospital's plans and budget. {Site Coordinator P} continued the role of coordinator in relation to this monitoring task. Her role involved several aspects:

(a) seeing to it that "the budget was up and running" when the year started;

(b) attending to "the everyday running of the budget" so that she and the people in the services "always know what the various budgets are;"

(c) "tracking budget transfers coming in and going out of services and of the hospital as a whole;"

(d) ensuring that systems, such as accounts payable and salaries, were "working and interfacing correctly, in order that data is getting to the right place;"

(e) maintaining account codes in the general ledger;

(f) checking that suspense accounts were cleared; and

(g) maintaining accounting records that related to staff changes including new staff, staff who were leaving and staff who were relocating.

Because she worked at a training hospital relocations were frequent, and house surgeons and registrars changed at three and six monthly intervals. She was also involved in control related tasks intended "to stop errors occurring." These tasks included checking

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1 {Central HQ PA} related that when the 1992-93 year commenced units and departments needed a budget to which to work:

> After the budget was finalised [at central headquarters], but before the contract was signed by the Minister [in November 1992], steps were taken to enable monthly budget reports to be produced at the end of each month from the general ledger system based on the budget that had been finalised within [the organisation].

requisitions to "ensure that the people signing them have the right delegated authority, and to a lesser degree keeping an eye on who is buying what."

{Site Coordinator P} related that, in preparation for the arrival of the July monthly general ledger report, she sent the service and responsibility centre managers copies of their respective budgets for the year ahead, including a note indicating that these budgets were provisional. In this way "budget holders" were updated about "the ins and outs to their budgets," as negotiated and agreed in the course of the budget preparation process. She also described how budget transfers were made between responsibility centre budgets as the year was progressing. These transfers resulted from negotiations between service managers and/or responsibility centre managers, and were notified to her with the authority of the service managers. There was "a regular flow of these throughout the year" and she entered them in the general ledger system frequently to keep the budget up to date.

The general ledger was maintained by the people at central headquarters. In addition to recording the budget, it was also used to record transactions, mainly in the form of expenditures on labour and goods and services purchased. These data formed the basis of the monthly expenditure reports produced at central headquarters in the form of computer print-outs. These reports related to each responsibility centre and showed the totals of both the monthly transactions and year-to-date transactions on each account code within a responsibility centre. The reports also showed the variances between the budget and the actual for the month and year-to-date for each code. The hospital organisation payroll office produced staffing reports[2] analysing fortnightly payroll expenditure in each responsibility centre on an employee by employee basis, to coincide with these monthly general ledger reports.

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[2] In basic form, responsibility centres' fortnightly staffing reports appeared similar to the monthly general ledger reports. They comprised a list of the people whose time and pay had been charged to the ward for the previous fortnight. Also shown, for each person and for the ward in total, were various details of time, pay rates, and payments, including various allowances, and of staff grades and numbers converted to full-time equivalent units.

The monthly expenditure reports were received by {Site Coordinator P} in triplicate about 10 working days into the following month. One copy was kept on behalf of the financial services division and the general manager; the second copy was divided into sheets relating to each responsibility centre, and sent directly to the respective responsibility centre managers. The third copy was sorted into services (i.e., all the sheets for all the responsibility centres within a particular service were put together), and sent to respective service managers. {Site Coordinator P} also distributed the staffing reports in a similar manner. In distributing the expenditure reports, {Site Coordinator P} reminded recipients about the budget transfers which should have been shown in the reports and asked them to notify her of any other budget changes shown on the reports so that she could "check them out."

{Site Coordinator P} perceived that most responsibility centre managers made use of the reports they received. She related that they had "got to grips with controlling supplies" and had "a good idea what the report data should be saying." She found that if the reports differed from expectations they would "raise questions about what was going on" and come to her for detailed breakdowns of the unexpected figures. She described a rostering computer programme in use covering nurses and some other occupational groups. The respective responsibility centre and service managers tended to rely on that for salaries data, but used the expenditure and payroll reports to obtain data on annual leave and to check that people had been charged to the correct account code. {Site Coordinator P} saw the expenditure and payroll reports not as a source of answers about people's actions, but more as a confirmation to the responsibility centres of what they should already know, including what had been done or any problems that had arisen. It worried her that "some people might be relying on these reports to tell them what is happening, [because] the reports do not appear until three weeks into the following month which is too late to do very much." She felt that other, more current controls ought to be in place.

{Site Coordinator P} related that the monthly reports generally formed the basis of one-on-one discussions between responsibility centre managers and their service managers. She observed that practices varied in part because of the varying number of

responsibility centre managers in each service: For example, in one service in which there were 29 responsibility centre managers, it was "just not feasible for the service manager to see each of these individually every month." She imagined in this particular case that the service manager "focuses attention on the responsibility centres which are having problems."

{Site Coordinator P} also perceived that charge nurses had "too full a clinical load on a daily basis to have time to manage the financials to the level that they are being expected to." While most managers at service and responsibility level could cope, she had found it difficult to persuade them how important this management had become, whereas "five years ago it was not important and did not matter." She also noted that many of the problems that occurred related to "really basic things, such as account codings, which if not understood can lead to incorrect data being compiled about spending."

{Financial Controller P} believed there was a problem with the monthly budget and staffing reports in terms of "what they are supposed to be about and how accurate they are," and that this was deepened because people had too high expectations of these reports. He also believed that far too much importance and relevance was placed on them compared with what they deserved and warranted. He supposed that part of the problem arose because these reports were the only financial information many people in hospitals had seen. He described how the general ledger system had gained a poor reputation since its delayed introduction in 1991, when for six months the problems with it "were phenomenal." They included:

> garbage data, interfaces being missed and parallel interfaces doubled, accruals being missed, accruals being doubled, and accruals not being reversed. . . . Just about anything that could go wrong was experienced, and there were no reports for four months at one stage because the system just fell over and nothing could be got out of it.

He added that by 1993 "those reports were actually good and that there was nothing wrong with their contents, although their physical format and their presentation could

be a lot better in terms of the information each service and responsibility centre manager was getting."

In 1992-93, {Site Coordinator P} became involved in collating output data from OPIS discs completed in services and responsibility centres. She commented that until these data began being collected, there were no comprehensive output data. She described several sets of outputs which were reported on, and that these fell into two categories. First, there were mandatory outputs, which comprised those stipulated in the hospital organisation's contract with the Department of Health. It was these which she believed had provoked the change in 1992-93 for monthly reported outputs (see p. 278). Second, there were other outputs, which responsibility centres had been allowed to define for themselves. These related to activities they were doing not specified in the contract. There was little significance currently attached to this second category of measures and they were not part of the summarised output reports which {Site Coordinator P} sent to service managers, the district general manager and central headquarters.

{Site Coordinator P} also sent these people summary expenditure reports. These were produced from the individual responsibility centre expenditure reports using a spreadsheet. They related to each service in aggregate and to the district overall. The 1992-93 budget, and actual expenditures for 1991-92, served "as a basis of comparison to assess how things were going in 1992-93." The figures for each year were put side by side, and trends were compared. The reports formed the basis of a meeting, and other discussions, between the district general manager and each service manager individually, and between these people as one group[3]

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[3] Further insight on this "group" came from {Nurse Manager PM}. She stated that in addition to their individual service responsibilities, service managers collectively were supposed to control what happened at the hospital and be accountable. She understood that though service managers had regular weekly meetings, "these overviews . . . of budgets, expenditures, and over or underspendings by service . . . are not discussed openly as a matter of routine." She also understood that "the relationships between service managers are not particularly good. If anything, opinions are expressed and matters discussed outside of meetings, and behind people's backs." She also related that "there have been a few occasions when the issue of redistributing resources has been raised, but the discussion has not come to anything."

The summary reports prepared by {Site Coordinator P} were also the basis of monthly reports by the district general manager to the hospital organisation and its general manager. They helped the district general manager "pull together" his own monthly reports to headquarters. "They explained variances between the budget and actual spending, and related the outlook for [ensuing months]." These explanations were put together based on the discussions the general manager had with service managers, and on anything to which responsibility centre and service managers had alerted the financial services division. In particular, {Site Coordinator P} provided information "about big things" that might shortly occur so that these could be incorporated into the overview part of these monthly reports. She claimed to be able to provide the general manager with "a pretty good idea of what was happening by service, and was also breaking the data down by expenditure categories across services." This allowed them to "look at what was happening from a different view to the service managers." Some of these signals related to adjustments made to incorrect general ledger data. She kept a score sheet of these adjustments, and this showed what she believed was "the true position compared with the uncorrected position in the general ledger."

{Financial Controller P} related that he also provided support for the district general manager. This entailed "aggregating, critiquing and overviewing," so that the general manager, going into a monthly review, would have an indication of the problems which {Financial Controller P} believed might arise, including explanations for them, if any. This allowed the general manager to raise these problems with the service managers. {Financial Controller P} stated that in general "the hospital has to overcome the problem of trying to fit within the budget for the full year in the face of various uncertainties that make forecasting difficult." To do this, the hospital was "evaluating the situation at the end of the first three [winter] months of the budget year, and then manipulating discretionary cases and activities over the summer months according to how high or low this winter throughput has been."

One of {Financial Controller P}'s general concerns was that hospital staff did not have "any real idea about how the place as a whole is doing, or where it is at, either in terms of financials or the number of people going through." In the three winter months of

1992, for example, patient numbers had been 10% higher than the norm of the previous five years. He considered this positive and that it indicated staff were working harder, and he felt they should be given some recognition. But all that most people knew was that they seemed to be busy. He anticipated tackling this problem by presenting a monthly or quarterly summary of the performance of the hospital when it became a Crown health enterprise. "This will show things like trends about what the business is doing and where it is going, whether a profit or loss is being made, and whether the organisation is on budget."[4]

{Site Coordinator P} described how the district general manager's monthly report to central headquarters was submitted towards the end of the following month. These reports gave rise to monthly meetings between headquarters staff and the district general manager which dealt with both "clinical outputs and financials." While "very little feedback was resulting," that which did was "reasonably positive on the whole," although it was not clear whether this was because the hospital was one of the few organisational units "operating on budget, or for some other reason that has to do with the quality of outputs."

SITE Q

{Cost Accountant Q} described how monthly budget report print-outs were distributed to departmental managers. These were generated from the general ledger, maintained by the central headquarters finance office. Departments did not have direct computer terminal access to these data[5], but there was "an intention to go that way and to make

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4 {Doctor RT} and {Doctor RP} reported on the usefulness of a similar quarterly report which was produced in their hospital.

5 {RUS Support Person Q} stated that there were computer terminals in many wards and other places, but usually these could only access the patient management system. This system maintained data on individual patients. He opined that ideally these should have included personal and demographic details, history, waiting lists, visits and admissions, movements, episodes of care and discharges; and it should have been possible for doctors to access their patients records from it. However, the system was provided through a bureau and quite a lot of these data were not available, including the individual detailed patient

(continued...)

the data live." He indicated that the RUS system also processed financial data. Again, the means of access for departments was through print-outs rather than computer terminals. He believed RUS print-outs were only available on demand, and were not sent out to all departments as a matter of course. {RUS Support Person Q} explained that the basic application of RUS was the production of monthly variance reports which used to be circulated to heads of departments. But a decision was made in 1991 at institution level to discontinue the routine distribution of these reports to managers. Since then they had been sent only to heads of departments who requested them either on a one-off basis or a regular basis, and {RUS Support Person Q} indicated that very few managers made these requests and that "the supply of all information by RUS has been reduced considerably."

{Cost Accountant Q} felt that both the general ledger and RUS data were useful only for routine monitoring, rather than for decision-making. He thought that there were few incentives to use output and cost information to analyse situations at departmental level:

> The emphasis of the budget reports is on keeping spending within an itemised input budget regardless of throughput. There is also a tradition of either spend it or lose it. This tradition encourages spending up to the limit of the budget.

{Cost Accountant Q} described the general ledger as being concerned "entirely with an input orientation. It provides total cost information based on actual expenditures by departments." Reports from it showed inputs, but had no record of any outputs, and "this side of things was neither being measured, nor allowed for, in the budget figures shown in reports." The departmental budget reports had tended "to cover only direct costs, and it is only recently that some indirect costs or overheads, such as charges for the laundry, have begun to appear." He also indicated that under existing arrangements the monthly data received by departments was about a month out of date. Although reports appeared about a week after the end of the month, "the decisions reflected in the data were taken a month or so ago."

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[5](...continued)

> records that would have been of most use to doctors. In any case, most clinical staff lacked terminal access to this system.

{Cost Accountant Q} described how any variances shown on departmental budget reports were examined by the service managers. He stated that these variances were caused "primarily by fluctuations in patient throughput." Costs rose if throughput increased, and so during periods of high throughput difficulties were caused because "departments were measured by comparing actual expenditure with the fixed budgets" shown on monthly general ledger reports.

{Cost Accountant Q} believed there was a tendency for the cost information flowing to departments "to stop, or be lost, at the manager level, rather than for it to be fed to the workers in order to encourage them to work smart or reduce costs," and was not aware of many instances in which filtering down happened. He felt that this was caused by "a lack of understanding of the information at the level at which it is stopping." In essence, the managers concerned would not talk to people at a lower level if they did not fully understand what they were doing. He felt that for this to change, managers, and people in general, needed to appreciate that "they are part of cost programmes and that information is there to help them and their colleagues." He also detected positive attitudes to the organisational changes at various levels, including "below where information is presently stopping," and expected that such attitudes were likely to be more widespread "when information begins to flow more freely."

{RUS Support Person Q} indicated that despite the routine circulation of RUS variance reports having stopped, the processes necessary to generate these reports continued. In essence they showed the difference between actual spending and a flexible budget derived from standard costs of procedures and actual numbers of procedures carried out. RUS could also be used to compute various monetary and volume statistics for cost by patients and patient demographic groups, cost by departments, and cost by specified clinical aspects. The last included cost by procedure, and by DRG, ICD9 or other compatible diagnostic classifications. There were, however, few requests for this information either.

{RUS Support Person Q} stated that the reason given for discontinuing the circulation of variance reports was that people in the departments receiving them were upset and

confused by two budget reports, one from RUS and one from the general ledger. {Cost Accountant Q} felt that the existence of both the general ledger and RUS had made for many duplications and confusion as far as costing processes were concerned because the two were separate. For him, the critical issue was that RUS used historically based standard costs as the basis of its data, and so it was impossible for departments, or anyone else, to reconcile the total of the costs indicated by RUS with the costs from the general ledger as shown on the budget reports.

{RUS Support Person Q} was able to explain several differences between the RUS data on the variance reports and that in general ledger reports. First, while both reports showed the actual direct expenditure of the department to which they related, the RUS reports also included some allocations of the costs of indirect departments. Second, until the beginning of 1991-92, the RUS monthly periods and the general ledger monthly periods had been out of synchronisation. This was because expenditures shown in the general ledger reports were based on payments made during the report periods, whereas the RUS cost data had been maintained on the basis of physical events and when work was done, as opposed when it was paid for. Even though the two were brought into synchronisation from 1991-92, people still remembered the previous differences, and attributed any new differences to something wrong with either or both systems. Third, general ledger budgets were fixed for the period and were not varied with departments' outputs, throughputs or activities. By contrast, the RUS budgets were calculated from unit fixed and variable standard costs[6] and the actual activity levels[7]. As actual outputs

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[6] {RUS Support Person Q} described how these were calculated from the general ledger budgets using estimates of volumes of procedures, relative value units and assumptions about which costs were fixed and which were variable. This detail has been omitted because it would not add to the value of the description. It is enough to say that it was complex and required many assumptions to be made, including about the constancy of the way procedures were carried out from year to year.

[7] Data collection for this was done frequently, sometimes even daily, by many staff in many departments largely on a manual basis, and included data from the manual medical record system. Patient records were coded diagnostically by medical records staff rather than doctors.

invariably differed from budgeted ones and this affected the RUS budget but not the general ledger budget, the budgets shown on the two reports were invariably different.

While {RUS Support Person Q} accepted that this difference caused confusion among responsibility centre managers[8], and was the primary reason for variance reports being discontinued, he thought that there were other reasons for the hospital organisation's managers taking the decision they did. He believed these managers felt uncomfortable with flexible budgeting, and equated it with a lack of managerial control in that it went "up and down" according to departmental activities. "It lacked black and white contrasts, and had a lot of grey in it." He thought that another reason for RUS being effectively "sidelined" was that its mixed clinical and financial nature was contentious and had the potential to clash with existing cultures.

{RUS Support Person Q} believed that the primary problem with the general ledger budget was that it reinforced the concept of the hospital organisation having:

> a straight pool of money to throw at departments. No matter what these departments are doing in terms of activity, they cannot generate any more money, and so there is no incentive on the financial side for them to attempt to change activity. Nor is there any measure of effectiveness, and the only efficiency measure is whether they come below budget.

He added that this efficiency could be easily achieved by manipulating what was purchased independently of activity levels, although the quality of activity was likely to be compromised in some ways. For example, "corners could be cut by moving away from the concept of total patient care plans, in which a primary nurse was responsible

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[8] {RUS Support Person Q} felt that the level of understanding of cost concepts varied widely among the various managers who received data from the general ledger, RUS and so on. He described how the notion of different costs for different purposes was alien to most people, and that many people believed that costing was an exact science about which one could say, "There, that is the cost!". He had also found that many departments were unhappy with standard costs as a concept. "They tend to concentrate only on the variable actual cost as the true cost, and find it difficult to accept the idea of monitoring, and the use of standard costs for that purpose."

for a patient's wholistic care, to a situation in which patients were administered to as by numbers" ({RUS Support Person Q}). He perceived that the only accountability asked for by the general ledger budget was to save money, rather than to influence, or concentrate on changing, variable costs.

Service Managers

SITE Q

{Service Manager QS} described how once the budget year had started, he and the heads of departments received a financial budget report on a monthly basis. He received a copy of each entire report, while the heads of departments received the part(s) of the report relating to their responsibility centre. "Each part showed the actual ongoing direct costs of the department."

He explained that direct costs were the various costs actually charged to the responsibility centres budgets. For example, currently the direct costs of a ward included "the cost of nurses, linen, food, medical gases, and purchases of supplies of dressings, hip joints and similar paraphernalia, and of things like miscellaneous equipment" {Service Manager QS}. He also explained that during 1992, support service costs, such as linen and food, began to appear in the reports of departments receiving these from other parts of the hospital. This change was "part of an ongoing exercise to bring in more items into the budgets of people using the resources. Thus, items such as sterile supplies and pharmaceutics are expected to be incorporated soon." However, he was uncertain when other indirect services, such as "domestics, orderlies, clerical support and power," would be treated as direct costs. This was also the case with "ACC[9] levies, superannuation, land and premises costs such as rates and leasing charges, and capital costs."

{Service Manager QS} indicated that monthly reports showed actual costs for the month and the year-to-date. Each one was "lined up against a budget amount" which was a figure estimated on the basis of what would have been spent were the approved annual

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[9] ACC is the acronym of Accident Compensation Corporation, and the levies are a tax on employers which go to fund an accident insurance scheme.

budget adhered to. At that time, the monthly and year-to-date budget amounts were one-twelfth of the annual budget amount, and this amount multiplied by the number of months that had elapsed since the start of the year. He stated that these amounts "side by side on the report" gave him an indication of whether he was "over budget, under budget, on budget, or . . . ."

{Service Manager QS} described how he went through each part of the monthly report with the appropriate head of department. He stated that this was something which had come about "with the service management structure," and he felt that in the meantime "the charge nurses and other heads of departments have reached the stage at which they actually understand budgets." He tried to "hold them accountable for the way they are spending money rather than against the actual budgets." He believed that using these budgets would be unreasonable because the people concerned were "unable to control total spending," because "spending depends to a large extent on workload and patient throughput, and these are things over which, say, the charge nurses have little influence." But given a particular level of workload, he believed that they could influence what was spent dealing with that workload, "without prejudicing their responsibility to patients." Thus, he held them accountable for "maintaining staff levels and staff mixes which are compatible with workloads." He felt that "to press them any further, such as keeping to the fixed staffing budget irrespective of high workloads, would be tantamount to encouraging dangerous practices, such as not bringing a nurse onto a shift simply to save money" regardless of the number and dependency of patients.

Further to this point, {Service Manager QS} related that "beyond merely keeping a lid on total spending, there is the notion of getting the most out of the money available." This involved "achieving a continuous balance between the staff levels and patient load within a unit." Essentially, he did not want a unit to carry any more staff than was "absolutely necessary," because money to pay staff was limited. He indicated that if "more staff than necessary were working one day," then "staff could not be paid to work on another day, which prevented patients being brought in for surgery on that other day."

{Service Manager QS} described how "monitoring throughput" had become important in order to "keep track" of his service's "fluctuating workload." He indicated that the fluctuations were due primarily to the acute nature of the service, although "a lot of the workload is more predictable than is sometimes thought, in that acutes can be expected to occur everyday." Nevertheless, there were aspects of acutes which were not predictable from day to day, and coping with these was the biggest problem. Moreover, there were other factors which also contributed to the fluctuations, but these were more seasonal and predictable, and it was known that some periods of the year would be much busier than others. He indicated that to take advantage of any foreknowledge about fluctuations of patient numbers, some flexibility was needed in the number of staff and the hours they worked. It was "alright for surgeons to arrange leave around school holidays, as long the staff whose workload is driven by the surgeons are taking time off at the same time." Even so, "the acutes still come through the door and sufficient staff are needed to care for them." He described how he had found that each unit should have enough permanent staff to cover a normal workload. Beyond that, they each needed to have the ability to recruit staff on a casual basis to cover increases in workload as they occurred, both on a seasonal and a daily basis.

{Service Manager QS} noted that some departments were fairly constant in what they did and in their rate of spending. These departments tended "not to attract attention as much as the departments whose activities fluctuate." In any case, he was "taking a bit more of an interest in the departments that are traditionally or actually overspent." He tended to compare the report of one month with that of the previous month, and to take a particular interest "in areas if there has been quite a lot of activity." However, unless a report pointed to "anything out of the ordinary," he interpreted it to mean "business as usual." For the departments which were traditionally underspent, he would be concerned "if they show signs of overspending because the non-occurrence of these underspendings makes it difficult to balance the books overall." He also looked for signs of change from past patterns of under and overspendings. In going through the reports with the respective heads he tended "not to have too many concerns."

{Service Manager QS} related that the budget reports did not include a physical report on activity, and that traditionally he and most people at the hospital had received no output data until 1992. There were various ways by which he could identify how busy departments had been in the report periods. These included a monthly report covering staff and the payroll, and a daily print-out from the admission and discharge system. The staff reports were by department and distributed to the heads of departments as well. They appeared fortnightly and showed the earnings of individual staff members for the fortnight, by area, hours of work, penal hours, and overtime and allowances. The form of these reports was adapted in 1992 to pick out annual leave, sick leave and "those sorts of things," in order to "see the level of these that is being paid." He added that the inclusion of annual leave only started at the beginning of the 1992-93 financial year, and by the time of the interview he had had little time to analyse the two or three reports he had received in which these leave items were included. Notwithstanding, {Service Manager QS} felt that the fortnightly report gave him "quite an extensive breakdown of what was actually happening." It allowed him "to calculate quickly the number of full-time equivalent staff who had worked in the fortnight covered by the report." Hence, he saw it as especially useful if there were areas over which he wanted to keep "special control."

Print-outs from the admission and discharge system purported to give a patient count at a particular time of the day. But {Service Manager QS}'s experience was that these data were not always accurate, particularly when wards were full and these was little time to collect the data properly. He related that, "unfortunately, in terms of managing within the service's total fixed budget, these are the more critical times." He needed to have "quite a good idea of how costs compared with the budget, as obviously more patients tended to mean higher usage, and higher rates of spending, for many items, including staff."

In addition to the daily report, he had asked the information services people to supply him with a monthly report on patient days, but this had not yet been received and he was not sure how he would use it, except to combine it with budget and fortnightly staff report data to work out the cost per patient day on each ward. When these data on

output and cost per patient day were ready, he intended to feed them back to the charge nurses, and to other heads of departments. He anticipated that these data would encourage new ideas for improving their activities. He speculated that he might "build a graph over a 12 month period in order to see what things looked like."

{Service Manager QS} indicated that working with figures was an interesting and enjoyable part of his job. He believed that had he the time, he would spend more of it "analysing figures." He enjoyed explaining and interpreting these figures to doctors and other clinical professionals, and thought that their problem of understanding was one that needed to be overcome, and that the way data were presented was of great importance. If these problems were surmounted the people concerned could correlate the output and unit patient day cost data with the budget report data they already received. He anticipated that "if wards knew their own costs and those of other similar wards, they would be able to see what the differences were and bring this to the attention of the doctors." He believed that in these various ways, "people will become a little more aware of costs, outputs and everything else, provided that the data are explained to them in the first place in order that they have some meaning." However, for the time being, "[these] people do not want to worry about that sort of thing. Their concern is for the patient."

In regard to RUS, {Service Manager QS} stated that while he would have appreciated the detailed data being produced by RUS, he found that RUS had a major failing in that the costs it indicated:

> bore no relationship to the real dollars which people in the hospital actually spent. Thus, if one obtained from RUS a cost for everything done by his service during a particular period, or a department within it, the total of these costs would not come anywhere near the amount of money which had actually been spent by the service or department.

SITE P

{Service Manager PC} described how she and her responsibility centre managers received end of month expenditure reports. Following on from these she saw each

responsibility centre manager formally "to work through various problems and opportunities" relating to their respective centres. She saw all of them together once a week for a briefing session. Essentially, this was a means for her to communicate with them, although there tended to be "quite a bit of discussion at the end of these."

{Service Manager PC} indicated how important it was for the reports that went to responsibility centre managers to contain "plenty of positive accentuation," rather than negative, because the latter tended to "send some responsibility centre managers into a bit of a dither or quandary." By contrast, the monthly expenditure report was "notoriously inaccurate," and it was "very difficult to find out how it has been put together." Attempting to do so was "taking a lot of energy" out of the people in her service. Notwithstanding, she found that her managers were able to "spot problems indicated by the data quickly and obtain explanations." She attributed this to "the very good job done by [{Site Coordinator P}, who] seems to be able to access explanations from the [central headquarters] system quite easily due to having on-line access to the mainframe computer." {Service Manager PC} noted (with an air of complaint) that neither she nor anyone else in the hospital had their own on-line access to this computer.

{Service Manager PC} found it "quite pleasing" that her service, along with the rest of the hospital, had moved towards flexing the 1992-93 budget. The essence of this was that the monthly division of the annual budgets was based on the 1991-92 spending profile, rather than the assumption that expenditure occurred at the same rate each month. She pointed out, however, that some parts of the budget were known to be unpredictable, and so "not worth flexing." On the question of predictability, she noted a lack of consistency in the levels and composition of services which had been provided over the five years up to 1992, both year-on-year and seasonally. She related that matters had changed so much during this period that 1992 service mixes did not even resemble what had happened five years earlier. She saw it as pointless to use earlier data to analyse the future, and even data from the previous three years had been made useless to some extent because of the dramatic changes occurring.

{Service Manager PB} described how he encouraged both responsibility centre and other service managers "to look beyond the general ledger reports for control mechanisms . . . which were current, rather than delayed." He also noted (with an air of understatement) that "the management information systems in [the hospital organisation] have always left something to be desired," and that the data being produced were "very poor". {Service Manager PB} thought that the ability of hospital managers to question the credibility of general ledger report data was to their credit. But he believed that not many were able to generate accurate data of their own. He opined that "generating data can be a simple matter, requiring managers to ask themselves what they really need to know, and what is important in their operations." He felt that valid data relating to these questions could be obtained locally, without the aid of the central computer.

{Service Manager PB} felt that although the poor state of the general ledger system was unacceptable, this could be turned to advantage. For example, when the report production process broke down in 1991 he had intervened with a briefing paper "alerting managers to the notion of not waiting for reports until after the event in order to find out what was happening." This paper was based on his experience in the private sector in which "early bird reports are common." In these kinds of reports managers were expected to be able to indicate what the results for the month would be as it came to an end. {Service Manager PB} stated that in the private sector "a manager's ability to devise early bird reports is seen as reflecting just how well that manager knows the business. Anyone not able to produce accurate reports was likely to be penalised." He thought that things should be "heading this way in the hospital, although many people still have to learn the principle of managing the business and its costs." With 70% of the hospital budget covering personnel, he felt managers should know "what is going on before it actually happens," and that they should "really be able to write their own expenditure report before the end of the month." For him, the good manager was one who "manages the number of staff, and knows whether what is happening is over or under budget. General ledger reports should only be reflecting what the manager knows already," whereas in his experience "many managers are still waiting for data," which were appearing after the month had gone, in order "to find out if the business was over- or under-running."

{Service Manager PB} also stated that people were becoming "more aware of costs", having been asked "to make budget cuts" in the period since 1989. While he welcomed this greater awareness, he thought that many people, certainly on the clinical side, "still see these cuts as cuts in services, rather than as challenges to see how output levels can be maintained while doing things differently." He described how people in his service were not allowed to change budget numbers without putting forward some form of action plan. For example, "when prices and quantities are going up, but budgets are required to show savings, [my managers] have to indicate what planned changes in behaviour they are going to make before their budget will be accepted." Even so, {Service Manager PB} thought that there was still "a knee jerk reaction" from people in some services which took the form: "if there is more work, then give us more people." For example:

> when patient billing was introduced as part of levying patient charges for all patients in 1991, a request for more staff was made by the people in the departments affected. . . . I perceived that the job could be done within existing staff numbers. However, rather than make this assertion and refuse the request, I instituted a review, and in the meantime, agreed to set on some temporary staff.

He added that the review was in line with a policy he had introduced to the effect that "no permanent staff are to be taken on anywhere in my areas of responsibility until a systems review is carried out." He explained that he agreed to the temporary staff because he did not want to "generate tension with clinical people," whom he perceived generally as "working very hard." The episode left him wondering why it was that he and the clinical managers had perceived the same situation quite differently. Nevertheless, he believed that in time "clinical and other managers . . . will adopt a more positive approach to wanting, or having, to do things differently and to doing new things." This would close the gap between clinical managers' perceptions of a situation and his own "in an environment which requires more to be done with less money." He related he was "not questioning how hard people are working." Instead, he claimed to be "questioning whether the activities being done are worthwhile."

Nurse Managers

{Nurse Manager PS} described how she scrutinised the budget report print-outs which were sent to her service manager each month for the 20 responsibility centres within the service. First, she checked "for overspendings and highlighting questionable things." Then "I sit down with each responsibility centre manager and discuss the items I have highlighted." The responsibility centre managers also received a print-out and "anything else which they identify is also discussed." The purpose of discussion with each manager was to ascertain "reasons for problem areas." She indicated that these reasons tended to fall into several categories, including errors in data entry, higher than expected output, and overspendings needing further investigation. Having ascertained reasons for overspendings, {Nurse Manager PS} gave the service manager a monthly summary, which he in turn submitted to the district general manager.

{Nurse Manager PM} explained that her service manager was supposed to control what the service was doing, and he was also supposed to be accountable for events. She received the "financial print-outs," which covered expenditure, staffing and payroll for all responsibility centres in the service, and a copy of the relevant sections were also going to each responsibility centre manager. The print-outs arrived about three weeks after the end of the month, and, as there was no direct computer link from her office, were the only way she had of accessing the data held on the system. The print-outs incorporated transactions and events up to the month end from most sources including payroll, purchases/accounts payable and internal transfers. When the reports were received, {Nurse Manager PM} checked them for large or unusual items of expenditure, but tended to concentrate on salaries because "80% of expenditure is on them." She also paid "attention to the overall position and to trends indicated by the year-to-date information," and she checked monthly figures relating to full-time equivalents, including penal amounts and accruals. In contrast, she paid "little attention to variances for individual months," which in any case were "usually minor and attributable to seasonal factors."

{Nurse Manager PM} found it was "not easy to reconcile the print-out data" with her own recollections and the records she kept. {Nurse Manager PS} had similar problems.

Between them the two aired several criticisms which were echoed by the responsibility centre managers at both sites. In particular:

(a) the print-outs were difficult to decipher and understand, and were not in a format which allowed them, or people responsible to them, either to monitor things properly, or to investigate situations and obtain explanations;

(b) controlling spending against the budget and avoiding overspendings was made difficult by time lags in the information. The time lapse between an item being ordered and its cost appearing on an expenditure print-out was usually several weeks, and this included "billings which lag two or three months behind goods which have been received." ({Nurse Manager PM});

(c) it was difficult to tie up bills for particular items with the total expenditure amounts shown on print-outs. People were "finding a lot of billings for things they have not received" ({Nurse Manager PM});

(d) the report periods were in calendar months, and therefore of unequal length and varying weekday and weekend combinations. As a result, there was no tie up of staff expenditures on the expenditure report with the pay and staff full-time equivalents data shown on payroll reports, which reflected fortnightly pay periods[10];

(e) individual employees were sometimes on the wrong payroll print-out compared with their actual work location during the particular period to which a print-out referred. But checking that employee location details were correct was sometimes hampered because names were not in alphabetical order; and

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10 There was some confusion about this among the interviewees. This seemed to arise because in about 1990 the budget report periods were changed from four weeks to calendar months. Meanwhile, most staff continued to be paid on a fortnightly basis. This change seemed to have been made because the general managers' reports to the central authorities in Wellington were required to be on a calendar month basis. {Service Manager PC} commented that though this difference might seem minor, controlling monthly spending and comparing calendar months was problematic compared to using four week periods.

(f) report formats were often changed without warning[11].

{Nurse Manager PM} relied on responsibility centre managers to make "detailed checks of expenditures." She related that this kind of work among these managers had been "developing over the past year or two." There had been also a "sudden changeover to more devolved budgeting, . . . [whereas] initially a lot of budgets for inputs acquired from within the hospital used to be outside of the control of people at both responsibility centre and service levels." With devolved budgeting, "budgets had become bigger" because of supplies costs being traced to responsibility centres.

{Nurse Manager PM} had created a service financial report pro-forma on which she "made notes and recorded explanations month by month" arising from her discussions with the responsibility centre managers. These were mainly for her own use so that she could reflect on the historical picture in making future forecasts, although she also gave them to her service manager and to the hospital general manager. She pointed out that there were also centrally produced report forms which purported to be for this purpose, but she did not see them as being very suited to the task. She also responded to requests for data from other sources; for example, "people working on the purchaser-provider split." And she had started supplying an output variance report to the hospital general manager.

For this report she was required to enter monthly measures of quantity and quality onto a disk through her personal computer. The disk contained a template for each of the responsibility centres in her service and was supplied from central headquarters via the financial services division. There were over 120 items to enter each month in all. She remarked that much of these data were not of great use to the responsibility centre managers in the form required by the template, and that complying with these requirements involved much costly and time consuming paperwork. Even so, to

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[11] {Site Coordinator P} related that this gave rise to difficulties generally; "just when people were getting comfortable with things, these things somehow got changed."

computerise their collection at patient source[12] would be even more onerous. She claimed that several of her colleagues, faced with the same sort of data production burden, felt as she did that the data were of doubtful relevance and seemed too voluminous. There was also no internal check on the accuracy of the data.

One of the main tasks {Nurse Manager PS} performed on a continuous basis related to workforce planning, and was called *rostering*. Plans or rosters were compiled by charge nurses (and some other responsibility centre managers) to show which staff would work which shift in the next two fortnightly pay periods. {Nurse Manager PS} checked these to ensure that "plans would match workloads in terms of busy days and non-busy days being appropriately staffed." She also calculated the cost implications of rosters using a personal computer, "but the amounts calculated do not match financial report information due to the incompatibility of the two systems. . . . Rosters are covering a four week period, while financial reports are covering a calendar month" (see above). Even so, the cost information generated by roster calculations did provide "an idea of where the service is headed financially." In August 1992, this task mainly applied to nursing, but its extension to some other occupational groups "is being implemented." {Nurse Manager PS} saw the ideal situation as one in which "everyone working in the service is rostered, and costed, under one system which ties back to financial reports." However, the extension of the idea to "other groups, including doctors, is being held up due to lack of time to examine its potential development."

{Nurse Manager PM} stated that as a result of the new demands of their jobs, the responsibility managers had shown "a tremendous increase in their technical financial management skills." They had been "fairly successful at making substantial savings in their responsibility centres." However, they still had "skill deficiencies," that included being unaware of how outputs caused costs to behave, and not understanding accrual accounting for leave pay. She felt that they possessed "a certain degree of narrowness in outlook." In making decisions, "sometimes insufficient regard is paid to how a

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[12] {Nurse Manager PM} explained that most of the patients seen by her service were "non-admitted" patients (i.e., outpatients) and this made the task more difficult than if they were inpatients.

decision which suits one responsibility centre adversely affects other responsibility centres and the hospital as a whole."

{Nurse Manager PM} explained that these savings were in response to reduced funding, on a proportional basis across the whole hospital and community services. These savings had been hard and were often achieved by leaving vacancies unfilled when they occurred, or by restructuring. She believed that "further substantial spending cuts can only be achieved by deliberately reducing access to particular elective services." She added that dealing with a cut is "one kind of issue which does bring some of the front line service managers together. . . . When these happen, they go into the ramifications of the options."

Clinical Department Managers

{Chairman P} received "a few sheets of paper each month which do not make a great deal of sense." As more than 85% of his allocation was committed to staffing, "the most significant sheet is the one relating to salaries." He had ascertained that:

> this sheet contains 895 figures about salaries but none of them are what I actually want to know. . . . while the data I receive are meaningless for my purposes, they probably have some meaning for somebody somewhere else. After all, what is shown as salaries is actually being paid to the people concerned.

{Chairman P} was concerned about "the quality of the data that are on the salaries sheet." He gave as an example the sheet for October 1992 which "indicated that there are 18 registrars in this department, whereas it actually only had 11." He assumed that this meant "the department's salaries allocation is being absorbed in part by seven registrars who are not actually working in the department," but he was unaware of their specialty, or their location, or if they worked at the hospital. The salaries sheets also show house surgeons working for the department:

> They receive a set salary for this work and no overtime or penal rates. However, these surgeons do other work, the cost of which gets put onto the department's payroll sheets, and so is charged against its allocation. For example, some of

> them did some work at another hospital in 1991-92. They were due some overtime for this work, but this was not paid until 1992-93 by which time they were on the department's payroll. As a consequence, this overtime was included in the department's payroll, so that has paid about $20,000 for work that was done elsewhere.

{Chairman P} related that on other occasions he had been charged for work not on his rosters and for work relating to covering in other places at the hospital and elsewhere. These examples were part of the frequent occurrence of costs not traced to the actual place of work. He drew the conclusion that "the financial information being provided to the hospital by [central headquarters] is not reliable." He indicated that "I raise the issue of data quality on monthly print-outs every two or three months, and write letters on the subject. But nothing much happens to improve data quality." Whenever he mentioned the matter of budgets at senior staff meetings "the service manager sighs."

{Chairman P} stated that were he to check the data for inaccuracies in order for these to be put right, "this would waste quite a bit of my time (say 1 day every month)." He could make time for this task about one month in three. When he was able to do it:

> much of the time involved is spent telephoning the payroll unit at [another location] for assistance. The reason for having to do this is that the salary sheets do not provide sufficient detail about those data which look questionable and may need correcting.

In general, he believed that the system of collecting, storing and disseminating what were poor quality data added to his work as chairman. Given his experiences, he felt that "the cost of controlling costs within the hospital organisation as a whole does not bear thinking about" ({Chairman P}). Moreover, he believed "some of it is pointless because at the end of the day the inaccuracies do not alter the amount spent by the organisation. Instead, they just mean that the money has been taken out of the wrong pocket."

{Chairman P} felt that the consumables side of his department's budget would be very important if it was a "*budget*, but as it is really an *allocation* then really it is a meaningless figure." He explained that this was because:

> spending on consumables depends on the number of cases completed and cases cannot be attended to unless the appropriate consumables are bought. As the department does not control the number of cases it has to attend, it cannot control its consumables and if spending on these goes over the allocation then I am not sure that it matters or what can be done about it.

He reiterated that "this is not to say that we [i.e., himself and his departmental colleagues] do not try to cut costs when we can" (see also p. 262). He explained that:

> this philosophy has been around in the department for many years even though there was never any credit for money not spent, and regardless of allocations. Ironically, it may be working to the department's detriment in that had it not applied some years ago, the department would probably have had more slack money from which to cut in the present period. ({Chairman P})

One of the implications of the lack of data quality, he felt, was that "accountability is totally out of synchronisation with responsibility. . . . [Also,] insufficient use is being made of many potential incentives which if they were in force would encourage saving money and improving efficiency." Departments were frustrated "carrying spendings in their budgets over which they have no control. . . . and frustrating for the departments driving the spendings because they do not get the rewards of altering behaviour in order to reduce spendings not in their budgets." {Chairman P} doubted whether those responsible for creating the system of budget holders "much cared about these incentive issues." He added that "no one has ever contacted me about these issues. . . . Nor is there any mechanism either by which I am asked to put forward improvements from the ground floor up, or for letting these people know how they can do things better." He had "a feeling of immense futility about the data, the system and the way things are done or not done."

In order to counter the inaccurate data received on the monthly print-outs, {Chairman P} had developed his own data collection system. This was based on outputs, and the data were collected in a way he was familiar with from his private sector work, in which blocks of time (15 minutes) were coded to the patient for billing purposes. The data collected included "workload in hours and cases, costs and the amount of supervision given to registrars." It was logical for people in the department to collect this output data "as they are the only people who really know what they are doing; other people do not have to care about such details as long as the department does what it is supposed to do." He stated that:

> these data have proved quite useful and quite interesting. For example, doctors in the department belong to a College [of specialists]. The data are used to show the College that the department continues to be suitable as a training location. Loss of that approval would mean loss of registrars with grave implications for staffing and costs. The data also affords some comparison with what is going on at neighbouring hospitals.

Notwithstanding, {Chairman P} felt the approach to be "futile . . . under the existing system of allocating slices of spending . . . [in which] income or allocations are not tied to outputs . . . and output costs." However, he expected that in the new hospital enterprise system income would depend on outputs, and the data would be valuable:

> This is because the department will know its output, the time spent on particular kinds of patients, and the costs associated with each kind. . . . [Moreover,] it would be interesting and worthwhile to develop an accounting system which provides reliable data on procedures.

While {Chairman P} believed that should the new health system work as announced in 1991 it "would allow the community to put the resource where the value is obtained," not all his colleagues approved. He attributed this "to some of them feeling that they are not attached to services which do give the community, as opposed to the individual, value for money compared to other services." He also believed that:

> alongside the financial accounting system there should be a quality accounting system. At present nobody much cares about overall accounting for quality,

> although a lot of lip service is being given to quality as a concept. . . . Existing quality assurance programmes are run within departments and are quite incestuous.

He added that:

> accounting for quality is a difficult thing compared to the bean counting approach which goes with straightforward financial accounting. One of the problems is the ambiguity of it all, such as in the long term dead patients are cheaper, but in the short term that is not really what one wants. ({Chairman P})

{Doctor QC} received periodic general ledger data on computer print-outs. As far as he was aware:

> a print-out is received each month and is up-to-date for the month to which it relates. It is torn off from a longer print-out, which presumably covers the whole of the [hospital organisation]'s budget. Also, it must be printed off at the end of each month, and probably arrives about a week or so afterwards. However, I am not sure about these details because I do not take much notice of the print-outs. The data on them are inadequate. These data are not presented in a way that would allow a doctor to make any sensible decisions in relation to anything realistic, including outputs and what is actually being done. The information is neither predigested, nor worked over, in order to show the highlights of over and under spendings. Nor does it prompt any executive decisions about how the service might be changed. As a senior doctor, I should be spending my time running clinical services. I do not have time to act like a clerk going through reported items with crudely stated budget variances such as +$300 and -$600. The job of predigesting the basic data should be done by somebody else who would then bring it to an executive type of group in a form on which the group could make decisions.

Charge Nurses

All five charge nurses interviewed received general ledger print-outs two or three weeks after the end of the month[13]. These were used to monitor each class of item in ward budgets by comparison of actual spending for the year-to-date with the proportion of the budget. In this way they knew whether they were overspent according to the official figures. The general ledger print-outs were supplemented each fortnight with more detailed print-outs on ward staffing and payrolls. Both print-outs were a single sheet and the charge nurses did not make any real distinction between the two. Given the proportion of the typical ward budget which related to staff (i.e., about 70% or 80%), staffing reports played a major part in what the charge nurses did with the monthly budget reports.

Being answerable for the way money was spent compared with ward budgets was a principal feature of the charge nurses' relationships with service managers[14]. As a result, despite some dislike of the print-outs, charge nurses were obliged to work with the data on them. The reports contained minimum description and many headings and item names were abbreviated, and had initially been difficult to decipher. The number of items on the print-outs had increased from month to month during 1991-92. Consequently, coverage of the wide variety of direct, support and overhead activities involved in providing care and running the wards had similarly increased. In addition, these alterations led to increases in the amounts of money linked with wards.

Each charge nurse experienced a similar monthly process in connection with answerability, a process which was stimulated by the receipt of the monthly budget report. Meetings between the charge nurse and the service manager (or the intermediary person) took place about three or four weeks after the month was over, although very

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[13] There were variations in how long this had been the case. This was attributable to how service managers expected individual charge nurses to react or respond to the ideas inherent in monitoring spending. For some charge nurses receiving the print-outs was quite recent (c. 1992), and previously they would only see them when they met with their service managers each month.

[14] At SITE P people such as {Nurse Manager PS} or {Nurse Manager PM} acted as intermediaries between the charge nurses and the service managers.

occasionally these meetings were cancelled if the service manager saw nothing wrong. At the meetings, the two participants reviewed the reports: The focus was on checking that the ward had not overspent, and charge nurses prepared beforehand along these lines.

The charge nurses interviewed intimated that unless a budget and/or staffing report indicated a ward was overspending service managers said little of importance. Thus, on receiving their reports, their main interest was in any overspendings revealed. If there were none, the report was put aside until the meeting, and filed after it. Conversely, when reports revealed overspendings, the charge nurses first checked the correctness of the staffing and spending data, and the appropriateness of the proportion of the budget against which they were being compared. This arose from their experience of errors and mistakes in the reports. Checking was frequent and took several hours each month as it was difficult to accomplish. The charge nurses had no direct computer terminal access to the data systems, and had to access them through other staff either at their hospital (e.g., {Site Coordinator P}), or at the central administrative headquarters.

This intermediary process was time consuming, difficult, subject to delays, and restrictive in terms of what could be asked of the system. Consequently, this step was sometimes foregone on the grounds that too much nursing time was lost. Checking caused annoyance and frustration among the charge nurses because errors were usually attributable to others. Moreover, one source of apparent errors were a consequence of the frequent alterations made to report contents. {Charge Nurse PB} stated that she had voiced displeasure at the changing format of budget reports especially to payroll services. These representations were made through {Nurse Manager PS}.

> One of the huge frustrations has been that the monthly report has had its format changed on a regular basis without any prior warning. The information . . . moves around a lot from one report to another quite frequently. This is a nuisance but I tend to be able to find what I am after. However, anyone struggling to cope with the whole idea of the budget reports would find this very annoying, and a lot of frustration has been expressed about these unannounced changes. ({Charge Nurse PB})

Generally speaking, charge nurses found various problems with the interpretation of the reports. The format, content and the technical accounting basis on which they were compiled (e.g., the accrual of leave pay) had altered from month to month in the period since they were introduced. Notwithstanding, the charge nurses felt that budget and staffing reports had gradually improved and by 1992-93, they regarded the quality of the data and other aspects of the reports more favourably. {Charge Nurse PA} stated that she found "the budget sheets are fairly reliable but if they show a big deficit compared with previous months I investigate that to ensure that the figures shown are accurate. I have more faith in the figures on the budget sheets now because I understand them a bit better." {Charge Nurse PB} was also finding the more recent print-outs:

> very useful. . . Great! Because I can use them to acquaint my staff about where the ward is at, and this makes them more committed to some of the little schemes we come up with to save money. . . . The main shortcoming . . . is that the information is retrospective . . . . [and] as a result I am constantly chasing past events. Also, there are often mistakes in the data. . . . that is, what the report indicates and what actually happened are at odds with each other.

The charge nurses sought to ensure that data on the general ledger and staffing reports were consistent with events and transactions in other ways, such as the checking of previous periods. They attempted to explain overspending, and to reduce spending in the budget classes in which it occurred. Ready with explanations, usually to do with patient throughput and turnover, and perhaps with proposals to put things right, each charge nurse went to meet her/his service manager. The meetings concentrated on big items, and so inevitably came back to staffing, and to overspendings in that area. The focus was on answerability and items were "drawn to one's attention" ({Charge Nurse PA}).

This monthly process continued throughout the year. As each year proceeded, the period covered by year-to-date information grew longer, and staying within budget became more of an imperative as the time diminished in which adjustments could be made to correct any overspendings. There was also an element of ensuring that all the budget was spent to avoid underspendings and the impression that the ward could absorb

a cut. However, given the trend patterns in patient numbers and acuity occurring, and the systematic cuts imposed in any case, it was difficult to underspend unless a ward had been closed or some similar spending interruption had occurred.

Rostering, Reducing Nurses' Pay and Other Savings

All the charge nurses claimed that their wards were faced with increasing patient numbers and acuity, and tighter budget limits. The most consequential means they had of reducing spending rates to keep within their fixed budgets was through the control of staff numbers and the amount of staff remuneration. The primary means by which they exercised this control was to draw up staff duty rosters. Staffing reports also played a significant part: {Charge Nurse QB} stated that "rostering is far tighter now because of the cost implications shown in the budget reports."

In addition to rostering, charge nurses reduced spending by other means. These included making nurses more aware of the cost consequences of their actions and choices. For example, in changing bed linen or selecting dressings, nurses were encouraged to weigh the costs of the linen and dressings. Although the actual decisions were made in the management zone nurses were caught up in other means of reducing spending, including ward closures.

Rostering

Ward staffing requirements were tied to patient numbers and acuity, and changes to the rate of spending on a ward through rostering had been problematic. However, changes in the way staff duty rosters were prepared and implemented had allowed substantial savings to be made. The charge nurses described how all rosters had been drawn up off the ward by someone in the now defunct nursing administrative hierarchy. The number of staff planned for ward duty from day to day had been based on the capacity of the ward, regardless of projected numbers of patients for specific periods. If there was

absenteeism, additional staff were brought on duty as a matter of course, regardless of the actual numbers of patients[15].

By contrast, in 1992, each ward roster was prepared separately by the respective charge nurse, or a nurse from among the ward staff. These people had a more intimate knowledge of events on their wards than had been the case with someone doing the job centrally. The rosters were being drawn up for four-weeks periods at SITE P and eight-week periods at SITE Q, according to planned or expected patient numbers and dependency. {Charge Nurse QA} described how:

> the roster is based on the ward dependency rating of each patient measured each day by the nurse looking after them using a system called *nursing intervention measurement system* or *NIMS*. The units of measurement of nursing interventions are six minute work units.

She added that the NIMS data was "quite interesting in that it shows where all the time and work is going, . . . [although] I can usually judge fairly accurately how many units the ward is worth using a rule of thumb" ({Charge Nurse QA}). The system generated graphs which highlighted gaps between workload and staff caused by variations from the roster. These occurred quite often and:

> are a combination of unexpected staff absences and sudden fluctuations in patient numbers due to acute admissions or cancellations. These variations require some action to be taken. . . . However, there are difficulties in narrowing the gaps. For example, one cannot just send a nurse home unpaid because of the unexpected absence or loss of a patient.

One factor which had contributed to savings in nursing costs was that rostering was now done with knowledge of, and taking into consideration the rates at which staff were paid. These rates included penal rates for certain times of the day and days of the week, and

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[15] {Nurse manager PS} had observed that in the past "often too many nurses were being rostered on days when penal rates applied compared with the work available." She stated that she had taken an interest in rostering in order to ensure that staffing on each shift was more in line with workloads.

rates applicable for different types of staff according to their level of qualification and seniority.

Following the initial roster, some fine tuning took place on a daily basis. {Charge Nurse QP} had to "make a decision about whether we need extra people on given days. . . . These are drawn from a casual pool of nurses all skilled in [the ward specialty] rather than drawn from a hospital-wide pool." He added:

> we now think more critically about not only numbers of extra nurses, if any, but also about whether they should be enrolled or registered, and whether they should be for a full shift or only for part of a shift. Both of these considerations make a difference to costs, and money can be saved which over a year can be considerable. It is also quite different from the past when not being responsible for running a budget meant that there were no consequences at our level for getting extra people in just because it was thought that they might be needed.

{Charge Nurse QB} found that it became easier to manipulate staff numbers than before because nurses were more willing to work only part shifts, and to come in at short notice. Charge nurses had established informal nursing pools from which to make up staff numbers if they were short, or to discard staff to when they were not needed. But this method was only suitable at the margin because of the heterogeneity of both the patients and the skills possessed by individual nurses. It was considered desirable to have the same nurse or nurses look after a patient for the duration of their stay. This desire for consistency was reflected in the rostering and involved assigning particular nurses to particular patients.

According to {Charge Nurse QP}, "tighter rostering and manipulating of hours of work . . . undoubtedly affects staff but there is not much we can do about this." The charge nurses were conscious that fewer nurses worked on each ward, and took home less money than they used to[16], and so less money was spent on nursing care. The

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[16] In the year or so after the interviews this problem boiled over from time to time in different hospitals throughout New Zealand, most evidently in the form of strikes and marches (see Morrison, 1993).

corollary of this was that nurses faced higher workloads, and these were added to by increases in patient acuity and the additional demands associated with applying new technology.

{Service Manager PC}, who was also director of nursing, indicated that there were moves towards distinguishing between jobs that required trained nurses, and those which could be done by lower paid people. But this kind of distinction was muddied by how each task was perceived. For example, bed-making or similar tasks might be seen as purely mechanical, but it might also be seen as socio-medical and therefore within the purview of providing wholistic patient care. To continue the practice of assigning individual nurses to specific patients was a similar issue. The alternative was to have groups of nurses specialising in particular tasks and nurses from each group performing their specialist tasks for all patients. Such developments were regarded warily from a professional nursing perspective because they would shift the emphasis away from wholistic care in one-on-one social relationships, and place the emphasis on physical mechanics. Nursing would be:

> more impersonal because each patient would be looked after by many more nurses and on a task by task basis, but it would probably allow the completion of the same number of tasks with fewer staff, and therefore reduce spending rates.

She added that this change would be against the current professional trend which recognised greater benefits accruing to patients from receiving care on a more wholistic basis.

Ward Supplies

{Charge Nurse QP} pointed out that "after staff, the next biggest cost on the ward is probably for pharmaceutics and disposables, the bulk of which are linen. These things tend to be ones which are an unavoidable part of the service so there is not much scope for short run savings." He thought that better estimates could be ascertained for budgeting purposes by studying the costs of these items in relation to different cases and by using case-mix forecasts to prepare budgets.

Other charge nurses described how they had become more conscious of the monetary consequences of their actions since they had been provided with knowledge about prices. They felt that this applied to the nursing staff in general when it came to the use of ward supplies, such as food and linen. This contrasted with a certain amount of past waste, not through any wilful neglect, but because of a lack of appreciation that actions and choices had a cost side. However, {Charge Nurse QA} thought that this waste had been overstated, and that instead:

> people in the service are being screwed down and I feel oppressed by the whole attitude that health is not worth spending much on. I can appreciate that money has been wasted in the service though I am certain that it has never been so at clinical level. Before managers appeared we were pressured by supervisors. Systems have always been in place to keep staffing levels down because of the cost in money terms, and the service has always been required to economise because extravagance has never been acceptable. I cannot remember there ever having been a spending spree, . . . most activities can be justified on the basis that they provide money's worth.

She added that "I have this feeling that it is considered much more important to put money into other things. I also have a feeling of having been sold down the street or the river" ({Charge Nurse QA}).

{Charge Nurse PA} explained that her ability to control ward spending, was "limited to manipulating staff costs at the margin and to do a few other little things around the ward." These included checking meal allocations to ensure that meals were not wasted, and similar measures in relation to the use of linen, sterile supplies and so on. "The major aspects of spending are beyond my control, and many costs are driven by the medical staff." They controlled patient throughput, and charge nurses only have a small amount of influence on this[17].

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[17] Many interviewees beside charge nurses acknowledged that ward spending fluctuated according to patient numbers, lengths of stay, methods of diagnosis and courses of treatment, all of which were decided by people outside the ward over whom charge nurses could exert little control.

Reconfiguring Wards

Decisions taken in the management zone that affected ward operations fell into two categories; namely, taking temporary action to stay within a budget for a period, and taking longer term action that would reduce spending rates more permanently in response to reductions in budgets. Though these decisions were made among managers at the hospital level, they often required the general acquiescence of the more senior doctors as well as the charge nurses. They also affected patients and nurses.

The first category was typically a combination of reducing the rate at which elective patients were admitted, and of closing wards for a period. The latter could entail emptying a ward by moving or rescheduling patients to other wards thus taking these other wards closer to their physical capacity. {Charge Nurse PB} described how each surgical ward was closed for one weekend each month. "When it is our ward's turn, the theatre schedule has to be altered so that any of our patients who are in for major surgery are operated on on the Tuesday, and only day stay patients are scheduled for the Friday." The second category comprised more permanent mothballing of some wards; designating some wards as ones only open on weekdays to cater for day and short stay patients; reducing lengths of stay through earlier discharges of patients with particular diagnoses; encouraging doctors to be more conscious of the costs of alternate forms of treatment; and asking consultants, who set the standard courses of treatment followed by junior doctors in particular, to review (i.e. change) treatment protocols.

Competing Nursing and Financial Considerations

There were some potential conflicts inherent in the dichotomy between making savings and carrying out full nursing responsibilities. Charge nurses thought that some decisions made economic sense and were probably better for those patients who were able to obtain treatment. But inevitably some decisions meant that people had to wait longer before being admitted. This was of concern to the charge nurses and their staff, because it clashed with their basic beliefs, values and motivations. {Charge Nurse QB} stated that although overspending had not been an issue on her ward:

> if overspending did occur in the patients' interests, I would not be troubled by it, though I expect that someone else would see it as a problem. Avoiding

> overspending is not my first consideration, though that does not mean that wastage does not concern me. On the contrary: it does.

But this conflict did not surface explicitly very often once a patient was admitted. Indeed, {Charge Nurse QP} felt that:

> if the ward is run efficiently from a clinical perspective this surely has a flow on effect as far as the budget is concerned. . . . anything the ward does has an expenditure attached to it but if we can justify it in clinical terms then so be it, the money is spent. If it comes down to a situation in which a financial decision is going to compromise the care, we forget about the money and deal with the situation. By doing something well now, in the long term this may well produce a benefit in that patients will not need to come back into hospital.

He added that "there are very few medical decisions made in the department which are based on financial reasons and even these are not made such that they will compromise medical considerations" ({Charge Nurse QP}) and cited the possibility of substituting a cheaper drug for a more expensive drug as an example.

The charge nurses found themselves in a dilemma about savings and their adverse consequences on potential patients and services. While some money saved was spent on other health care and related matters which they felt was good, savings were used by the hospital to make up money lost as a consequence of reduced funding from the central authorities. They were sceptical of the motives of some managers and politicians, questioning whether they cared what happened to people, or understood either the care, or long run cost consequences of withdrawing money from the front line in the short term. However, while not enthusiastic about the implementation of service cuts, most felt that they had little choice or matters could worsen for potential patients. Notwithstanding, {Charge Nurse QB} held the view:

> if someone sick comes through the door, they should be cared for and the cost carried regardless. I do not believe in skimping on care at all; the most important thing is the patient. The concept of money driving absolutely everything goes against what I believe in and I dislike it when I hear people in

> the hospital advocating that costs should be reduced even if it means inconveniencing patients. The dollars attached to caring for someone are not of primary importance when a person is sick. . . . [In any case,] it is cheaper to treat a patient and do it properly than to have them come back later for treatment.

Wholistic Care Reduces Costs Per Patient?

The impression of the charge nurses was that wholistic care reduced individual patient costs in the longer run by bringing about speedier physical and mental recoveries, and reducing the likelihood of readmission. But they perceived that considerations about long run individual patient costs were ignored by the data systems and the people in management. The data concentrated on total amounts of money spent in the year-to-date, and encouraged savings on short run spending, even though it might be obvious that these were gained by deferring care and much higher long run costs. Similarly {Charge Nurse QB} described how among all the data that she received:

> one set that might be useful is missing. That is data relating to what happens to people once they leave the ward. Even if they are readmitted we are not bound to find out about it unless they happen to come back to the ward. As the ward deals with people a lot more quickly than in the past, they are obviously discharged earlier than similar cases used to be, though not dangerously early. It would be interesting to know how particular kinds of patients manage to cope at home compared with when they used to stay longer, and whether there are any problems.

The charge nurses wanted more systematic data on patients after discharge to enhance their sense of purpose and to provide feedback on the suitability of different approaches to providing care. There was a general belief that output measurement and the use of patient data, including patient consumer questionnaires, would be very useful in evaluating various aspects of their wards on which the budget report data cast no light.

Clinical Support Service Managers

{Clinical Support Manager PP} provided the overall picture. She and her "boss" (i.e., {Service Manager PC}) met monthly in order to:

> look at the budget and consider why there are over and under spendings on various budget items. This takes place a few days after I receive the monthly print-out. Usually I am able to answer some of these questions by going through the figures and seeing what was purchased although difficulties with data do present a problem. From this analysis I can attribute some occurrences to particular sets of circumstances such as a particularly high cost prescribing pattern. However, there are many questions which I cannot answer specifically because of inadequate data.

Managing Spending and Data

The clinical support service managers were generally expected to manage their departments' spending within the approved budgets. This ensued in a manner similar to the charge nurses and involved monitoring their departments' spending, reducing rates of spending, and answering for overspendings to their service managers. They also received monthly budget reports and staffing reports, and had monthly meetings with their service managers. These monthly meetings prompted the clinical support service managers to analyse their monthly reports and derive explanations for what they showed. The emphasis was to ensure that the total dollars in their departments' budgets balanced with those reported as spent, and that there were no catastrophes as far as services were concerned. Clinical support service managers obtained the impression from their service managers that the managers above them showed little interest in fluctuations in patient and service volumes and unit costs.

The clinical support service managers first saw monthly spending reports in about February 1990. Before this, all they had were vague, isolated messages. These would refer to being "overspent", but who or what was overspent, and in comparison with what, was unclear. Since that time the amount of data supplied to clinical support service managers had greatly increased. But these were often not the data needed by these managers, or asked for by others in the managerial hierarchy or the central

authorities. As far as daily monitoring of spending went, monthly reports were little use because they generally arrived "just before the end of the following month" ({Clinical Support Manager PP}). "All the information [from headquarters] arrives on paper rather than via a computer terminal" ({Clinical Support Manager PD}). Furthermore, they "lack for information about purchase order commitments" ({Clinical Support Manager PL}), and so:

> if I want to check the position on a specific budget line up to the actual present I have to combine the most recent print-outs and the result of a manual sift of purchase orders. This could mean sifting through a few weeks orders. Last year I tried to build up a record of outstanding commitments and tie this in with the accounts payable/general ledger information but there was no way that I could reconcile these records. ({Clinical Support Manager PD})

Unlike the charge nurses, the clinical support managers tended to know what the reports should say and when variances were likely to occur. The clinical support service managers had found that the errors and omissions in the monthly reports were profuse. {Clinical Support Manager PP} described how she dealt with the report:

> I usually have to spend some time comparing the budget with spending and checking the things out which I was not expecting. Often there are problems with the figures on the print-outs so much so that I have to check all the figures, particularly the accruals, and often have to ask for corrections to be made.

These occurrences made these managers dubious about the quality and correctness of the reports; and this also applied to other reports emanating from centrally maintained systems. Another difficulty with the monthly report was:

> the highfalutin approach to accruals of both salaries and some consumables which might be an accountant's delight but for the poor managers means trying to figure out what is happening each month. The accruals were suddenly introduced without warning or explanation and took people by surprise and some time to get used to. This is typical of the problem of someone somewhere making a change without realising the impact it has on other people. No doubt

> to them it looked fine and dandy and made good logical sense. ({Clinical Support Manager PL})

{Clinical Support Manager PP} described it as:

> anybody's guess how the accrual based figures on the print-out are put together. . . . There are times however when the print-outs depict a situation which is just not right. . . but lack of access to the way figures are made up makes checking out this sort of situation near impossible.

Up to 1991-92, reports were not accompanied by an accounts payable report showing a detailed breakdown of the expenditures on each budget item. "All invoices go to accounts payable and we rely on photocopies of inwards goods records to keep track of filled orders against our copy orders" ({Clinical Support Manager PD}[18]). {Clinical Support Manager QP} felt that:

> a detailed breakdown [of expenditures] would help in two ways. First, it would provide data on prices of things which we are about to [re-]order. . . . [because] spending time checking the price of a lot of things is not worth the trouble at present, but with easy access to data about previous purchases this trouble would be reduced considerably . . . making checking out and comparing prices more worthwhile. Second, [it] would allow us to check that what has been billed to the department is actually ours . . . and being able to check would allow errors to be corrected and would increase confidence in the information. As it is, we have to telephone purchasing with the occasional queries about specific things and as this is time consuming we do not do it much.

{Clinical Support Manager PL} also thought that detailed breakdowns might reduce the problem of items mis-coded to the department's accounts being overlooked. "In the past

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[18] {Clinical Support Manager PD} explained that everything of a financial administration nature including information was:

> centralised at the [area health board] when it took over from the old hospital board. The way the centralised functions work is of variable quality. We did not have any input either into the way things were centralised or since.

we were reluctant to ask for this breakdown because we had to go cap in hand to its source and to wait several weeks for them to find time to do it and for it to appear." However, from 1992-93 the breakdown was provided with the monthly reports at SITE P. Also:

> arrangements have been made to obtain a monthly analysis of what each department in the [organisational unit] is ordering. Previously this information was only available by keeping in-house records which lacked some details such as freight charges. That duplication of essentially a bookkeeping function will now disappear. ({Clinical Support Manager PL})

{Clinical Support Manager PD} described how:

> the central accounting system is a dismal failure. They have a new system but it does not appear to be any better. There is some talk of some computerisation of purchasing, reports and information dissemination but having already lived through one disaster . . . [the interviewee made various gestures such as a glance at the ceiling].

She pointed out that data on activity levels and outputs "are absent from the central print-outs and we maintain records of these" ({Clinical Support Manager PD}). She did no formal variance analysis (that is between volume and price effects) but saw this as a possibility in the future. She felt that:

> the [hospital organisation] do not seem that interested in volumes or seasonal or similar variations so much as total expenditures. Also, responsibility for volume and total cost changes as a result of other people's decisions are not traced to them but remain in our budget analysis. For example, the decision to close wards at holiday periods is taken relatively late and it usually falls to me to make enquiries rather than wait for someone to notify us.

{Clinical Support Manager PD} stated that from 1992-93, the amounts on her monthly report for the budgets for the month and year-to-date were as a result of proportions which she had determined instead of twelfths. She referred to the budget as "flexed according to expectations of [activity]," and thought that "this should make comparisons

between budget and actuals more meaningful," whereas previously variances were "a kind of nonsense."

Incidence of Local Data

The circumstances of poor and inadequate data described above prompted most clinical support service departments into gathering their own data. These data covered quantities of services provided and other events, and expenditures and spending commitments. As a consequence of these collections, some clinical support service managers saw the monthly reports merely as confirmation of what they already knew, rather than news providers. Their only surprises stemmed from the errors and omissions in the reports, rather than from problems in the departments. But although they were inclined to trust their own data more than those supplied from central general ledger systems, they felt obliged to reconcile any discrepancies between the two sets. The primary reason for this was that they were answerable on the data provided from these central systems, albeit through service managers who tended to be empathetic about their situations. However, even with this incentive, some of the clinical support service managers found it difficult to devote much time to correcting mistakes in these reports.

Computer and Management Tools

One of the problems faced by clinical support service managers was having no easily available computer access to the general ledger and related central systems. In any case, not all of them had had enough hands-on opportunities to become computer literate, even though they would have liked to be. Although computer access to the system was obtained at SITE P in 1992, this was limited to one terminal in the hospital's financial services division. In spite of the willingness of {Site Coordinator P} to help, such an arrangement merely eased the bottleneck on straightforward queries previously telephoned to central headquarters. It had not made the essential difference of allowing the clinical service managers to study the data in detail. Their problem was not merely one of a few queries; they needed to eye the data to induce questions and develop answers.

These particular problems relating to computer data were seen by the clinical support service managers as part of two bigger problems. First, despite the increase in management tasks, and the enthusiastic way these were approached by the managers, they felt that the supply of management tools lagged behind these developments ({Clinical Support Manager PL} and {Clinical Support Manager PP}). And second, they and their staff often had to work with centrally championed systems and data which were not user oriented, nor user friendly, nor user driven. {Clinical Support Manager PD} stated that "there has been some limited consultation on management, budgeting and accounting matters, but this is relatively recent and comparatively minor. Many things have been imposed and feedback has been very, very poor on a lot of things including OPIS data and the use of OPIS as a system."

The only system for which the interviewees had a positive word was the RUS installation at SITE Q. {Clinical Support Manager QP} described how "the people associated with that system are helpful," due largely to their occupation of an office in the main hospital, and their promotion of the system. But data from that system, such as cost per patient data, was ignored by managers because its relationship to dollars spent was not straightforward. Moreover, the introduction of RUS at SITE Q in about 1988 had been top-down: it was imposed by central management with little or no consultation and "very, very poor provisions for feedback." It was only later, after protests from disaffected staff, that this situation changed.

Similar top-down approaches had led to what the clinical support service managers regard as "some dismal failures" ({Clinical Support Manager PD}). The central accounting systems were the biggest butt of the comments, and attempts to improve these appeared to make little difference. Moreover, these failures gave rise to concerns about the use and interpretation of data from these systems. For example, {Clinical Support Manager PP} stated that despite the misleading data that were perceived to be in the central accounting system:

> Perhaps quite a lot of reliance might be placed on this data up the chain through the [hospital organisation]. This might be affected by how long individuals have

> been around the [organisation] and how much time they have had to realise the extent of the holes in the system.

In any case, there was a general belief that everyone involved was learning to use the data, and that mistakes were bound to occur. The problem was that the people whom the mistakes might affect were unlikely to be aware of how and why had happened. The clinical support service managers linked this with a reluctance among managerial people to confer, either in the same way that professional people did, or in the consensus manner used as feature of hospital organisations under the old triumvirate system.

{Clinical Support Manager QP} also raised the question of whether there was too much data; so that people were in danger of spending too much time gathering and using them. Her concern was that this detracted from the basic task of treating patients. However, she acknowledged that while matters were changing, it was not yet clear which data collections were unnecessary and could be discontinued.

Spending Patterns and Savings

In a similar manner to the charge nurses, the clinical support service managers were expected to influence spending in their departments. It was generally recognised that spending varied with changes in service output volumes and mixes. For the most part, these were determined or caused by people from outside the support services, such as doctors, nurses and patients. The staff providing particular clinical support services had little choice other than to respond to requests by these people, although they recognised that increases in demand led to increases in spending. Like the charge nurses, the clinical support service managers attempted to manage spending patterns over which they did not have that much discretion or control. But they were more cognisant than charge nurses that their relationship with spending and budget management was equivocal. That is, they were answerable for (over)spending without possessing the authority to do much to prevent it. This cognition could be attributed to their greater management acumen. Like the charge nurses, they attracted much understanding and empathy over their plight from others in their hospitals, and were not so much held answerable for overspending, as for taking action that would reduce spending.

In {Clinical Support Manager PP}'s department overspending occurred frequently. Her standard explanation was that while her budget has been fixed, patient numbers had risen. Faced with similar circumstances in other departments, both clinical support service managers and service managers accepted this explanation and had been unable to do much to rectify matters. The lack of management tools had made it difficult to "track patterns of service demand, consumption and costs across hospitals". This inability to analyse situations in any depth was seen by both clinical support and service managers as a potential area of data development in the form of doctor and specialty profiles of drug, laboratory and radiology use. However, while the RUS system at SITE Q had had this capability for some time, {Clinical Support Manager QP} had not used it.

Clinical support service managers had five stratagems for making savings:

(1) change the way in which staff were used in an effort to increase productivity and reduce overtime. This was similar to the rostering carried out by charge nurses;

(2) substitute less costly items in situations in which two or more choices of consumable supplies were available. In this regard {Clinical Support Manager PD} described how she provided some feedback to various groups of staff connected with her department: "I see a need to keep them up to date with what is going on and encourage them to evaluate what they are doing and watch dollars. The staff have an incentive because of wanting to maintain their income;"

(3) influence other people, particularly doctors, in the way they approached tasks which affected the spending in clinical support service departments' budgets;

(4) change the way in which materials (e.g., food, chemicals and drugs)[19] were purchased and inventoried, taking a more businesslike approach to prices and other terms of supply with suppliers; and

(5) vary the amount of discretionary work performed.

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[19] In the case of the pharmacy and laboratories a large proportion of their budgets went on these materials.

The first three of these stratagems are similar to those which charge nurses also took to bring about savings. The third stratagem included making doctors in general aware of costs of procedures and asking senior consultants to review standard diagnosis and treatment protocols. These protocols were a guide to doctors' diagnosing and prescribing habits, and junior doctors in particular were obliged to follow them. They affected the quantity and mix of diagnostic tests done in laboratories, and the quantity and range of drugs dispensed by pharmacies. The clinical support service managers felt some protocols could be changed without reducing patient benefit. For example, many of the laboratory tests ordered in the teaching hospital were by junior doctors and contributed to their learning as well as their diagnoses and treatment of patients ({Clinical Support Manager PL}).

Also tied to with this stratagem was the notion of keeping doctors informed of the costs of specific services. Doctors were not traditionally aware of such information. Although experience with this approach was brief, clinical support service managers felt intuitively that providing this information made individual doctors reflect on the necessity for certain services. A major obstacle to this development was that the information systems needed to collate or disseminate this information were not in place. The little information that clinical support staff supplied to doctors and nurses about drug costs and laboratory test costs tended to be done manually, selectively, sporadically and inefficiently. However, {Clinical Support Manager PP}, {Clinical Support Manager PL} and {Service Manager PC} related that a new computer system capable of providing clinical profiles on a monthly basis was to be installed at SITE P in 1993. They expected "large savings" to accrue from the data, provided the system was "geared towards users."

The fifth stratagem was available to the physiotherapy department in performing preventative work. This work could be reduced (or increased) according to the rate at which over (or under) spending occurred. {Clinical Support Manager QP} argued that this work was desirable from a socio-medical perspective because it helped sustain the independence of the elderly and kept them out of institutions. The longer term cost

implications of reducing this work would be for people to become dependent on more expensive institutional care sooner than if they could obtain preventative therapy.

The issue of short term spending considerations obliging responsibility centre managers to ignore long term costs and benefits was raised by several interviewees in the operating core in relation to preventative, discretionary work (as well as early intervention in elective cases). One reason given for reductions in discretionary work (and delays in electives) as a method to cut short term spending was that the benefits were difficult to measure quantitatively (e.g., who can say how many hospitalisations are avoided or deferred by home-based physiotherapy). It was felt that this undermined its importance in the eyes of some management people, who, generally, gave acute curative care an implied priority. In a related fashion, {Clinical Support Manager QP} felt that the imposition of a $31 tax by the central authorities on outpatient treatment in 1992 had deterred people from obtaining preventative treatment.

Non-clinical Support Service Managers

For the four non-clinical support service managers, "running" and monitoring their budgets as a year progressed involved the ability to discern trends. They looked ahead two or three months, and to what the final result for the financial year would be. To do this they were reliant on information from their staff and data from both their own systems and centrally maintained systems. They used data from their own systems to monitor the utilisation of staff time, and to calculate performance indicators which they had developed (e.g., ratios of running time to idle time for various vehicles). These uses of data aimed to make their services more competitive through better use of the resources available.

In general, as recently as 1990, data about the quantities of services being supplied had not been collected. Since then, non-clinical support service managers had tended to purchase[20] or develop systems to collect data about service outputs in total and to

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[20] For example WIMS (the acronym of works information management system) and NIMBUS (a tradename for a commercial package for small businesses handling customers on a jobbing basis).

analyse them according to their distribution in their hospitals. There were several reasons for this change:

(a) in their previous jobs the non-clinical support service managers had become accustomed to collecting and using data, and had developed appropriate analytical and computer skills;

(b) the nature of their services was such that quantitative data were relatively easy to derive for someone with these skills. The products of non-clinical support service departments were more susceptible to measurement, compared with the situation on wards and clinical and clinical support services departments. These products did not vary as much as services in clinical areas, despite the heterogeneity of the patients for which they were meant. What is more, the products were easier to describe and specify for counting the number produced;

(c) since about 1991, the managerial hierarchy had come to expect data about outputs, activity levels, inputs, and costs of services and of patients to be increasingly available; and

(d) the non-clinical support service managers knew their departments would have to compete with potential service suppliers from outside, and felt that they could not do this without data.

The data collected were a mix of physical quantities, expressed in units such as hours worked, kilometres travelled or pieces laundered, and costs. These data derived from records maintained by staff as they worked, including staff and machine time sheets, vehicle logs, and requisition and purchase order forms. The data collected within the departments made up "as much as 90%" ({Non-clinical Support Manager QL}) of those on which the managers relied. Two kinds of reports produced from these data are worth noting. The first were weekly or monthly statements issued to other responsibility centre managers indicating the quantity and costs of services supplied to their wards and departments. The seriousness with which managers took these reports varied, but it was increasing and had led to some controversy and changes in behaviour (see pp. 372-377).

The second were departmental profit and loss accounts. The revenue amounts for these were calculated using notional prices of services supplied to wards and departments. These accounts were produced because the non-clinical support service managers needed to justify themselves when compared with private sector competition. They realised that very few managers in other responsibility centres produced similar styled reports, and acknowledged that this set their departments apart and reflected the direction in which they were moving[21]. They were aware that in the hospital enterprise environment, incentives would develop that would make further changes very likely. {Non-clinical Support Manager QT} stated that:

> information about costs and knowledge of cost structures is vital to the survival of the organisation and the various parts of it including the [named] service. The [hospital organisation] is part of a system in which attempts are being made to duplicate market driven forces to establish something described as a level playing field. This means that the organisation and its departments will be playing the game on an equal footing with someone in private industry. The people making this attempt at duplication in the commercial services area . . . want these services to have to face similar costs to a private operator including rent for buildings, interest on money invested in vehicles, and depreciation. However, facing up to such things is difficult for someone like me when they are not that immediate. For example, I do not have to deal with things like cash flow at my level and so I am unsure how to take such factors into account in what I do.

General Ledger Data

The non-clinical support service managers received data which derived from central systems including monthly general ledger budget reports and staffing reports. {Non-clinical Support Manager QL} stated that the general ledger report "shows estimates and actual expenditures, but I find the information I get lacks credibility." {Non-clinical Support Manager QT} described how the:

> cost data from the general ledger on a monthly basis is very limited and of limited value, and really only provides a global picture in a sense. However, if

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21 {Central HQ Manager RC} reported a similar development at SITE R which set the non-clinical support services apart (see pp. 159-160).

> this picture is one of over or under spending I still have to go back to the finance people and ask why the data shows this. Unfortunately, they will not be able to come up with any answers to this question straightaway. In essence, the report is really a statement and it does not give me any information at all that enables me to diagnose why the under or over spend is occurring. . . . The finance people, and their general ledger system, are not user friendly in that I cannot really get a lot of useful information out of them. . . . It has been envisaged that people like myself would be able to access budget and general ledger data on terminals around the hospital. However, this has not happened yet for one reason or another.

{Non-clinical Support Manager PE} described how "quite a lot of the problems with general ledgers are due to coding errors, cheating and other normal things related with systems of this kind."

Rather than being a source of new data, the general ledger reports were something against which the non-clinical support service managers could reconcile their own financial data. One problem was that reports did not appear until two or three weeks into the following month, and there were lags between orders placed, transactions occurring and data captured by the central system. Another problem was that the data were analysed in ways determined centrally and not in ways which suited the purposes of the non-clinical support service managers, such as in a profit and loss format. The form of the reports was thought to derive from the hospital organisation managers' need to report to the central authorities each month in order to obtain funding. In any case, the general ledger data were considered unreliable, despite gradual improvements[22].

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[22] Notwithstanding, {Non-clinical Support Manager QT} indicated that some of the former hospital boards had maintained commitment based ledgers manually, but that this practice had been discontinued some time ago. He described how some useful details were on the staffing reports, but these were also discontinued several years ago. The researcher obtained the impression in reading Owen (1983), that general ledger reports were reaching non-clinical support areas in the early 1980s.

The non-clinical support service managers were able to check data more easily because they had their own systems. They felt obliged to do this because they were judged by service managers on how year-to-date spending compared with budget. The checking ensured that what they were judged on was reasonably correct, but they complained about having to do it "because it wastes my time and that of my administrative staff. This state of affairs [i.e., duplicating data collection and doing so much checking] shows that people who work at [central headquarters] are not doing their jobs properly" ({Non-clinical Support Manager PE}). Three of the managers felt that "these people" were concerned with control and power.

The other major deficiency in the data from the central systems was the lack of coverage of outputs or activity levels, and, as related earlier, this was an area which the non-clinical support service managers had developed for themselves. They pointed out that their hospitals were not in a position to measure inputs for the individual treatments they provided, and none of the central systems were capable of indicating the unit costs of specific treatments and clinical procedures, or the costs of different case mixes[23]. They felt that broad indicators of patient numbers and mix, and of activity levels generally, would be useful to explain service demand and spending trends. The only way for them to obtain data of this nature was through feedback from staff and questioning other responsibility centre managers.

Rationalisation, Restructuring and Ongoing Savings

The four non-clinical support managers ran and monitored their budgets in a similar manner. This task involved the ability to manipulate spending to keep it in line with budgeted amounts. They felt that money had got tighter and changes to the way services were operated had been brought about to keep spending within budgets. Some changes took the form of rationalising or restructuring services. For example, {Non-clinical Support Manager PE} and {Non-clinical Support Manager QT} were charged specifically with implementing changes immediately they took up their posts in 1990 and 1991 respectively. {Non-clinical Support Manager PE} had to "reduce the number

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[23] This was said of SITE Q despite the presence of RUS.

of employees in the department by a third." Having done that, he "quickly got on with the job of trying to get the best out of the staff who remained." {Non-clinical Support Manager QT} indicated that his service "quickly moved to a situation in which it could produce the services that are needed using a smaller group of staff from two locations both controlled from the main location at a reduced cost." Restructuring of this kind was common after about 1988, and the retrenchments entailed in them were not without some "pain" for both the staff who left, "and those who stayed".

The non-clinical support service managers made use of other measures to keep spending within limits, and to achieve savings on a permanent basis to accommodate budget reductions. Budgets were a constraint on how many people could be employed, and by the same token many employees could mean having much flexibility. {Non-clinical Support Manager PH} described how he rostered orderlies and cleaners in similar manner to the way nurses were rostered on the wards. Thus, several related changes had contributed to permanent reductions in his budgets. These included rostering according to actual demand rather than potential capacity, reducing working hours, rescheduling shifts, and avoiding penal rates by rostering over five days instead of seven. He indicated that:

> one of the first things I did was to change quite a few of the domestic service staff positions [i.e. cleaners and orderlies] into Monday to Friday people rather than have them all rostered on seven day shifts. This saved about $6,000 per position per year in penal rates. This was the kind of thing which had never been thought of by the old hospital management presumably because they did not realise that the rostering system [of working seven days] was unnecessary. With the new responsibility I was given, I was able to bring my local knowledge to bear on the situation and make this and similar savings.

He added that another factor which helped in relation to orderly and cleaning staff was that turnover among these groups was traditionally high. Consequently, "not filling vacancies for a few weeks" was a means of "bringing things around financially" ({Non-clinical Support Manager PH}). He stated that to cope with "the demands of the higher surgical throughput recently experienced by the hospital, [the service] has been stretched

to just short of its complete limit but it is still doing what is expected of it." He added that "turnover in staff makes it possible to change the working conditions of employees without too much fuss or of a feeling among workers of having lost out. These changes in conditions are not usually imposed on existing staff."

{Non-clinical Support Manager PE} described how his department "has a permanent staff who do most of the work and absorb most of the budget. When demand exceeds what this permanent staff can do, jobs are contracted out for a while." Part of the budget "is designated for special improvement projects, and if defect maintenance exceeds that expected, some of this special projects budget is diverted." He believed he had managed to integrate the technical and budgeting aspects of the service:

> by getting the staff to become accustomed to doing things better and more cheaply. The workers are encouraged to question and challenge what they are doing, and to work through the budget cuts in groups emphasising the links between getting things done and the costs involved. They are also encouraged to try and purchase the things they need more cheaply.

{Non-clinical Support Manager PE} stated that in a related development his hospital's budgets for such areas as electricity, crutches and food services were being:

> completely redistributed to recipients on the basis of estimated existing usage. The general idea behind the transfers of these budgets is to move responsibility for these items away from responsibility centres who have little or no control over them, and give them to responsibility centres which have quite a lot of control, so making more people aware of the costs that they are causing.

Some of his staff were opposed to his relinquishing these budgets. "One problem I came up against in trying to [give budgets away] was a tradition that the size of a person's budget is a measure of that person's importance" ({Non-clinical Support Manager PE}).

Answerability

The non-clinical support service managers were answerable to their respective service managers. A meeting between them took place every month on a one-to-one basis, except that at SITE Q these were sometimes foregone due to "lack of problems" to discuss. These meetings were used by the participants to discuss service and financial matters. While the monthly general ledger report figured in these discussions, it was not the main item of focus. At SITE Q, the two non-clinical support service managers had designed profit and loss reports which were specific to the respective services. These had the agreement of the service manager concerned. The financial information these reports contained was supported with details of service usage by the various service recipients, which comprised about 300 cost centres across the whole hospital organisation. {Non-clinical Support Manager QT} stated that "this system of charging out shows how the [named] service's traditional block allocation is being utilised."

The focus of the reports was on the period just ahead, as well as on the past period. Even so, the data in them had to reconcile to the corrected general ledgers, and the discussion between the non-clinical support service manager and the service manager tended to be about measures taken to regulate spending in line with the budget. The reason for this was that people further up the managerial hierarchy were concerned about spending in either the hospital as a whole, or the hospital organisation as a whole. This was also true of SITE P, where the main focus of the meetings was on the current month and what was expected to happen then, rather than on the previous month on which the general ledger report featured.

Another feature at SITE P was that the non-clinical support service managers met as a group with their service manager usually every week. {Clinical Support Manager PH} described how "everything which is going on is covered and [{Service Manager PB}] passes on information coming down from above." He pointed out that although {Service Manager PB} had adopted this style of openness, it did not mean that it was universal at SITE P "by any means." Both interviewees there indicated that different service managers had different styles, and they felt advantaged compared with other

responsibility centre managers whose service managers had found the changes and the new environment "difficult."

Internal Charging

By 1992-93, internal charging had become a major issue for the non-clinical support service managers. Part of this was because they already used profit and loss criteria in running their departments. {Non-clinical Support Manager QT} described how the hospital organisation wanted:

> all costs to be passed down to departmental level. . . . in order to calculate patient day costs. . . . this charging out is on paper only at this stage rather than through the budgeting and accounting system. . . . although the facility and the information to start charging departments for their use of [the service] [already exists] . . . [Also] the charges are not showing as revenue in our accounts to offset our costs.

The non-clinical support managers envisaged that internal charging would entail wards, residential units, clinical departments and indeed other support services, billed according to the volume of the different services they received from non-clinical and clinical support service departments. These bills would give rise to expenditures appearing on the recipient responsibility centres' monthly general ledger reports, and to revenues on the same reports of the departments which provided the services. These revenues would be available to meet the expenditures or expenses incurred by the latter departments in providing the services which they had distributed.

The non-clinical support service managers had more to do with internal charging than the other responsibility centres. There were several reasons for this, among them that data were more readily available about their services, and these services were seen as available from the private sector. The non-clinical support service departments were initially treated like other responsibility centres and allotted block budget allocations to provide services. Although that arrangement was still predominant in 1992, the non-clinical support service managers were aware that it was the intention of hospital organisation managers that they would become dependant for finance on revenue from

internal charging[24]. They had found that the onus for implementing developments connected with internal charging had been placed on them, rather than on the departments receiving these services, or on a third party. Thus, non-clinical support service managers were involved in technical efforts to make charging systems function, starting with passing service usage and cost data to managers of responsibility centres deemed to be the recipients of services. Before this started (in about 1991), nobody knew who consumed or used what, or indeed what precisely was supplied.

The non-clinical support service managers found the issue of internal charging fraught with controversy and not that popular; and they were in the firing line. They believed that the initial distributing of data in memorandum form had increased service recipients' awareness of the skills and services with which they were provided, and had resulted in these recipients providing feedback to service staff about what they expected of them. But the move to more formal billing met various problems which slowed its coming. Implementation was achieved piecemeal, and attempts in some departments had failed. The non-clinical support service managers attributed the problems to a range of issues which affected many relationships between different parts of the operating core, especially those between people in support services and everybody else. All these issues at some stage affected the non-clinical support service managers. They usually had a technical, a political, a cultural or a social side to them.

The more technical issues included distinguishing separate services, measuring them in volume terms, arriving at cost-based prices, and processing and recording data. These gave rise to more political, cultural and social issues such as:

(a) the amount of paperwork required of clinical staff;

(b) choosing how to redistribute existing support service budgets;

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[24] {Cost Accountant Q} indicated that:

> when . . . charging for services between departments starts, all costs including overhead costs will be attributed to production departments; that is, those with the patient throughput. The support departments will be zero based in budgeting terms and they will tender for the services required by the production departments. They will charge for the services they are asked to supply and so will derive all their funding from these charges.

(c) causing services to be rationed by price;

(d) instilling positive incentives and avoiding perverse ones in the billing and charging mechanisms;

(e) allowing or not allowing users to trade with alternative suppliers;

(f) making usage explicit to make users answerable for the services they used; and

(g) suspicions that the introduction of charging was used by hospital organisation management as a cover for spending reductions.

These issues gave rise to two specific questions. The first was how to decide which responsibility centre should be billed for each service. In many cases, services were delivered or used by people, mainly staff and patients, and deciding to which of tens or even hundreds of cost centres they belonged was not always easy ({Non-clinical Support Manager QT}). The second one was that many episodes of service were quite short, and while recording every episode would clutter the records, to ignore short episodes would leave significant gaps in those records.

Even more of a problem was getting managers to accept the amount being charged to their responsibility centre. In 1992-93, this was the most controversial area between non-clinical support service managers and the managers of responsibility centres who would pay bills once billing was in place. The basic calculation of these amounts was quantity multiplied by price, and the potential for disputes over quantity and units was implicit in the discussion above. Another dimension to this was raised by {Non-clinical Support Manager QL}, this time as the receiver of a service for which he had been billed for some time. He had found that the reliability of this service was a problem but he had no means of redress for what was essentially a lack of quality. Withholding payment of charges due was not possible because the "payments" were made automatically by the central finance people without his authority.

Prices were also a matter of dispute. Although non-clinical support service managers had tried to base prices on expenditures incurred in producing services, the items counted as expenditures or expenses were open to argument and manipulation. {Non-

clinical Support Manager QL} reported that a dispute arose with service users in 1992-93 when he tried to introduce internal charging through the general ledger with revised prices. Up to 1991-92, he had been issuing quantity, unit price and total price data to responsibility centres via memoranda. The hospital organisation management directed him to increase the prices shown on these memoranda in order to reflect full costs, including depreciation/renewal and the cost of capital. He described how:

> the revised pricing structure was much closer to the commercial pricing criteria which applies to the [department]'s outside contract work. Needless to say these prices were higher than before and reflected the need to supply a quality product and a Rolls-Royce service. However, it came to the [hospital organisation] management's attention that these changes to the way charges were to be accounted for, and, more particularly, the changes to the pricing structure, were going to be politically unacceptable within the organisation. This led to a directive which stopped me in my tracks.

He added that this pricing basis would have allowed his department to recover its costs and be self sufficient, thus preparing it for the more competitive environment which it would face under the hospital enterprise structure. He and {Non-clinical Support Manager QT} identified two main difficulties of developing prices of this kind. First, they were not consistent with the emphasis on cash flows and spending. In general, people in the operating core were still learning about costs and the reasonableness of costs. And second, there was no indication of how the prices might be interpreted. For example, {Non-clinical Support Manager QL} referred to hospital quality standards, and environmental health standards. The former meant that his services' full cost based prices would be higher than private operators working to domestic standards. And the latter meant having to be extra careful in, for example, not polluting the air or watercourses because of the link to an organisation identified with environmental health. He felt that people using his department's services probably did not, or did not want to, understand these quality aspects, especially if a private operator meant lower prices. He also explained that such a move would not be in the hospital organisation's interests in the short term because it would have to carry the fixed costs of the service and paying for the work to be done somewhere else. This would lead to a restriction on the use of

outside operators, but that this restriction would upset internal users because it would be their budgets that would be affected by the higher prices.

Between them {Non-clinical Support Manager QL} and {Charge Nurse QP} explained that in the episode outlined above, the lack of political acceptability of prices based on full costs would not have been so great had it not been for the intention to implement the charges through the general ledger. The furore about prices escalated when people in recipient responsibility centres realised they were about to pay for services from their budgets, and at the new higher prices. This caused the hospital organisation managers to rescind their previous instructions to several non-clinical support service managers, which stopped the implementation of the new charging system for their services. During this episode, the hospital organisation managers never clarified the basic issue of how budgets were to be adjusted to take account of recipients having to pay providers for services. The non-clinical support managers had expected to lose their annual block budget allocations and become zero budgeted. But recipients were not sure that they would be allocated extra amounts in their budgets to pay for services received, nor if the amounts would be sufficient to maintain the quantities of services which those amounts could buy. Thus, some responsibility centre managers interpreted internal charging as potentially removing part of their budgets. Naturally, they resisted its implementation to protect these budgets, their departments and their ability to do their clinical work. Reflecting on the postponement of internal charging for his support service, {Non-clinical Support Manager QL} stated that "the whole equation of who is responsible for various aspects of the internal exchanges of services has not been worked through" by the people in management who appeared to champion the idea. Similarly, {Non-clinical Support Manager QT} stated that:

> the [hospital organisation] environment in which the [named service] operates is not yet ready for some of this. . . . [However,] without the transition from a block allocation held by the . . . service, to individual budgets held by departments with their use of [the service] charged against these individual budgets, there is no incentive among [service] users to make more efficient use of the service within their own area.

He added that until charging was introduced, people in responsibility centres using support services would continue to take these services for granted. Support service managers would have no incentive to take on additional internal business because, although the demands were there, the resources available were restricted to those that could be acquired within the fixed block budget. He wondered whether responsibility centres wanting more support services (e.g., use of vehicles) were using their budgets to buy them from outside because of the limits on their internal availability.

At SITE P in 1992-93, internal charging had also struggled but in a less public manner. {Non-clinical Support Manager PE} attributed the basic difficulties to a clash between the business culture of the service providers and the traditional hospital culture of the recipients of these services. Even so, charges from several support services appeared on responsibility centres expenditure reports, or were imminent (e.g., food, clinical supplies). {Financial Controller P} described how the hospital had used a crude method based on a rough estimates of existing usage to reallocate budgets. Though this was not altogether satisfactory, it seemed to have been "acceptable to most people," provided they believed it could be "refined" as problems or grievances arose.

A Note on the Financial Representation of Responsibility Centre Interrelationships

Internal charging was among what {RUS Support Person Q} referred to as a "variety of initiatives going on," to clarify financially the interrelationships in hospital organisations, particularly between doctors, front line services and support services. In 1992-93, {Nurse Manager PM} stated that "each service holds its own budget and the interrelationships are not tracked financially." Among the drawbacks she saw was that someone in one area could not offer to provide extra funds in exchange for an increase in the quality or quantity of a service provided from inside the hospital. A service which had an option which would result in a cost saving in a support service budget, and thus a saving for the hospital, was not bound to have a direct financial incentive to take that option, or even a full knowledge of the savings to be made overall.

{Financial Controller P} indicated that operational and financial linkages between support services and the services looking after patients directly had developed quite quickly. He attributed this to:

> the financial reality nowadays in which at the end of a month when the budget report comes out a responsibility centre is pointed at if it has overspent, and the responsibility centre manager is taken aside to be 'roughed up for being bad' type of thing.

He also referred to "the situation of people using [a support service] to their heart's content without any implications in their own budget" ({Financial Controller P}) in the absence of internal charging. By contrast, charging would create a situation in which "at least the costs and the consumption of resources will fall at the level at which they rightly belong." {RUS Support Person Q} pointed out that making a head of department responsible for salaries and total costs was completely facile because in many cases the decisions which affected departmental spending were made outside the department, particularly by individual doctors. {Financial Controller P} was unsure whether management would "ever be in enough of a position to start . . . holding [doctors] accountable," but he thought this might come about "through some sort of peer review . . . [with] pools of doctors . . . identified as budget holders. . . . The members of each pool would be expected to exert pressure on [each other]." As a result of the introduction of charging, support service responsibility centre managers would no longer be asked:

> to do the impossible of controlling volumes, quantities, usage, prices or anything else in their environment which are driven by support service users. Nor would they keep ending up with an overspent budget due to this lack of ability to control.

{RUS Support Person Q} felt a flexible budget based on revenues, variable costs and fixed costs would provide some method of accountability which distinguished between responsibility for volumes of activity and responsibility for performing each unit of activity. He had found that some heads of departments could see how flexible budget variance reports fitted in. Notwithstanding, they attempted to justify their expenditure

in terms of the fixed budgets on the general ledger reports. He thought the underlying reason for the prevalence of a fixed budget was that it allowed central management to feel in much more direct control over what departments did. He expected that in the hospital enterprise period the hospital organisation would need to move to case-mix management because of DRG funding[25]. That implied a change in the distribution of power from the hospital organisation's central management and heads of departments to doctors, and "whether the [various parties] are ready for that is another matter" ({RUS Support Person Q}). He also felt that:

> some people are getting carried way beyond the basic concept of an internal market. These people do not appreciate either the costs arising from changing entire services; or that, if only one or two departments opted out of an internal service, fixed costs would still have to be carried in order to provide the service to the other departments. Contestability needs to be kept within bounds, and in order to do this some directive needs to come from the top on how to proceed on some of these issues. . . . Without this direction, what is best for the organisation as a whole may be set aside by departments taking unilateral decisions guided by what seems best for them in the short term.

Doctors

In the discussions with all five of the doctors interviewed, there was a general feeling that access to accurate data informing each doctor of their activities, and their performance, was lacking. {Doctor QC} thought that, "as a very minimum, it would be useful to know how many patients I see each year, with some analysis of these patients." But what he and {Doctor QP} would have preferred was more frequent, perhaps monthly, information about how many patients they saw, into which diagnostic groupings they fell, and some analysis of "the number of outpatients who have a

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[25] {RUS Support Person Q} stated that the interest and importance of RUS in the organisation had declined since 1991, during which period the general ledger report had gained the ascendancy. However, in 1992, he had noticed signs of the system's re-emergence. In fact, he had "seen the writing on the wall ever since the 1993 health reforms were first mooted," and by late 1992 the whole thing had "got an edge and an air of urgency," because of the regional health authority and the need for case-mix cost data.

particular diagnosis; and of those, how many go to have an x-ray and a cardiograph, and how many do not."

The experience of both doctors was that the people collecting information were not able to tell them these things. They also felt that the problems which needed to be overcome to change this were not great, "so long as one has the people to do it and the equipment" ({Doctor QP}). {Doctor QC} described how some information was collected through a patient records system and through RUS, but:

> doctors have no tools which allow them to interact with the records on either system. Thus, what information that can be had from these systems is only available third and fourth hand, and only in very crude and not very user friendly forms which are relatively useless from a doctor's point of view.

He added that information about how patients, or their families, felt after their treatment was completed was even more vague and spasmodic. "Doctors may get to know of a patient who was dissatisfied, or of one who was happy, or may hear about a family who thought what happened was terrific, but with most patients this does not happen" {Doctor QC}. He explained that while scientific studies provided the basis of technical knowledge, how a patient was treated was guided by how he or she responded to a particular treatment. "Without basic data, the already subjective feedback environment in which doctors work is accentuated." On practice patterns generally, he felt that he and his colleagues at the hospital operated "pretty much in a vacuum." They had little idea how they compared with each other in how they dealt with similar patients. The doctors were given no information about the number of investigations they caused to be performed, nor about the cost of investigations. {Doctor QC} believed that:

> if this sort of real and relevant information was to be fed back to doctors, or made accessible to them in other ways, they would be more inclined to evaluate what they are doing, and this will lead to better decisions and an improvement in performance.

{Doctor QP} was aware of the existence of budget data relating to the ward on which all his patients stayed, but described this as "still in its infancy." He was also aware that

in the late 1980s, "there had been an attempt to cost individual dealings with patients, but it finished up as a disaster[26]." He attributed this outcome to "too many unknowns in the whole thing," and to the data used to compile these costs being "very inaccurate." He used such words as "bizarre", "ludicrous" and "nonsensical" to describe how this attempt was carried out, and stated that "the sum of all the inaccuracies was so gross as to be laughable. . . . The figures were worthless." He pointed out that a suitable way of costing individual patients "down to virtually the last dollar has not been found." Nevertheless, he considered that to attempt this at his hospital and elsewhere in New Zealand was a feasible option, but thought that "a very much higher labour input would be required to overcome the inaccuracies which arose before [in the late 1980s]." He also questioned whether "the activity of collecting these data would be a wise way to spend money [given that] administration is met largely from the public purse and is competing with clinical activities for limited funds from this purse." {Doctor QP} believed that a reasonable result on which to base decisions could be "got much, much cheaper" if he and his colleagues could obtain patient and related data about what they all did. From these they could deduce where resources were spent. "Not only that, but this kind of data would make it possible to see what options exist for shifting resources from one area to another."

{Doctor QC} indicated that both the financial and patient data that were currently available had been developed by three groups: information systems people, the finance department, and managers such as the assistant general manager for secondary services. But these data "are of no relevance and no use to me or other doctors." He gave two reasons for this, as follows:

> [first,] the hospital has not evolved ways for doctors to have sensible or functionally useful input into decision making about resource allocation. Therefore, there is no real motivation for them to be too worried about what happens, because they do not have any say in it anyway. [And second,] the data presentation is neither relevant to the doctors' information needs, nor makes for a good use of doctors' time. In general, the data are presented in a very crude

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[26] The interviewee appeared to be referring to RUS.

> and coarse sort of way. There is no attempt at grouping of the data in a meaningful way such as by diagnoses; nor do doctors have any interactive access to the data on the computer.

He felt that decisions were often being made at the wrong level by managers who were "not operating at the coal face" ({Doctor QC}). Instead, he wanted many more decisions to rest with doctors, and other people in the hospital, because "it is they who generate the costs stemming from the decisions and so they should be made accountable for these things." He thought that doctors should influence both the kind of data that were available and the way decision making was structured.

One positive thing which {Doctor QC} saw arising out of the irrelevance of budget and similar data was that others had not been able to impose on his work. He could recall being questioned only once, and that was about an increase in the budget for a particular surgical implant. He had informed the questioner that the increase occurred because he had more interest in the area of surgery using that implant than his predecessor.

End of Year

As one financial year comes to an end, another begins. For the interviewees at responsibility centre level the future was of more interest than the past. The non-clinical support service managers described how nothing very different occurred with the June monthly report and in the regular monthly meeting with their service managers. The charge nurses indicated that it was probably less of an event because it was too late to do much about over- or underspendings.

Things were marginally different at the service manager level. {Service Manager PC} related that at hospital level for 1990-91 and 1991-92, there had been "a debriefing which involved comparing budgets with actuals, and looking at service increases." She indicated that various ups and downs had occurred and she had taken notice of these in broad terms. From doing some analysis she perceived that her service's activities and costs rose with the level of acute services, but seem unaffected by the changes which had taken place in the level of elective surgery. {Site Coordinator P} also indicated that

immediately after the end of 1991-92 "some assessment was made of the outturn situation compared with the budget, . . . [but] most of the analysis of the 1991-92 outturn was done during the 1992-93 budget round." She added that from July 1992 until she was interviewed in late August 1992, "all had been quiet" as far as 1991-92 was concerned. She presumed that at central headquarters "there were perceived to be no problems with the district's outturn, and so nothing has been raised about it."

{Nurse Manager PM} related that the budget for her service for 1991-92 was overspent. She attributed this to "some one-off items which occurred to do with restructuring the service," but added that "the budget would have been underspent if I had not taken certain steps." She described how there was no rolling over of unspent portions of a budget to the next financial year, and so while she had not spent up to her limit merely for the sake of reaching it, she had used the unspent part of her budget to buy things that she would need in 1992-93, before the 1991-92 year had ended. On this issue, {Chairman P} expressed "frustration over the lack of freedom to move the budget around between items and between years." He stated that there was "an incentive to spend money to avoid underspending at the year end," and that this was "possibly wasteful and almost certainly less than optimal in value for money terms." Similarly, {Site Coordinator P} indicated sentiments from other managers that if a service or responsibility centre came in under budget, and with a better than planned service, no tangible credit was given for this and the financial benefit accrued to services which had overspent. She noted that budget allocations from headquarters level downwards tended "to be historical rather than tied to output or productivity." For many the main incentives to do better were intrinsic and stemmed from "the personal satisfaction of having assisted individual patients or done a support job well."

{Nurse Manager PS} also described how at the end of the 1991-92 budget period, her service was overspent overall. Her service manager had to explain this for each budget item to those to whom he was answerable. She felt that he experienced problems providing reasons and convincing people that nothing could be done that was not already being tried, to avoid a further recurrence. She stated that in essence the high service productivity of the previous year (i.e., 1990-91), which had also been overspent, was

maintained without the required dollars having been forthcoming in the budget. She added that "overspending trends are continuing in 1992-93," and that "the crunch would be to cut services and jobs."

The S Service area at both SITE P and SITE Q was one most hospital-based interviewees knew had recurrently overspent. Several of them saw this as a consequence of fixed block allocation budgets in an area in which there was little discretionary expenditure. It was generally accepted that the area was demand driven and that overspendings were beyond the control of either hospital. {Non-clinical Support Manager PH} indicated that there "was no way that [departments in the S Service] can achieve the levels of service expected of them with the money in their budgets." {Non-clinical Support Manager PE} indicated that "such behaviour on the part of a manager as allowing his/her responsibility centre to overspend would not be tolerated in a normal type of business. But the hospital is not a normal type of business in that it faces clinical and political pressures as well as economic ones, and so overspending is tolerated."

Other interviewees generally expressed empathy and support for overspending by S Services' areas in response to patient demand. They were prepared for their departments to contribute savings to cover these overspendings, and for the same to be done with savings in other areas. But they did not think that some of these savings could be sustained without failing to maintain the fabric of some of the areas making them. Thus, they saw the longer term solution to the problems of recurring overspendings being political moves to get more money from whoever would be funding their hospitals[27].

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[27] {Non-clinical Support Manager QL} made the point that one of the main problems in the system in 1992 was that the government had not made it clear whence hospitals would be getting funding from in the future; that is, from taxation or from private individuals and private insurance.

Annual Reports

{Financial Controller P} was the only interviewee at SITE P who connected the end of the financial year to the publication of an annual report. He described how the hospital organisation was the reporting entity and that the hospital's involvement was limited to "doing a stock take and making sure accruals were complete." {Site Coordinator P} stated she had nothing to do with the hospital organisation's annual published report; nor was she aware that such a report existed. This was true of virtually all other interviewees among the responsibility centre managers. However, it was reported from SITE R that in about 1989 each staff member was given a personal copy of the annual report. This led to an outcry among recipients at the cost of producing such a "glossy, prosperous-looking document" when they were being asked to cut spending in the hospital ({Doctor RT} and {Auditor R}).

Closing Pointers

Following the development of controlling, monitoring and answering for spending as part of broader changes in the hospital system, related in chapters 5 to 8, this chapter illuminates several processes and interactions that occurred during a financial year as people in hospitals (i.e., those in the operating core and support services, and in the service manager and support staff element) become increasingly obliged to monitor spending against budgets. This obligation began to encroach increasingly on the activities of these people during the early 1990s. Monitoring became more elaborate because these same people were involved in budget preparation and setting, as described in chapter 9, and as internal charging, output measurement and product costing were introduced.

These developments were also sources of new conflicts both between elements and across levels. The emphasis placed by central authority level and hospital organisation managers on short run reductions in total spending was sometimes difficult, unpopular, painful and exasperating. Clinical areas in particular were affected because those involved in patient diagnoses, treatment and care saw themselves as having very limited discretion in admitting and dealing with patients, and over how much spending could

be avoided. Moreover, they saw the early intervention into patients' problems as medically and socially desirable, and also less costly in the longer run.

Correspondingly, responsibility centre managers and service managers attempted to cope with the demands of patients and with staying within ever tighter budgets. This resulted in changes to the way staff worked, to how and when services were offered, and to the way patients were looked after. Those dealing with support services faced the added incentive of external competition, and had moved towards evaluating their activities on a profit centre basis. But the norm, as determined from outside the hospital, was for fixed annual budgets to be set and for managers at each level to be evaluated on the criteria of "not overspending" compared with these. These aspects are among those thickly interpreted in the next chapter.

CHAPTER ELEVEN
A THICK INTERPRETATION OF THE SITUATED PRACTICE OF ACCOUNTING

This chapter presents a thick interpretation which takes the reader to the heart of the accounting processes and interactions thickly described in the two previous chapters. The interpretation illuminates and promotes understanding of the situated practice of accounting among doctors, other health professionals, and service managers and their support staff.

Accounting Operating Vertically

A broad picture emerges from probing the thick descriptions in chapters 9 and 10 alongside the material reported in earlier chapters. It is one of managerial processes and structures which operate more and more vertically (Hopwood, 1983, also cited in Michelman, 1988). These have been imposed by a new breed of management zone staff on staff practising professionally in the operating core or working in non-clinical support services. This process of imposition has proceeded rapidly since about 1990 and had caused organisational processes and interactions within the operating core and support services to change both cross-sectionally and longitudinally. The degree to which this imposition was considered legitimate varied among the staff in different basic units. In any case, various counteractions and coping strategies have been put in place by these people and the service managers above them in the new hierarchy (Markus & Pfeffer, 1983, also cited in Michelman, 1988). The result is the emergence of accounting in several roles or purposes (Burchell et al., 1980; Kelly & Pratt, 1992).

The Importation of Accounting Ideas

In the pre-reform period (i.e., up to c.1988) accounting was virtually absent from the operating core, or even the support services, and the management zone barely existed inside hospitals. Looking after money was the task of the treasurer in the board office. In the ensuing six years, a variety of ideas associated, *inter alia*, with accounting as a managerial functional discipline have played, or are beginning to play, a key role in the

way in which hospitals function. Within each hospital organisation these ideas have included:

(a) establishing a master budget for revenues and expenditures for a financial year covering the whole organisation;

(b) establishing responsibility centres[1] at different levels of a managerial hierarchy and placing spending allocations/limits on each one in the form of fixed discretionary annual budgets. The degree to which responsibility centre managers have participated in setting budgets has gradually expanded;

(c) using centralised general ledgers for keeping track of expenditures which were analysed by responsibility centres;

(d) producing monthly reports in which spending to date in each responsibility centre was compared with a portion of its annual budget;

(e) measuring levels of clinical and related activity such as patient numbers, numbers of procedures, numbers of items produced or processed within each responsibility centre;

(f) redesignating some basic unit level responsibility centres (primarily the clinical and non-clinical support departments) as profit centres[2], introducing internal charging (at prospective transfer prices) in the general ledger and recasting the monthly budget reports of these centres in profit and loss format;

(g) redesignating other responsibility centres at this level (primarily the clinical departments and wards) as standard expense centres and introducing standard costs and variance reports; and/or

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1 The name *responsibility centre* was applied to organisational units at the basic unit level, but the concept of responsibility centres (Anthony & Young, 1994) was also applied at service manager level and unit manager level (e.g., district general manager).

2 As reported in chapter 7, hospital organisations themselves were redesignated as investment centres by the Department of the Prime Minister and Cabinet in that balance sheets, net assets and return on investment were replacing scrutiny of expenditure against the master budget as the basis of control.

(h) designating the costs of central activities, lines of middle management and departments not incorporated into (f) or (g) as overheads and allocating them to clinical departments and wards using, for example, activity-based costing or the step-down method of overhead allocation.

How these accounting ideas and processes have emerged during the Study period is illustrated in Figure 11.1[3]. This Figure takes a similar form to the Figures in chapter 8, except that the area health period is subdivided into three in order to show the changing picture in more detail. An additional feature is an indication of the relative numbers and location of accountants.

A Rational Interpretation of the Emergence of Accounting Ideas

Whereas in the pre-reform period, hospital organisations depended for their daily cash needs on the Department of Health, this changed going into the area health period and they became responsible for their own cash grants and managing cash. "Also, the allocations are fixed, and if [a board] over spends then that is its problem and not the government's" ({Non-clinical Support Manager QT}). The hospital organisations also had to report more fully (Area Health Boards Act of 1983; NZSA, 1987; Public Finance Act of 1989); and soon moved onto a basis of accounting which included accruals. The initial emphasis was on the annual report, but this was soon superseded by an emphasis on monthly reporting to the Minister and the Department. The reports took the form of a comparison between spending and the annual estimates (Minister of Health, 1990). These annual estimates became part of the annual contract round (Minister of Health, 1989), and, once approved, the financial side of contracts was monitored by analysts at the Department. The initial emphasis of this monitoring was on spending against budget, but closer to the start of the hospital enterprise period it began to take in the balance sheet and an assessment of the government's investment as owner of the organisations.

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[3] In Figure 11.1, a reminder that the regional health authorities created in 1993 form part of the central authorities level in addition to government agencies based in Wellington.

Period	**Pre-Reform**	**Area Health**			**Hospital Enterprise**
Level	Central Authorities				
	Funding formula allocation; daily cash requisitions	Funding formula grant; annual reports, cash-based reports	Funding formula grant; contract/annual estimates, monthly and annual reports in standard form	Funding formula grant; contract/annual estimates, monthly and annual reports in standard form	Roll over of 1992-93 funding, contracts on fee for DRGs basis at prospective prices up to agreed volume
Level	Institution				
Accountants	*One or two*	*Two or three*	*Several*	*Several*	*Three or four*
	None	Cost centres with spending limits	Responsibility (discretionary expense) centres with monthly budget reports; budgets set centrally	Responsibility (discretionary expense and profit) centres with monthly budget reports; participatory budgets setting; volume-based cost allocations between basic units	Discretionary and standard expense, profit and investment centres with monthly reports; participatory budgets setting; cost allocations and transfer charging between basic units
Accountants	*None*	*None*	*One or two*	*One or two*	*Several*
Level	Basic Units/Individual				

Figure 11.1. Developments in processes of accounting in the hospital system across three periods.

These developments between the central authorities and the institutions had repercussions within institutions. The need for better cash management, and to live within grants that were more fixed, gave rise to a need to manage spending. Systems of cost centres were devised by accountants originally co-opted to help cope with changes to reporting. This idea was combined with general management, and responsibility centres resulted. Each had a manager who reported to the manager above him or her in the structure. Managers at each level were given fixed budgets within which they were to contain spending for their part of the organisation. These soon reached down the structure as far as responsibility centre managers, who also began to receive general ledger reports from the central accounting systems. These reports were produced monthly, and formed the basis of checking spending against budgets and answering to the next manager up the hierarchy for overspending. The reports and these answers were aggregated and formed the basis of general managers' monthly reports to the Department. These reports also went to board members, and later commissioners.

The allocation of items in budgets gradually expanded, and responsibility centre managers became interested in indirect as well as direct expenditures on their monthly reports. In the offing was the introduction of internal charging for support and similar services between basic unit level departments at prospective transfer prices. Whereas budgets were originally handed down to managers, towards the end of the area health period their participation in budget preparation began.

Thus accounting came to figure prominently in the vertical processes and interactions imposed from the management zone by 1993. It also emerged in the revised horizontal relationships among basic units, and the prospects were for it to continue to figure in vertical and horizontal developments linked to the hospital enterprise period. These developments included measuring the performance of Crown health enterprises and evaluating them as successful and efficient businesses (Health and Disability Services Act of 1993).

Related prospects for the hospital enterprise period included contracts between hospital organisations and regional health authorities on a fee per type of patient basis, based on

DRGs and prospective contract prices and volumes. These and internal charging developments provoked attempts at costing patient types and individual procedures associated with different patient types. Previous attempts to introduce case mix and related patient costing under the auspices of RUS had failed, probably because the Department was interested in data to control total annual spending rather than individual patient costs. The flexible budgeting implicit in standard costing was at odds with the need for organisations to keep within their fixed annual grants. But it was probable that case mix systems would come to the fore with the change in financial arrangements between the central authorities and the hospital organisations. This change might also give rise to changes in the financial basis of responsibility centres (now being called business units) from discretionary expense centres with fixed budgets, to standard expense centres, profit centres and investment centres, all of whose budgets would vary with activity levels.

The other development in prospect for case mix costing and pricing, was for individual professional staff to be given reports about revenue and spending that reflected their own decisions on volumes (admittances), diagnostic and treatment procedures, discharges (lengths of stay) and task completion. These reports would form a basis for staff, primarily doctors, to answer for their actions to managers.

Micro-Macro Discord: "Bomb Blasts" and "Aggravation"

Despite the espoused theory of economic rationality, efficiency and effectiveness attaching to these accounting ideas, probing revealed occurrences that were more complex to explain. The accounting ideas, and the processes and structures which they gave rise to, were related to macro-concerns about resource allocation and less spending. While many people at the basic unit level were not unreceptive to these concerns, their predominant concerns were micro. The official data system (i.e., the general ledger) was wholly concerned with monitoring and reducing total organisational spending, and the way it divided spending between responsibility centres was largely irrelevant to those needing data to manage daily operations at basic unit level. Predictably, the restrictions placed on spending caused "micro-level care choices to be increasingly interdependent with macro-level care issues" (W. R. Scott, 1982, p. 222). These circumstances caused

problems and apparent irrationality at the individual level (see p. 93 of this thesis). However, tension was lessened because of the empathy between professionals cast in managerial roles, the general contempt that existed towards general ledger data, and a willingness to accept explanations that overspending was due to increases in patient numbers and acuity, and to similar matters beyond the control of responsibility centre managers.

Nevertheless, some frustration, strife and exasperation were present and the situation was exacerbated by the way accounting ideas continued to be imposed from the management zone, and from the central authorities as part of changes to the health system as a whole. The imposing was done by groups and individuals who were for the most part only loosely linked. The varying degrees of success and failure related to the importation of concepts and systems foreign to hospital organisations by people who were unfamiliar with life in hospitals. For example, there are lessons to be learnt from attempts to introduce case-mix costing in the form of RUS late in the pre-reform period (i.e., c.1988). It suffered from political difficulties of implementation consistent with hypotheses advanced by Markus and Pfeffer (1983, p. 209) as follows:

(a) the "power distribution system" implied by RUS did not correspond to the power of doctors being in the ascendancy;

(b) the "language and symbols" of RUS (e.g., $s, products, relative value units and standard costs) did not correspond to those of the "dominant organizational paradigm and culture" in which proficiency dominated;

(c) the "goal and technology assumptions" of RUS did not correspond to those "widely held in the organization."

Similar charges can be laid against accounting systems and related ideas since RUS, but these have been longer lived because they are backed by the central authorities, and people in the expanded management zone. Even so, these systems and the way in which they have been implemented, have attracted much criticism from hospital service managers and at the basic unit level. Some of the severest criticism came from {Non-clinical Support Manager QL} who stated:

> while there is clearly a theme of change in the [health] service, there is no coordinated plan for change. Nor is very much lateral thinking taking place among the people driving the change. The policy directives from politicians and the Department are a wishy-washy mishmash of political rhetoric which explode all the time like bomb blasts down where we are. . . . There seems to be something up there which people in hospitals are supposed to be aiming for, but it is not known what it is. The actual changes going on are a mix of a whole lot of things with lots of people having an input. However, these various things do not have much bearing on each other, and nor are they aiming for anything specific or which is stationary. It is like having a circular, level playing field with 300 teams all playing with the same emotively charged ball, going in different directions, and without any fixed scoring lines. . . . Because of this we all take a very insular view and are inclined to shield ourselves from political events and the changes inferred by them.

He added that:

> we are having a whole lot of bits and pieces tacked on to the task of providing a service. These bits and pieces amount to mechanisms [e.g., internal charging] by which questions are raised about why, how and where the service is going. They originate from outside influences and generate a certain amount of stress and pressure, particularly as we have no input into how these mechanisms are created in the first place. ({Non-clinical Support Manager QL})

Reduced Spending as an Unpopular Agenda

Poor articulation of direction from the central authorities and hospital organisation central headquarters managers was a common theme at service manager and basic unit levels. Some of it was believed to be due to an unwillingness to impart an unpopular agenda, particularly at political level. Both staff within the health system, and the communities and interest groups to which the outside interviewees were related, were opposed to reduced quality of services, and reduced access to services and hospital closures. Many interviewees saw all these as the likely outcome of cumulative reductions in spending for a sustained period. Whatever other changes occurred, the

common perception obtained by the staff from the new structures, processes and interactions imposed on hospitals was that they were expected to spend less.

Problems of Hierarchy

The other factor which contributed to lack of articulation of direction was a more general problem which manifested itself in poor communication from the top down. This problem was one of hierarchy (Peters, 1988, 1992), and affected specific changes including the introduction and development of budget preparation and monitoring, the development of the general ledger and staffing reports, and the introduction of internal charging. It also affected processes once they were in place because people were not informed about the progress of the budgets or estimates they submitted, nor about deliberations on capital expenditure requests. Problems with these last two were reinforced by two other aspects:

(a) the annual focus of accounting and the often retrospective nature of the processes in which it is implicated. Thus, whereas hospital activity was naturally continuous because people could require treatment and care at any time, in the financial regime it was portrayed as discrete[4] (see Roberts & Scapens, 1985, on the propensity for accounting to impose artificial temporal limits). Also, whereas hospital people were dealing with what was happening and was going to happen, the accounting reports prompted questions about what had already happened;

(b) the government budget process and contracting rounds which tended not to be completed until four or five months of the financial year had elapsed, and about which there was continuous uncertainty.

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[4] This gave rise to adverse publicity in May 1994 when one Crown health enterprise announced that it would not carry out any more elective surgery until July 1994 because it had completed its contract and a new contract would not come into being until the next financial year. Presumably the people who would have benefitted from being treated in the unused facilities in May and June, would be first on the list when "production" recommenced in July. See also the subsection below on the increasing productivity increasing spending paradox (pp. 399-400).

Some of the interviewees who had been in the system for the longest time indicated that "poor communication" from central administrators was normal. However, this was added to by people towards the top of the new management structures who overlooked the need to keep their "subordinates" informed. An exception were the responsibility centre managers interviewed who reported to {Service Manager PC} or {Service Manager PB}, and the latter's support staff. These seven people were clearly the most enthusiastic interviewees to perform managerial tasks and deal with management zone staff. All indicated that these two service managers kept them informed as much as possible, and discussed the future with them regularly. But both these service managers, and virtually all other interviewees, were critical of what was imposed from further up the zone without consultation, explanation or signs that those there understood much about life, work, processes and interactions in hospitals. {Financial Controller P} stated that despite his hope and enthusiasm for the future:

> looking back, probably people in the hospital have been shunted from pillar to post in what has been an unwieldy process to get things done, bring about changes, and produce information. There have been so many things going on at so many levels in this regard. . . . Everyone should be able to expect a certain amount of stability in their day to day plans, but they are not getting that in this environment. . . . The impact of the changes has meant a lot of aggravation as well as hard work within the organisation. . . . The pace of change in the organisation, like that of the whole reform process, has been pretty phenomenal.

Learning Lags

A significant feature of the implementation of many specific changes was the lag that occurred before each one reached the basic unit level. This was caused by intermediates in the chain of command becoming familiar with something before passing it down to the next level[5]. Thus, in 1993 while the central authorities and hospital organisation managers were involved with balance sheet items and output performance measures (see pp. 160-162, 168-170, 173-174), many people at basic unit level were involved only

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[5] {Service Manager PB} referred to developments of a resource rationing nature having "trickled down the organisation since 1990, rather than having been introduced everywhere all at once."

with spending compared with fixed budgets[6]. In addition, some distortion seems to have plagued the passing down of some developments, and also interfered with processes. People in the chain of command[7] added to and omitted items from developments, so that when these reached the basic unit level the coherence of the original intentions, explanations and instructions was impaired.

Short Run Spending Horizons

With some exceptions, the general feeling was that the managerial changes did not affect patients either adversely or beneficently once they were admitted. However, it was not clear how they affected access or admissions; nor how long some cuts could be sustained without affecting facilities, services and patients. A related matter mentioned by several interviewees was that concern about short-run spending in total was sometimes at odds with the cost containment of dealing with individual patients. Their argument was that early treatment and care often meant speedier physical and mental recoveries, and allowed patients to become independent more quickly. It also reduced the likelihood of readmission. By contrast, deferring care could often entail much higher costs because patients' conditions worsened, they spent more time in a position of dependency, and the probability of their readmission increased[8].

The overall approach to contracting and budgeting from the top down was limited to reducing budgets to see how people would cope. This was promoted, apparently successfully, under the slogan "let's try and see if we can do more for less" by {Service Manager PB} within the non-clinical "business units" for which he was responsible. However, most people at institution level and basic unit level were limited in their

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6 The researcher was informed by an accounting consultant that in 1994, while the central authorities were concerned with developing contracts based on DRGs, the people at basic unit level still operated with data systems which kept the budget and spending data separated from output measures.

7 They were among the groups and individuals involved in the crafting of strategy (Mintzberg, 1987) who were referred to earlier (see p. 394).

8 {RHA Official R} raised parallel concerns about the ability of hospitals to think strategically and plan financially for the long term at a macro-level.

financial thinking to the current year's budget. This was reinforced by the method of financial monitoring carried out by the central authorities on the hospital organisations, by the hospital organisation managers on the hospital and service managers, and by the service managers on the responsibility level managers. In addition, much budget preparation at basic unit and service manager level involved allocating a fixed amount for "Year 1", and for the most part was based on "Year 0". Several interviewees, including {Service Manager PC} and {Chairman P}, would have preferred the compiled budget based on forecasts of patient numbers and mixes, and estimated costs per patient type. They saw the imposition of allocations as undermining the usefulness of the budget setting and monitoring process, and as an opportunity for centrally located managers to interfere in their activities.

This means of budgeting seemed to reinforce the status quo, and encourage repetition[9], despite the fundamental shifts in perspectives and approaches to operations demanded by other aspects of the changes throughout the system. In order to make these shifts, and keep abreast with changes in medical technology, money needed to be moved far more flexibly around basic units and services[10]. This was put forward as another

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9 The contrast between annual budgets and long term planning are modelled by Gluck, Kaufman and Walleck (1982). Based on their model, the evidence is not consistent with hospitals having evolved into the diversified form of organisations (see p. 96).

10 {Ministry Official R} described the health system as:

> a multiple set of industries grouped together. . . . [This] makes it very difficult . . . to actually pin down precise definitions [of services] which are going to last for more than a few months before somebody out there at the clinical work face chooses to do something differently. Hence, all of a sudden it is found that great areas of work start to change in classification from, say, medical to surgical, or inpatient to outpatient. Due to these circumstances, the accountant in the health industry is perpetually behind the times simply trying to keep up with the way that the technology drives the way in which the accounting world must necessarily look.

This description seems to fit the "garbage can" school of thought in which "an organisation is a collection of choices looking for problems, issues and feelings looking for decision situations in which they might be aired, solutions looking for issues to which they might be the answer, and decision-makers looking for

(continued...)

justification for instituting internal markets for support services, but comparable changes in the other basic units were seen by those interviewees who broached the subject as more subjective and to do with setting health priorities.

Various suggestions were made about how this question of priorities should be approached and ranged from having overall budget allocations decided by "a supreme being", to the unfairness of leaving doctors to make what were seen as essentially political decisions. Upton (1991) discussed this question under the heading "core health services" when he announced the 1993 reforms, and established a National Advisory Committee on Core Health and Disability Support Services. In its first report (1992), this committee provided data which it claimed "is a significant first step in tracking what happens to the $5.6 billion we spend on health services each year in New Zealand" (letter to the Minister which accompanied the report). The Minister's reply made it clear that determining priorities between competing wants within a fixed amount of funding was a major difficulty and that "we are still some way from consensus in choosing between services" (p. 3). Meanwhile, people throughout the health system were caught between a lack of long term strategy and an emphasis on short term financial goals. This situation seemed to parallel the criticism of accounting as being excessively focused on short-term financial performance measured by return on investment (Kaplan, 1984; Johnson & Kaplan, 1987).

The Increased Productivity Increased Spending Paradox

Paradoxically reductions in average lengths of stay and increases in productivity produced pressure to increase spending. This was because there were always patients available to fill beds which became empty, and a disproportionate amount of patient costs occurred in the early part of a stay and were dependent on diagnosis and treatment rather than length of stay (Drummond, 1989). This led {Central HQ Manager RC} to point out that additional productivity was sending his organisation broke and to suggest

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[10](...continued)
work" (Cohen, March & Olsen cited in Bryman, 1984, p. 392; see also D. J. Cooper et al., 1981).

that a hospital enterprise approach needed to be slightly different from a commercial one: It should entail maximising what is done with the money received.

Verdict of More Good Than Harm

In spite of {Non-clinical Support Manager QL}'s criticisms related above (see pp. 393-394), he seemed generally in favour of change. Indeed, he was critical of people in the operating core and support services whom he saw not doing their managerial jobs properly and frustrating some aspects of the changes. His specific complaint was that those located in clinical areas in particular would not accept internal charges for the services his department provided, nor would they use the "proper codes" for orders and invoices. Despite other similar specific problems, most of those interviewed after 1991 thought more good than harm had come from the changes. None wanted to revert to past attitudes and methods, if only because so doing would have meant another change in direction and more changes to the ways work was done. But {Charge Nurse QP} indicated that:

> there are probably two camps of people in [the hospital]. The one I'm in consists of staff who are keen to make the system work and who believe that what is done does have long term service implications in the sense of making the money go further. The other camp seem to have trouble with accepting this belief. Some members of this camp have probably been around a lot longer than those in the first camp.

Variability of the Emergence of Loosely Coupled Structures

The managerial change, including accounting which was central to the change process, gave hospitals the outward appearance of having adopted more formal management control and accountability than existed in the past. In terms of structure, the small "middle line" (Mintzberg, 1989, p. 174) normally associated with professional organisations had expanded with general and service management. Characteristics of structure and process such as the delineation of individual managerial responsibility, devolved authority, divisional budgets, managerial performance measurement, transfer charging and answerability are usually associated with the machine and diversified forms of organisation discussed on p. 96 of this thesis (Gluck et al., 1982; Lapsley, 1994;

Miller & O'Leary, 1987; Mintzberg, 1991; Swieringa & Waterhouse, 1982). Although these forms are more familiar in the for-profit business sector, the diversified form in particular has been linked to accountability as spoken of by governments (Mintzberg, 1991).

This veneer of business sector structure and process met the expectations of accountants, central headquarters managers (especially those with little knowledge or experience of the operating core), and similar people in the central authorities (Mintzberg, 1989). With the possible exception of some non-clinical and clinical support services, beneath the veneer were organisational units organised along professional lines. The people located in these units carried out highly complex tasks associated with diagnosing, treating and caring for sick people, and these tasks contained a high degree of uncertainty, non-repetitiveness, immeasurability and ambiguity (Hofstede, 1981). This would seem to suggest that the new official order structures reflected "the myths of their institutionalized environments instead of the demands of their work activities" (Meyer & Rowan, 1983, p. 22). Meanwhile, the social order in these units was characterised by loose coupling. The staff in them were "building gaps between their formal structures and actual work activities" (p. 22) to safeguard the interests of patients, themselves and the professions. But the success with which gaps were constructed varied, and had mixed results. Senior managers and accountants strove continuously to close some gaps to enhance their ability to control spending at the macro-level.

The formal devolution of managerial tasks related to staffing and spending caused the people designated as service and responsibility centre managers in the clinically-oriented operating core at least to reflect on macro problems, though their main mode of operating was a micro clinical one. The managerial task in which all responsibility centre managers were involved by 1992-1993 was to monitor spending against budgets. This process was imposed on them when still in an unsatisfactory state: the quality of the data and of the reports was poor, and the structure of budgets did not match the structure of task responsibility. In addition, charge nurses lacked the technical skills to make sense of the data, and they and the doctors found the concept of controlling total

spending did not sit well in the individual patient driven environment of their wards and specialties.

Poor Quality Central Data

As far as quality of data and reports were concerned, these were widely criticised over accuracy, timeliness, comprehensiveness, and lack of orientation to decisions at the service manager or basic unit levels. Most blame for this was placed on centralised accounting systems, geared to retrospective reporting to the central authorities on the overall picture of total spending compared with the budget for the year-to-date[11]. The general ledger incorporated no data for occupation or use of facilities, or any output data. Output data only began to be developed at basic unit level in 1992-93. The emergence of these data contributed to the management control image portrayed to the outside world, but the reality was one of different people in different locations collecting different data in different ways[12]. These data were then aggregated under headings that were in line with those shown in hospital organisations' contracts with the Minister, and/or which were decided upon by centrally located hospital organisation managers and support staff. Those in the contracts were incorporated into reports sent to the Department of Health as part of the contract monitoring process. Most of these output data were seen by the responsibility centre managers as not very relevant to the way they ran their operations. Fluctuations in them did not give rise to any changes in budgets, despite the implication that they affected variable costs.

Local Data

As a direct result of the dissatisfaction, exasperation and time wasting associated with central data systems, the trend among responsibility centre managers was towards

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11 Problems of timeliness and focus have been raised as a general problem with traditional cost accounting systems in large diversified organisations (see Johnson & Kaplan, 1987, pp. 193-207).

12 There are parallels here with the study by Berry et al. (1985) of coal mines. They found that "knowledge of events underground is a cause of constant managerial uncertainty. Also, information transmitted from the coal-face is frequently unreliable, due to a degree of control exercised over it by underground workers" (p. 14).

establishing their own local systems. These were used to keep more detailed track of orders and spending, and to track key aspects of output/throughput performance. These systems allowed their "owners" to fathom why and how spending trends were the way they were, and to correct errors in the centrally collected data. Paradoxically, the adversity engendered through people held answerable on central accounting system data provided them with incentives to see that these data were properly maintained. Previously there were no incentives, because errors in spending allocations to departments and organisational units had not mattered. These local systems were seen as doing a job which accountants were paid to do badly, but these local systems were frowned upon by accountants because they represented duplication, and people with "inappropriate skills . . . taking on things that they are not quite meant to do" ({Central HQ RF} quoted from a source who wishes to remain anonymous, 4 November 1993).

Responsibility Centre Managers as Symbols of Formal Management Control?

As far as the structure of budgets vis-à-vis the structure of task responsibility was concerned, difficulties arose in trying to articulate professional-patient processes, and in capturing similar interactions, in financial terms. As a result, most responsibility centre managers were asked to control expenditures on items which for them were uncontrollable. Many found that items over which they could exert some control were in other people's budgets. Many interviewees at responsibility centre and service manager level were critical of these arrangements, and several coupled these criticisms with the problem of fixed budgets set from above with or without meaningful participation or consultation.

The essence of their criticism was that while answerability for overspending was vested in a single person (Humphrey, Miller & Scapens, 1993), the actions giving rise to spending were those of numerous people who could not be singled out in complex hospital networks. These criticisms can be illustrated by reference to the Nucio Hospital case study (Anthony & Young, 1994, pp. 688-694, 704-705) which incorporates a crude

model of spending in a hospital. This model portrays four elements[13] which determine spending: types of patients or services; mix and volumes of each type of patient or service; efficiency in the consumption of inputs in caring for patients or producing services; and prices of inputs. The Study indicates that each element was controlled by different and invariably disparate sets of people, quite often professional individuals, found in different parts of the operating core. This makes for such complexity that it was virtually impossible to tie each dollar, or bundle of dollars spent, to any specific individual, or set of individuals. In addition, patient mixes and volumes were given by traditionally responding to everyone and everything according to the professional ethic of providing care for those who qualified on medical grounds alone. As far as efficiency was concerned one could argue that responsibility centre managers in the operating core were able to control this, but one has to assume that these managers were able to exert some form of hierarchical, boss-worker, mechanical control over professional staff in their service. Finally, on price of inputs, the managers probably could influence these by considering how much particular staff would be paid were they rostered on particular days, or by calling for quotes and tenders for large or frequent purchases. However, there were limits to this influence in that a price must be paid to obtain people and items suitable for an intended purpose: special skills are only available from specialists!

As the circumstances just described did not fit with more traditional managerial theories of responsibility, authority and accountability, accountants and hospital organisation managers, faced with the imperative of controlling spending, identified sets of people (i.e., responsibility centre managers) located where they supposed those purchases occurred which gave rise to money leaving the organisation. It was as if responsibility centre managers were used to symbolise formal management control. Nevertheless, most of the responsibility centre managers interviewed saw themselves as accountable in some way for spending.

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[13] The description crude is used because even deriving these elements is problematic as one has to use the working assumption that there is a great deal of homogeneity among patients, services and the people and processes that go into producing services when in fact they are quite heterogeneous.

Power of the Medical Profession

A second reason for the use of responsibility centre managers as symbols, rather than articulating professional-patient processes and interactions (i.e., how much does it cost when Doctor Z deals with a patient of type E?), was the power of the medical profession. Doctors were in too strong a position to have a budgeting structure imposed which would disclose how much use of resources they caused. The only attempts to inform doctors of the financial consequences of their decisions were done unilaterally on an ad hoc, unsystematic basis by some clinical support managers[14]. Certainly it appeared that budgeting and similar financial controls had been resisted successfully by the doctors who were "driving" (R. Cooper & Kaplan, 1988, 1991) most of the costs. To some extent jointly, but in the main severally, doctors appeared to control access to hospitals. They were the gatekeepers (Stone, and Starr, cited in Michelman, 1988, pp. 8, 83-84) and responded to anyone who sought access on the basis of medical criteria. They were unreservedly supported in this by the charge nurses. Doctors determined the diagnosis and treatment of their individual patients, and the more senior of them determined policies on diagnostic methods and treatment procedures. The independence of these senior doctors from hospital managers was reinforced by their ability to practice privately in addition to their work at the hospital.

Furthermore, it was the decisions of doctors which determined everyone else's volumes of activity (e.g., number of beds occupied by patients who needed nursing care, number and mix of tests done, number of meals served). These decisions were based on what they judged to be appropriate for each individual patient, independent of other patient needs, and independent of the limited resources available with which to treat all patients. The problem of limited resources had traditionally been tackled implicitly through physical limits on how many patients could be accommodated at any one time. People who passed the medical criteria for admittance, but who could wait, were put on waiting

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[14] Apparently an attempt to do something at SITE Q along these lines using RUS in the late 1980s ended up as "a disaster" because the data were "worthless" ({Doctor QP}).

lists[15]. Meanwhile, doctors had no way of knowing the condition of resources because of lack of any data, including basic data about the numbers and types of patients they saw. The five doctors interviewed stated these data would be useful to them.

Standard Costing

In 1993 the idea of applying standard costs, standard expense centres and variance analysis[16] in a way which would impinge on doctors and clinical departments was contemplated by people in the management zone and central authorities. The potential of these developments was to interfere with the implicit power of individual doctors to spend money on their individual patients, and to control the interaction between doctor and patient (see Young & Saltman, 1983; see also Miller & O'Leary, 1987, on the socio-political origins of standard costing). However, there were several matters which suggested that these developments would be fallacious technically, to say nothing of their political and social repercussions. These included:

(a) having to use sick people with varying medical conditions, educational and social backgrounds, and personal characteristics, as a surrogate for standard products;

(b) pretending that admittance, diagnosis, treatment and discharge were standard and certain according to "patient type";

(c) believing that costs could be traced to arrive at standard costs in the first place, and that patients and related activities could be traced continuously in order to determine flexible budgets;

(d) relying on "standards" to remain unchanged, or to change infrequently.

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15 The waiting list mechanism was still in place, although it appeared that some aspects of it were changing. This might help explain why it was that many interviewees indicated that the proportion of acute patients being admitted was increasing. However, no one mentioned if the criteria used to evaluate whether someone could wait had been changed. Several interviewees outlined the ambiguities in waiting lists as a measure, and as well as any medical meaning they might have (see Sanderson, 1982), they were generally seen by the interviewees as something of a political football.

16 The Nucio Hospital and Union Medical Centre case studies (Anthony & Young, 1994, pp. 688-694, 704-705, 749-756) are examples of what is technically possible in this regard from an accounting perspective.

There is some irony in this idea being developed again. Not only had it failed in technical and socio-political ways in the form of RUS, but also it has been the subject of wider criticisms in the manufacturing sector whence it derives because of its underlying technological assumptions (Humphrey et al., 1993; Johnson & Kaplan, 1987; Peters, 1988). Even so, it seems to have the potential to enable institution level managers to increase their power over individual doctors by generating financial reports which can form the basis of answerability for "inefficiency" (i.e., overspending) (see Miller & O'Leary, 1987; Chua, 1995; Preston, 1992).

The Other Health Professions

In similar manner to the doctors, the other health professionals (e.g., nurses, pharmacists, radiographers) were also expected to exercise their skills as appropriate to each patient. Meanwhile their manager colleagues (i.e., charge nurses, clinical support managers) had been brought within the managerial hierarchy much more recognisably than the doctors who headed clinical departments. Accounting data seemed to play a more prominent role in the vertical relations they had with service managers, in particular through budget reports. These managers and their departments were less "decoupled" (Berry et al., 1985) than the doctors and clinical departments, and their efforts at muddling through managerially with a budget, and managing staff, were less "ceremonious" (Meyer & Rowan, 1983). However, they found that by simultaneously keeping within budget (e.g., by trimming spending incrementally on procedures and pushing up productivity) and having no service catastrophes, they were less prone to retrospective, outside interference. This combination was a necessary condition (although not always a sufficient one) to ensure support and legitimacy (Ansari & Euske, 1987; Bryman, 1984; Burchell et al., 1980) because questions of a managerial nature tended to be asked from above on an exception basis (i.e., when something was wrong according to the data). These questions tended to focus on overspending rather than on social usefulness and medical quality and risk. Departments looked upon lack of interference as an incentive to keep within ever tighter fixed budgets.

In 1992-93 internal charging began to play a role in the horizontal relations among basic units. This development involved a range of technical and socio-political issues (see pp.

373-374). There was a danger of these leading to political conflict between organisational units, when by contrast the effectiveness of the contributions of these units to patient welfare depended on ideological consensus and harmony (Swieringa & Waterhouse, 1982). Such conflict could outweigh any benefits to be gained by creating internal markets. {RHA Official} indicated that like costing systems, this was another issue which senior managers needed to address, and one which they could not leave to accountants to decide (see pp. 184-185 of this thesis).

Effects of Accounting on Relations Between Basic Units and Individuals

Whereas most responsibility centre managers favoured more managerial responsibility and power over their own special field of interest, particularly in the area of staffing, they were critical over spending and budget matters. All the managers seemed alert to aligning staff with workload, but apart from the non-clinical support services, much depended on how their professional colleagues performed the tasks which arose. Managers in professional areas portrayed themselves as "seeing that things were run", rather than "running things." Nevertheless, they attempted to make the savings imposed on their departments by pushing up productivity, and reducing staff and material costs. In conjunction with doctors and service managers, they reduced average lengths of stay, closed wards at weekends and reduced the routine use of clinical support services. These measures, seen in some instances as adversely affecting staff, were also seen as the least of three evils. The other evils were to be interfered with more directly by non-clinical central managers, or to be responsible (by neglect) for something which would have a more adverse effect on patients.

The largest single group of employees were nursing staff on the wards and they were more affected and alienated by the economically driven changes (Goldmond & Benson cited by Bryman, 1984) than any other group of staff. Tighter rostering led to fewer nurses who worked fewer hours for lower pay rates, and naturally these reductions led to morale problems. {Charge Nurse QB} stated that:

> recent events [i.e., breakdowns in pay talks and threatened strikes] have indicated that nurses are not particularly satisfied. . . . It is far harder to work now in the

> health system than it used to be; staff on the wards are unhappier than they were. . . . Other parts of the hospital are probably under just as much stress as the [nurses]. . . . Just chatting to people who come up to the ward indicates that they all face difficulties at the moment, and most of the difficulties seem to be financially driven, such as not having enough money to employ, say, another nurse or a person to do some work in supplies. This brings about situations in which one person is doing what was done previously by two people, and things like that. . . . Meanwhile, jobs are being cut out and tasks reallocated within other people's jobs. The people taking on additional tasks are expected to cope, although there comes a point at which they are doing enough even though they may be reluctant to say so for fear of difficulties from above. . . . There is a real reluctance to provide less service but savings are still expected on the use of resources. . . .
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> Nurses will still do things which they can see are better for a patient; they are still motivated by that. However, they are much less inclined to do it for the system, and so the system is losing these efficiencies.

Closing Pointers

In this chapter the researcher has presented a thick interpretation of the situated practice of accounting within hospitals and shown how accounting is implicated in hospital work and the hospital system. One of the main issues is the importation of accounting ideas which operate vertically and provide a tool by which macro-concerns of reducing spending are inculcated among operating core and support service staff. This has given rise to discord and conflict within the operating core and support services, and between them and the management zone. While these political consequences have contributed towards the implementation of the changes by challenging the status quo, they are not compatible with long run effectiveness. These ideas are incorporated into the theory-in-use presented in chapter 12. This theory sheds light on the past and the present, and also allows some speculation on the roles of accounting in the future of New Zealand hospitals.

PART IV: ARTICULATING A NEW THEORY

CHAPTER TWELVE
FROM SITUATED PRACTICE TO A THEORY-IN-USE OF ACCOUNTING IN NEW ZEALAND HOSPITALS

In this chapter a theory-in-use of accounting in hospitals in New Zealand is articulated. This theory attempts to explain what has occurred and to speculate about prospects for the future. It takes the form of a series of propositions which are set out chronologically and oscillate between the macro-industrial and the micro-organisational levels of analysis. The official sources in which the espoused theory of accounting in hospitals is portrayed are alluded to, and some comparisons and contrasts are made between the theory-in-use and the espoused theory. The remainder of the chapter contains reflections on aspects of the Study, including the methodology that was used, future research topics, and the researcher's personal journey.

Opening Remarks

This chapter is the final act in the thesis phase of the Study. It is comprised mainly of extrapolation induced from the descriptions, interpretations and related material spread throughout the thesis, and is presented in the form of a theory-in-use (Argyris, 1990; Argyris & Schon, 1974) (see pp. 3-4, 24, 86-87 of this thesis). This theory is the researcher's attempt to explain what has occurred in the hospital system, with particular emphasis on the roles of accounting and its reflective and constitutive capacities (Ansari & Euske, 1987; Boland & Pondy, 1983; Burchell et al., 1985; Chua, 1995; Kelly & Pratt, 1992; Loft, 1986; Roberts & Scapens, 1985), and to speculate about prospects for the future. It consists of 19 propositions, the first 14 of which have a chronological frame of reference covering the period 1984 to 1993. The next two propositions reflect on the roles which accounting has played during this period, and address other matters that prevailed by the end of the period; and the last three propositions are a mix of conjectures about the future and policy suggestions. The propositions oscillate between

the macro-industrial and micro-organisational levels of analysis (Becher & Kogan, 1980; Chua & Degeling, 1993). They are elaborated using explanations and arguments supported sparingly by references to earlier passages in the thesis and an "enfolding" of published literature (Denzin, 1989a, 1989b; Patton, 1990; Eisenhardt, 1989).

At the beginning of this thesis it is suggested that constructing a theory-in-use of accounting in New Zealand hospitals can facilitate, *inter alia*, comparisons between it and the espoused theory implicit in the health reforms (see p. 4). In articulating the theory-in-use, references are made to some official sources in which the espoused theory is portrayed, and space is given to comparing and contrasting the two theories. Among other things, this enables an evaluation, in the context of the Study, of the extent to which "the consequences of accounting do not necessarily have a close and automatic relationship with the aims in the name of which it is introduced and changed" (Hopwood, 1984, p. 185, also quoted in Ansari & Euske, 1987, p. 550).

In conclusion, the researcher comments on Study methodology and future research topics, and reflects on his own journey and where he now stands following on from what is conveyed in chapter 3.

A Theory of Accounting in New Zealand Hospital Organisations

A Rough Outline

In order that the reader can follow the detailed exposition of the theory-in-use, proposition by proposition, it is useful to consider an outline of what it entails. The theory starts in the first half of the 1980s by which time various problems had emerged in New Zealand. These were most public in terms of the national economy and at government level (e.g., precipitating the devaluation crisis of July 1984). But they also occurred within the health and hospital systems at all of its four levels as portrayed in Figure 4.3 (see p. 104).

As far as the hospital system was concerned, there were naturally those people who wanted changes to be made in response to problems; those who saw problems as an

opportunity to bring about changes they wanted regardless of what the problems were; and those who did not want any changes in spite of the problems. Different people saw problems differently, and championed different responses (e.g., see Advisory Committee on Hospital Board Funding, 1980; Area Health Boards Act of 1983; P. Davis, 1981; Health Benefits Review, 1986; "A Health Service", 1975). A change of government in 1984 brought with it ideas about changes to the economy, and opened the way for others, including accountants and accounting, and people interested in the hospital system, to introduce changes of their own. Also, among other things, an espoused theory of accounting evolved which stressed its technical-rational purposes of providing information for decision making, resource allocation, and accountability between agent and principal (Ansari & Euske, 1987; Burchell et al., 1980; Controller and Auditor-General, 1978; S. W. Davis et al., 1982; Hospital and Related Services Taskforce, 1988; NZSA, 1987; Treasury, 1989, 1990)

From the outset of this period of change, there were places in the hospital system where these "conditions of possibility" for, among other things, "innovations in accounting and practices of government" (Miller, 1990, p. 329) were used to advantage. But these did not start to envelop the system as a whole until the late 1980s. Since then, a series of changes have occurred consisting primarily of management control structures and processes (Anthony & Young, 1994; Mintzberg, 1989, 1991). These have emanated both from various parts of government and from quickly evolving macro-oriented, managerial parts of the hospital system; and their implementation has been based on the espoused theory of accounting (e.g., Minister of Health, 1990). They have swept through the system fairly relentlessly towards its micro-oriented, basic unit and individual levels.

The consequences of this pattern of change have included individualising answerability for spending within "networks of calculation" (Miller and Rose quoted in Humphrey et al., 1993, p. 17), and setting tighter financial limits on the choices health professionals can make about individual professional episodes of diagnosis, treatment and care for their patients (Preston, 1992). Thus, since 1992, "professional discretion [has become] shackled not by attempts to claim jurisdiction over the content of expert judgement, but

by encircling expert judgement within the discourse of budgetary calculation" (Miller and Rose quoted in Humphrey et al., 1993, p. 17). These consequences are not explained by espoused theory. Indeed, with the passage of time espoused theory and situated practice have diverged; it has become increasingly apparent that natural roles of accounting (Ansari & Euske, 1987; Boland & Pondy, 1983; see also pp. 53, 55-56 of this thesis) have dominated rather than the technical-rational ones of the espoused theory. In 1994 the changes are still in progress, and so it is possible here not only to elaborate on what has occurred, but also to compare and contrast this with the espoused theory as portrayed in official documents, and to speculate on the consequences that are ensuing and what might occur next.

The Theory Articulated: 1984 to 1993

The departure point of the theory-in-use is 1984. At this juncture, key figures in the newly elected Fourth Labour Government started to introduce radical reforms (James, 1986[1]) that have had multifarious economic, social, cultural and political consequences (Boston, 1995; Munro, 1994b), and provided the conditions of possibility for other innovations (e.g., see Dixon, Coy & Tower, in press, in relation to tertiary education).

Proposition 1

> The people at the centre of the newly elected Fourth Labour Government set in motion a macro agenda to restructure the economy, address the size of government debt, reduce public spending, and make public sector organisations in general more businesslike, so that some of them should be privatised as part of the restructuring.

The proposition in so far as it relates to changes to patterns of government and the public sector follows from material presented in various places in this thesis including

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1 This work by the then editor of the National Business Review gives a contemporary account of the key people involved and an insight into events connected in particular with the snap election which brought Roger Douglas and David Lange to power and the devaluation crisis which followed. The account of the reforms in New Zealand is all the more remarkable for being written without the benefit of hindsight.

pp. 15, 17-21, 61-62 (including Appendix A), 166-177, and 246-253. Core government departments, including the Department of Health, were the first group to be affected by the agenda being implemented (G. Scott & Gorringe, 1989). This included the creation of the initial assortment of (state-owned) enterprises, some of which were subsequently privatised (e.g., Telecom New Zealand).

It also included tentative changes to the way the practices of government were organised that would eventually materialise as a "new public management" (Boston, 1991; Hood, 1995; State Sector Act of 1988; Walsh, 1991) in which accountants and accounting were implicated (Broadbent & Guthrie, 1992; Hay, 1992; McCulloch & Ball, 1992; NZSA, 1987; Pallot, 1991a, 1991b; Public Finance Act of 1989). These developments provided a political means for the enforcement of public actions (Moonitz cited in Burchell et al., 1980) in that they altered the operational and normative modes (Becher & Kogan, 1980) of the hospital system, initially at the central authority level (G. Scott & Gorringe, 1989), and then progressively across to the institution (Caygill, 1988; Upton, 1991), basic unit and individual levels (see chapter 8). However, they were not the only force for change to a hospital system which was widely regarded as being overdue for remodelling.

PROPOSITION 2A

THE NEW GOVERNMENT'S MACRO AGENDA ENTAILED EXTRINSIC REQUIREMENTS BEING PUT ON THE HEALTH SYSTEM WHICH WERE NOT THOSE BEING ATTENDED TO IN THE SYSTEM OF THE MID-1980S.

PROPOSITION 2B

THERE WERE ALSO A GROWING NUMBER OF OTHER PEOPLE WHOSE EXTRINSIC REQUIREMENTS WERE NO LONGER ADDRESSED BY THE HEALTH SYSTEM OF THE MID-1980S. THESE PEOPLE WERE SPREAD ACROSS THE MEDICAL AND OTHER HEALTH PROFESSIONS, PATIENT INTEREST GROUPS AND GROUPS INTERESTED IN THE HEALTH STATUS OF, AND THE SERVICES AND FACILITIES AVAILABLE TO, THEIR COMMUNITIES.

The extrinsic requirements of the people referred to in proposition 2B stemmed from demographic, social and medical changes (e.g., an aging population, an increase in life expectancy, advances in medical technology involving new procedures and care) that entailed developments of the health system. The gap between these requirements and what the health system in general, and the hospital system in particular, had to offer had been growing for some time and was written about in a few cases in these terms (e.g., in relation to the period to 1980, see P. Davis, 1981; thenceforth, see Gillespie, 1983; Judson, 1985; Malcolm, 1984; "New Zealand Medical Association," 1988; "Population Trends and," 1984; Reinken, 1988; C. Scott, 1990; Seddon, 1983, 1988; "Towards the Reorganisation," 1983).

However, most of this gap was expressed more implicitly, in terms of progress in medical knowledge (e.g., every issue of the New Zealand Medical Journal included original articles on clinical practices), or findings on health status and changing patters of diseases. These findings focused on particular strata of the population or particular categories of care (e.g., the elderly, children, Maori, mental illness and psychiatric care). In addition, in advocating their requirements most of the people concerned did not take account of the financial implications (but see M. H. Cooper, 1988; Marwick, 1987; McKean, 1985), and from a macro-perspective some requirements may not have made much sense economically or socially. At the micro-level, however, they could mean the difference between life and death (in some cases "delaying death" would be a more accurate description than "giving life"), and for many that was all that mattered.

The collective effect of these pressures on the health system was the propensity to absorb more money despite management control mechanisms such as budgets. As the traditional source of money for many areas of health care services was government, and government was set on reducing spending (see proposition 1), a collision was inevitable between the central authorities, and the health professionals and patient interest groups (see Rose & Miller, 1992, on a similar situation in Britain). During the Study period the policies of successive governments in relation to health reform have met with widespread disapproval, particularly where hospital closures have been contemplated (e.g., see p. 253 of this thesis). Notwithstanding, the various parties have appeared in

agreement over the need for change of some sort to the health system. Thus, while many people to whom the researcher spoke from 1988 to 1993 criticised many aspects of the changes that were happening, and others conceded that they would have done specific things differently in hindsight, most agreed that change had been due or overdue by the time all hospital organisations were reconstituted as area health boards in 1989.

PROPOSITION 3

AS FOR THE HOSPITAL SYSTEM ITSELF, ITS FOUR LEVELS (I.E., INDIVIDUAL, BASIC UNIT, INSTITUTION AND CENTRAL AUTHORITY) WERE CONTAMINATED VARIOUSLY BY CONCENTRATION, CONSENSUS AND PROFICIENCY (SEE TABLE 12.1).

Table 12.1. Sources of contamination[1] to the hospital system c.1988.

Level	Contaminating Force(s)
Individual	Proficiency, consensus (also known as ideology)
Basic Unit	Proficiency, consensus
Institution	Consensus (stalemated triumvirates)
Central Authority	Concentration (a government department specialising in detailed procedural regulation of hospitals which could not see macro wood for micro trees)

[1] The concept of contamination and the forces tabulated under it were derived from Mintzberg (1991) (see pp. 96-98 of this thesis).

When the Study started the hospital system as an industry had been oriented for some time towards maintaining and expanding facilities, particularly institutions for dealing with ill health and practising curative medicine (P. Davis, 1981; "Minister Emphasises Need," 1989). {Central HQ Manager RC} stated:

> The patient [i.e., the health system] was not ailing; it was a burgeoning patient. It was very hale and very hearty, and that was the problem because it did not

> really consider what it was doing to itself. It was overweight and not just obese; it had coronaries and heart problems.

The system had been centralised gradually, and contaminated by a public service bureaucracy which concentrated on procedural regulation of hospitals. For example, {Central HQ Manager RG} talked about the "dead hand of Wellington," and {Service Manager PB} spoke in derogatory tones of "a government department type of approach" and "Kremlin-like central . . . control" (see also Caygill, 1988; Caygill & Salmond, 1989; Health Benefits Review, 1986; Hospital and Related Services Taskforce, 1988).

Meanwhile, the traditional and longer-term obligation to which hospital staff at the micro-organisational level claimed allegiance was "founded on providing the best quality care [for individual patients] and similar medical principles" ({Charge Nurse QP}). This was to be expected (see pp. 89-101), but this force of proficiency had become so dominant as to undermine efficiency and similar countervailing forces (Mintzberg, 1991). For example:

> the public sector provid[ed] the career structure for an awful lot of highly qualified technical people to the extent that the proportion of highly qualified technicians in the public health service to "indians" is far, far, far greater than one would ever find in the private sector. . . . "Chiefs" are coming out of everywhere. ({Central HQ Manager RC})

The same sort of situation prevailed at the institution level, where consensus management was also contributing to the contamination of the system:

> Once upon a time hospitals were run by management groups usually comprising three representatives[2]. . . . Everybody knew each other's position on various issues and although attempts could be made to try to work out any disagreements on anything, it was so often the case that a stalemate was reached. On these stalemates, nothing was done because it was seen as difficult to come to a compromise which would suit everybody. ({Non-clinical Support Manager QT})

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[2] This was a reference to the triumvirate system (see p. 50).

The report of the National Interim Provider Board (1992) provides a historical perspective (pp. 20-28) which mentions stalemates and alludes to much of the rest of the contamination. It also speaks of hospital organisations having "divided loyalties between patients, clinicians and other staff" (p. 33).

Additional insight into the forces prevailing in 1987 can be obtained from the events surrounding attempts to introduce RUS. In the initial enthusiasm for producing cost information at that time, a group at the Department of Health promoted RUS's adoption among the hospital and area health boards (see p. 51). The system was purchased by the board office administrators of several organisations, including two which eventually became part of SITES Q and R. But the system never really passed the stage of collecting raw data and producing numbers that were largely ignored, not only by staff in the operating core and support services, but also by most of the administrators cum managers (see pp. 141, 184-185, 323-327, 331, 360, 362, 379-380, 392-393). At best, its inception can be regarded as having been premature, given both the values, processes and interactions within hospitals, and the funding system between the central authorities and hospital organisations. The former centred on doing whatever was necessary for individual patients in blissful ignorance of costs. The latter was about allocating money based on population, and forwarding cash on a daily basis to meet the needs of the organisations as determined by their daily payments. This was done with little knowledge of what was being achieved, apart from notoriously inaccurate counts of beds in hospitals and patient days[3]. It has taken until 1994 for the new generation of managers and organisations to recognise the functions of which the hardware and software associated with RUS were technically capable.

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[3] This point arose at the administrators' seminar which the researcher attended at the G Hospital Board (see p. 51), and in interviews with {RHA Official R}, {Central HQ Manager RF} and {Ministry Official}.

PROPOSITION 4

IN THE MID AND LATE 1980S CHANGES WERE IMPOSED ON THE HOSPITAL SYSTEM BY DIFFERENT PEOPLE IN GOVERNMENT IN TWO WAYS: MEASURES THAT AFFECTED THE PUBLIC SECTOR GENERALLY, AND MEASURES SPECIFIC TO THE HOSPITAL SYSTEM. BOTH SETS FITTED INTO HOW THESE PEOPLE FROM THEIR DIFFERENT SITES ENVISAGED THE ROLES AND ACTIVITIES OF THE STATE IN GENERAL, AND THE PUBLIC SECTOR HEALTH SYSTEM IN PARTICULAR.

As indicated under proposition 1, the central authority level of the hospital system (i.e., the Department of Health) was caught in the Government's reforms as a core government department. Changes initiated by key ministers and in Treasury, the State Services Commission and the Audit Office not only affected the Department, but were passed across to the mixture of hospital and area health boards which existed up to the 1989 iteration of official order restructuring. These included changes in financial reporting, in that NZSA (1987) had the backing of the Audit Office (see p. 166) even before it was adopted by the accounting profession, and therefore before it was incorporated into the Public Finance Act of 1989. They also included the policy of general management implemented through the State Sector Act of 1988 (see proposition 6). This caused triumvirates to be replaced by general managers, who in turn established service management structures (see footnote 1, p. 477). A third aspect stemmed from a critical event in which the Minister sacked the elected board of the biggest hospital organisation because it failed to stay within its annual spending allocation, and appointed a commissioner (see pp. 251-252). Thus, the Government's macro agenda, and the espoused theory of accounting that was now part of this agenda, started to affect hospital organisations, but there were few inroads beyond the institution level board offices.

This also seems to have been the case with the 1989 restructuring of the hospital system, as announced in Caygill (1988). The decision to adopt the area health board model was out of step with the Labour Government's actions in other parts of the public sector (see pp. 248-249; also see McKinlay, 1990). This model of change was more in keeping

with the force for "cooperation through ideology" (Mintzberg, 1991, p. 62). It was implemented through the Department of Health and depended on the existing culture by which members of the system were bound together. The problem with this approach was that these members were encouraged to "take their lead from [the system's] own vision" (p. 62). But this ideology was a barrier to organisational effectiveness as it was defined in the philosophy of the public sector reforms. It "discourage[d] change by forcing everyone to work within the same set of beliefs" (p. 64), and so despite the primary objectives set out for the area health boards (see pp. 17-18 of this thesis), it was difficult for them to shake off their institutional orientation and their predisposition towards illness and curative care. Also, as accounting was not part of the ideology of hospital organisations, it was only able to operate on the periphery and could well have remained there if the externally determined change model had not been revised by the National Government after 1991 (see proposition 13). To what extent accountants contributed constitutively to that second model being introduced is a moot point. In the meantime:

PROPOSITION 5A

SEVERAL OF THE IMPOSED MEASURES INVOLVED ACCOUNTING COMPUTATIONAL MATTERS AND FUNDING MECHANISMS. THEY WERE SPONSORED BY PEOPLE WITH AN ACCOUNTING AND/OR ECONOMICS INCLINATION OR APTITUDE WHO ESPOUSED THEM AS OBJECTIVE, TECHNICAL AND RATIONAL.

PROPOSITION 5B

IN ORDER TO COPE WITH THESE NEW ACCOUNTING MEASURES, HOSPITAL ORGANISATIONS HIRED ACCOUNTANTS. FROM AN INITIAL CONCERN WITH BOOKKEEPING THIS NEW GROUP BEGAN TO BRANCH OUT EARLY IN THE AREA HEALTH PERIOD.

Up to the mid-1980s few chartered accountants had been employed in core government departments such as the Treasury and the Department of Health, or in hospital boards (Dixon, 1989). By contrast, the period 1987 to 1989 saw their first influx into hospital organisations and other parts of the public sector. They were hired by hospital

organisations to manage cash and spending in a more businesslike way, and to prepare external financial reports. These demands were in effect tangible expressions of the centrally imposed espoused theory and they arose as a result of the measures referred to under proposition 4 imposed from the central authority level (e.g., to keep spending within prescribed annual caps; accrual accounting and financial reporting under, first, NZSA, 1987, and then the Public Finance Act of 1989) (see Treasury, 1989, 1990).

In keeping with the traditional pigeonholing of responsibilities in hospitals (see p. 58), most staff initially saw the responsibility to ensure that spending stayed within limits as that of the accountants. This was a natural continuation of the role performed by board treasurers in the pre-reform period to ensure that bills were paid. But the accountants took a contrary view to this. Initially, they developed bookkeeping in the form of general ledger systems. These were attempts to trace the spending of money according to where staff were employed and who was in charge of them, and who raised requisitions that led directly to external purchases. The accountants tried to formalise this portrayal of the organisations using the concept of cost centres, to which some financial responsibility could be devolved and on which budgetary control and accountability could be imposed (see pp. 51-53, 58-59, and Appendix A).

The ideas and developments as espoused by central government and given expression by the new cadre of accountants had to do with improved data for decision making, efficiency and effectiveness. But such ideas were foreign to hospital organisations in those days and it took some time before they gained acceptance even at institution level (see pp. 51-52). Any semblance of acceptance among people in the operating core took longer despite being organised into so-called "cost centres". Moreover, from the outset few of the accounting data were seen as of any use for administering activities (see pp. 57-60).

Thus it was that although accounting played a part when the area health board system was implemented in 1989, there is some doubt about its significance, other than "for purposes of external legitimation" (Markus & Pfeffer, 1983, p. 209; see also Dirsmith, 1986). Commenting on the late 1980s, {Central HQ Manager RA} stated:

> In general, my impression is that in the past accounting at the top level in the board has probably been OK, albeit somewhat superficial. However, as with probably most area health boards, when one digs down below there is really not a lot of substance at all.

The scene was set for a lack of continuity between the ideas being promulgated centrally by government, and the ideology driving practice by the health professionals at the front line.

PROPOSITION 6

A SIGNIFICANT POLICY CHOICE WITHIN GOVERNMENT WAS TO INSTITUTE AN INDIVIDUALISING PROCESS WHEREBY EACH PERSON WAS ANSWERABLE TO ANOTHER SPECIFIED PERSON IN A VERTICAL CHAIN OF ACCOUNTABILITY. IN THE HOSPITAL SYSTEM THIS CHAIN STRETCHED INITIALLY FROM THE MINISTER OF HEALTH THROUGH THE DEPARTMENT OF HEALTH TO THE GENERAL AND OTHER SENIOR MANAGERS AT THE INSTITUTION LEVEL OF EACH HOSPITAL ORGANISATION.

The policy of general management which was given statutory backing in the State Sector Act of 1988 established the notion of individual responsibility being vested in a chief executive of a government department and a general manager (later chief executive) of a hospital organisation. The latter replaced a triumvirate at the head of each organisation, and according to the National Interim Provider Board (1992), "with a single head on the block, accountability improved overnight" (p. 26). In turn the general managers who were appointed initially established service management structures in which the principle was espoused of individual managers with specific responsibility and accountability for particular services or functions within the organisation. Treasury (1990) labelled similar ideas in the core government departments as a "chain of accountability". When attempts were made to operationalise these service management structures, the idea of cost centres, with which accountants had been toying (see proposition 5), fitted the requirements. Thus, this idea began to figure in the new structures and processes at the institution level and in the non-clinical support services,

which had been under the general administrator wing of the triumvirate structures. But rather than use the name *cost centres*, the more managerial name of *responsibility centres* came into circulation (see p. 111).

The acceptance at the institution level of the introduction of centres responsible for spending was facilitated by the significant personnel changes which accompanied the implementation, virtually simultaneously, of general management and the 1989 restructuring. This changeover in personnel was not only significant in terms of numbers, but also in terms of age and values. People who could not tolerate or cope with managing with the much stronger emphasis on keeping spending within cash allocations, tended to leave the system. As a result, other people within the system moved into management positions sooner than might have been expected and responded less defensively (Argyris, 1990) to accounting and other managerial processes. In addition, for the first time, people with commercial experience were brought into quite senior positions from outside the health service. These points were made by several interviewees who had been in, or connected with, hospital organisations since at least the early 1980s including {Non-clinical Support Manager PH}, {Non-clinical Support Manager QT} and {Central HQ RC}.

In retrospect, the introduction of responsibility centres and responsibility centre managers in 1989 and 1990 might be seen as the start of an "individualizing process" (Miller & Rose quoted in Humphrey et al., 1993, p. 17) involving contracts, general managers' reports, service and responsibility centre managers, budgets, expenditure reports and face-to-face answerability. These matters are described and interpreted in chapters 5 to 11. The introduction of responsibility centres might also be regarded as the point at which accounting emerged from its "Trojan Horse" of annual reporting (by which it gained entry into the hospital organisations despite its different philosophy), and started to be more constitutive in the values of organisational participants and their practical tasks. This occurred over the next few years (1990 to 1993) in concert with requirements and changes emanating from different parts of government interested in the hospital system, including the central authorities, and from the quickly evolving macro-oriented, managerial parts of the hospital system. These flowed towards the micro-

oriented, basic unit and individual levels of the system in a series of waves, each one making further encroachment on professional space. These waves are set out in propositions 7 and 8.

PROPOSITION 7A

THE PEOPLE AT THE CENTRAL AUTHORITY LEVEL OF THE SYSTEM CONTINUED TO EXERT VERTICAL PRESSURE ON HOSPITAL ORGANISATIONS TO STAY WITHIN ANNUAL SPENDING ALLOCATIONS THROUGH A FUNDING MECHANISM REFERRED TO AS CONTRACTING AND A COMPLEMENTARY MECHANISM BY WHICH CONTRACTS APPROVED BY THE MINISTER WERE MONITORED.

PROPOSITION 7B

ACCOUNTANTS WERE PARTY TO THE DEVELOPMENT AND MAINTENANCE OF THESE CONTRACTING AND MONITORING MECHANISMS, AND IT WAS INCUMBENT ON NON-ACCOUNTANTS AFFECTED BY THESE MECHANISMS TO HAVE A WORKING KNOWLEDGE OF ACCOUNTING IDEAS.

The combination of contracting and monitoring was a major development in central authority-institution relationships, and derived from the agency theory that was endemic in the reforms to government practice (Boston, 1991, 1995). Some measures for the monitoring of spending had been developed in the late 1980s and contracting was introduced in 1990 (Minister of Health, 1989) to come into effect for funding for the 1990-91 financial year. The contracting mechanism required institution level managers in each hospital organisation to compile an annual business plan and obtain approval for it from the Minister after having gone through a period of negotiation with a team of Department officials. Once approved, the plan was deemed to be a contract between the government personified by the Minister, and the hospital organisation personified by the general manager, although the board and chairperson of the organisation had some status (when elected boards were disbanded in 1991, the commissioner took on this status - see Appendix A). A key feature of each contract was a budget, which showed how the hospital organisation intended to spend its annual grant allocation. Also in regard to the

financial side, each contract contained a forecast balance sheet showing assets and liabilities as at the year end.

The way in which the contracting and monitoring mechanisms evolved side by side for the financial years 1990-91 to 1992-93 is described in chapter 7 and Appendix A, and interpreted in chapter 8 (see especially pp. 252-253). Their vertical effect and the inroads they made into the basic unit level are covered in chapters 9 to 11 (see especially pp. 295-302). Although contracts were supposed to integrate service outputs and finance, it seems that there was a dichotomy between these two aspects which was reflected a little in the negotiating process, and much more in how they were monitored. Thus, in negotiating contracts relating to 1992-93, it was reported that people representing the central authority level insisted that:

(a) numbers (supposedly indicative of the quantity of activities) within broad categories of service areas stayed the same or increased; and

(b) expenditure allocations were kept the same or were reduced.

Moreover, while the monitoring mechanism entailed that each hospital organisation compiled reports in the name of the general manager and submitted them to sites in Wellington, there were two types of reports going to two different recipients. By 1992, if not from the outset, the two reports had acquired different levels of importance. The lesser one was a quarterly report of service outputs to a not very prominent section of the Department of Health. The far more important one was a monthly financial report comprised mainly of financial statements. These were in a standardised electronic format consistent with requirements of the Minister of Health (1990). The initial focus of the report was the comparison of total spending with the budgets approved by the Minister, with explanations about how variations were being dealt with. Closer to the formal restructuring in 1993, balance sheets were also monitored to ensure that the government's investment in area health boards was transferred intact to Crown health enterprises. The monthly reports had to be submitted to financial analysts whose analysis went to the Minister of Health and thence to the Cabinet. These analysts were based initially in the Department of Health, but in the run up to the 1993 restructuring

they were moved to the Department of the Prime Minister and Cabinet, and some of their work was contracted to an accounting firm.

That greater importance was attached to the financial reports compared with the service output reports was in accord with the priorities of people at the central authority level of the hospital system, although in addition the financial side was regarded as easier to measure and so more faith was placed in the data in the financial reports. Moreover, dealing with the unfortunate patients was regarded as the professionals' responsibility. The central authorities merely supplied the money and left it to the managers of the hospital organisations to get the most out of it. It was seen as inevitable that the hospital organisations could spend more money than they were allocated[4]. It was up to individual general managers to ensure that this did not happen in their organisations, and this aspect was monitored by central authority level analysts using the monthly reports.

PROPOSITION 8A

IN ORDER TO ENSURE THAT SPENDING ALLOCATIONS WERE NOT EXCEEDED, MANAGERS AND ACCOUNTANTS AT HOSPITAL ORGANISATION LEVEL EXTENDED THE CHAIN OF ACCOUNTABILITY BY ESTABLISHING RESPONSIBILITY CENTRES WHICH COVERED WARDS AND NURSES, CLINICAL SUPPORT DEPARTMENTS, AND TO A LESSER EXTENT CLINICAL DEPARTMENTS AND DOCTORS. CONCOMITANTLY, THEY STEPPED UP THE IMPOSITION OF BUDGETS, MONITORING AND REPORTING PROCESSES TO MONITOR AND CONTROL BASIC UNIT LEVEL SPENDING FOR EACH DISCRETE FINANCIAL YEAR, AND MONTH BY MONTH.

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4 Minister Clarke is quoted in 1989 as saying: "it would be possible to spend almost all of the nation's resources on health care and still not exhaust the possibilities for expenditure" (McKinlay, 1990, p. 116).

PROPOSITION 8B

AS THE SEARCH CONTINUED FOR OPPORTUNITIES TO EXPAND ACCOUNTING PRACTICE, ACCOUNTANTS BEGAN TO ENVISAGE HOSPITAL OPERATIONS AS A PRODUCTION MANAGEMENT PROBLEM, AND TO SEE THE POTENTIAL OF PRODUCT COST ACCOUNTING AS A MEANS OF MEASURING AND CONTROLLING ACTIVITIES IN THE OPERATING CORE AND SUPPORT SERVICES.

PROPOSITION 8C

INSTITUTION LEVEL MANAGERS AND ACCOUNTANTS ALSO BEGAN TO SEE THE POTENTIAL FOR INTERNAL TRANSFER PRICING TO CONTROL THE DISTRIBUTION OF GOODS AND SERVICES FROM CLINICAL AND NON-CLINICAL SUPPORT DEPARTMENTS TO OTHER DEPARTMENTS, TO DEVOLVE BUDGET RESPONSIBILITY FOR SPENDING ON THESE GOODS AND SERVICES TO THE INDIVIDUAL MANAGERS WHOSE RESPONSIBILITY CENTRE STAFF WERE CAUSING THEM TO BE DEMANDED, AND TO USE PROFIT AND LOSS CRITERIA TO MONITOR THE SUPPORT SERVICES COMPARED TO ALTERNATIVE SUPPLIERS.

By about 1990, the requirements and changes associated with restricting spending had forced the operating core and support services to be structured into responsibility centres. Concomitantly, doctors, charge nurses, other health professionals and people from non-clinical support areas were designated as responsibility centre managers. These individuals were given a budget in the form of a spending allocation for staff and classes of items which were requisitioned from outside the organisation for use in the responsibility centre. This form of structure and process meshed with the quest to keep spending within limits by making individuals monitor and report on it.

The devolution of budgets in this way had wider implications for processes and interactions up and down the organisations, and it took time for intermediate people in the chain of command to become familiar with the idea. But it happened eventually, and by financial year 1990-91 or 1991-92, many responsibility centre managers were responsible and answerable for spending compared with budgets based on data collected

in general ledgers. Apart from those who were doctors, in relation to whom the reporting relationship was not well defined, these responsibility centre managers explained to their service managers any upward variations in their spending compared with their budget during the previous financial month and for the year-to-date. In doing so, they were obliged to interpret data which derived from central accounting systems. In accordance with the questions raised from the central authority level down the chain of accountability, the staff cast in the role of responsibility centre managers focused their attention on what was being spent and short term targets (similar developments in government departments in Britain are reported in Gray & Jenkins, 1993). These matters are thickly described and interpreted in chapters 10 and 11. By the time the 1991-92 budget was being prepared some of the responsibility centre managers were beginning to have a hand in this process (see chapter 9).

With these developments, general ledgers were to the fore in terms of financial systems. The basic form of these ledgers was coverage of the entire hospital organisation, divided into responsibility centres and subdivided in classes of expenditure. In addition to figuring in the relations between responsibility centre managers and service managers, ledgers formed the basis of answerability for spending between everyone up the chain which culminated in the general manager of the hospital organisation and its board or commissioner. In addition, they provided the financial data which were sent in monthly general managers' reports to the central authorities. The emphasis in this series of relationships was on "not overspending" (see proposition 1).

When the time came to prepare the 1992-93 budget, even more responsibility centre managers were involved. In addition, the general ledgers began capturing more items traceable directly to responsibility centres. Even after some embellishments were made to general ledgers in 1991 and 1992 a major problem persisted in that, for accountability to work in a rational way, the person who is accountable must be able to change or improve patterns of behaviour (Lipsky, 1978). From whatever perspective interviewees came, there was general agreement that the way in which general ledger systems portrayed responsibility for spending did not accord with actual responsibility (e.g., see pp. 339-341).

Aware of this problem, some accountants began to apply their technical skills to aligning budgets with the people causing spending. Naturally, they tended to bring their expertise to bear from whatever situations it had originated, and most of this was founded on their professional education and training, and its application during their industrial and commercial experience. This learning comprised financial accounting in the for-profit private company sector, and some coverage of cost and management accounting (see for example, NZSA, 1990). It dealt with businesses dealing predominantly in tangible goods, rather than human services. The traditional setting of cost accounting in particular was the factory (see for example, Burgh, 1994; Horngren, Foster & Datar, 1994[5]).

According to Kaplan (1984), the techniques and procedures associated with cost accounting and management control procedures were developed at the turn of the century for the mass production of standard products with high direct labour content (see also, Johnson & Kaplan, 1987). Notwithstanding the distinction between such settings and hospitals (Mintzberg, 1989, 1991), it was not surprising that in applying management control ideas, accountants began to see the potential of cost accounting as a means to measure and control hospital activities, identifying hospitals as factories with production and service departments, and patients as products (Chua, 1995; Chua & Degeling, 1993; Coombs, 1987).

This was an opportunity to apply accounting to "production management" (Burchell et al., 1980, p. 8), and accountants started by tracing cost links between responsibility centres within the hospital by applying overhead allocation methods. At about this time activity based costing (R. Cooper & Kaplan, 1988, 1991) was coming into vogue in manufacturing accounting and there was discussion about how to allocate overheads[6].

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5 This reference is to the eighth edition which undoubtedly has tried to incorporate "*newly evolving management themes*" and "*increased coverage of the service sector*" (p. xvii), whereas earlier editions such as the first four from 1962 to 1967 were steeped in the traditions of the large factory striving for efficiency and to ascertain the value of various inventories for financial accounting purposes.

6 This issue was discussed by {Service Manager PB}, {Financial Controller P}, {Cost Accountant Q} and {RUS Support Person Q}.

They then extended their attention to notions of user pays and market mechanisms within organisations, notions which were to the fore in the public sector reform process. Under this perspective, support services took the status of "intermediate products" (Fetter cited in Chua & Degeling, 1993) to be exchanged in internal transactions, for which sales and purchases could be recorded in the general ledger. Consequently, the principle of using market mechanisms to allocate resources began surfacing in place of previous bureaucratic mechanisms of allocation (see Bourn & Ezzamel, 1986b for a discussion of these concepts). Thus, by 1992-93, internal markets began to appear, and internal transfers of these intermediate products were recognised and recorded using internal transfer pricing. But this area was fraught with technical and socio-political difficulties (see pp. 372-377, 407-408), and was resisted successfully for a while by those whom it would affect (refer to proposition 14). In a related development some support services were, or were about to be, privatised or contracted out beyond the boundaries of the hospital organisation in an extension of markets and competition. These developments also called for costing and pricing of support services, and accountants were seen to possess the necessary skills to carry out these tasks.

The way in which the accountants who were interviewed represented their activities in relation to costing and pricing can be summed up as follows: These activities had the "goal of faithfully representing the economic reality that underlies a hospital's various product lines, thereby facilitating rational decision-making regarding resource acquisition, deployment, and use" (Fetter & Freeman cited in Covaleski & Dirsmith, 1991, p. 146), but within the confines of fixed annual allocations from government, fixed budgets for responsibility centres and the measurement of total spending in the general ledger. In approaching these activities the accountants placed emphasis on technical accounting aspects, and translating processes into a "single figure" (Meyer cited in Humphrey et al., 1993). But little recognition was given to the question of who and what was causing costs. The professionals were well aware that the answer to this was extremely complex, and included patients' ancestry/genetics, background and lifestyle as well as medical choices. These choices, including their implementation, depended on several people in relation to each patient, and were unlikely to be standard.

Indeed, choices were made on a day-by-day basis according to how each patient responded to treatment (see pp. 112-126, 339-354 of this thesis).

Furthermore, although the system of funding began to change after 1989, the changes were still not concerned with how much each patient cost. Thus, the capabilities of case-mix costing systems, such as RUS, were still not needed to comply with the funding system. Indeed, they clouded the primary focus of staying within a total spending limit because they showed how spending (and budgets) should vary as patient numbers and mixes fluctuated, assuming that some costs were variable and that there was some consistency between costs and activities.

PROPOSITION 9

AS THE MATTERS IN WHICH ACCOUNTING WAS IMPLICATED CONTINUED TO EXPAND, SO TOO DID THE NUMBER OF ACCOUNTANTS AND THE ROLES THEY PLAYED.

The number of accountants in hospital organisations continued to increase during the area health period as they carved out new tasks in which to involve themselves, and as new requirements were imposed on the hospital organisations by the central authorities. {Central HQ Manager RA} indicated that from 1992 he had started:

> putting the substance below the surface so that not only is the organisation able to prepare an annual report and send some numbers off to the Minister every month, but also there are managers around the place who are managing their performance against a budget, rather than just managing an expenditure budget.

In this way accountants changed patterns within the hospitals, rather than merely those operating in the corporate offices. The time of responsibility centre managers came to be divided much more noticeably into financial periods of months and years (Roberts & Scapens, 1985), and these people were becoming reporting machines (Gray & Jenkins, 1993) (see propositions 8 and 17). The accountants were not only doing specialised accounting tasks, they were also taking on more general management positions. For the most part these were based in the hospital organisations' central offices and involved

dealings with central authority funders as well as people throughout their hospital organisations. By 1992 some accountants were attached to hospitals, and most of the work of some others involved examining activities in the hospitals from their central office vantage points. The work that was done, including the systems that were created, tended to reinforce macro-concerns of the central authorities and the managers in the corporate offices, and facilitated the growth in power and influence of these people (for a discussion on matters of this kind, see Colignon & Covaleski, 1988; Hopwood, 1983; Michelman, 1988).

PROPOSITION 10

THE CONTROL STRUCTURES AND PROCESSES IN WHICH ACCOUNTING WAS IMPLICATED CHANGED THE PATTERNS OF POWER AND INFLUENCE IN HOSPITAL ORGANISATIONS IN FAVOUR OF MANAGERS AT THE INSTITUTION LEVEL. THEY ALSO DISTURBED THE VALUES AND FUNCTIONS AT THE BASIC UNIT AND INDIVIDUAL LEVELS.

The extension of the chain of accountability and the initiation of transfer prices governing horizontal movements of resources (see proposition 8) meant that more people at institution and basic unit levels were obliged to change their operational modes, and make efforts, real and symbolic, to monitor and reduce spending. In doing so they placed requirements on professionals at the individual level.

The traditional accountability of professionals was along professional lines, and being called to police and answer for spending was new for people such as doctors, nurses and other health professionals. Naturally, they showed some resistance to this change, perceiving it to interfere with their work and prejudice their clinical freedom. They did not like managers encroaching on their power to decide on the structure and process of health institutions. There was some escalation of the tensions that developed between managers and health professionals when the triumvirate system was replaced by general management (see pp. 50, 57-58). However, outlooks were slowly changing and some professionals were starting to accept that they should take an interest in aspects such as cost consciousness, cost awareness and accountability for the consumption of resources.

This change in outlook, which was by no means universal, was manifested by operating core staff taking on management duties, albeit reluctantly, and acquiring some accounting knowledge and skills to cope with them. Typical of the tasks acquired were forecasting resource usage and patterns of spending; planning the deployment of labour and other resources; monitoring spending; assimilating financial reports; and policing expenditures. The professionals concerned were required to provide explanations to people up the chain of accountability, and liaise with people running other responsibility centres, either from which goods and services were obtained, or to which goods and services were provided. These liaisons were reciprocal links of long-standing, characterised traditionally by crosswise communication, cooperation, interdependence and collegiality, and subject to an inter-professional pecking order. The formal establishment of responsibility centres with accountable managers started to alter the character of some relationships, and this change was accelerated by the onset of transfer pricing mechanisms (see propositions 9 and 14).

These matters are thickly described and interpreted in chapters 5 to 11. They are consistent with the "tentative observations" of Burchell et al. (1980, p. 13) of "how accounting systems, as modes of organizational control, can arise out of the interplay of political processes both within the organization and at its interface with dominant external agents" (p. 22). These developments did not come easily in a form of organisation in which the business philosophy on which accounting is predicated was despised ideologically by the staff. Indeed, people at different levels of the system saw these changes in contrasting ways. In addition, it is doubtful whether most New Zealanders, or most hospital staff, saw the actions of accountants "as being orientated towards some desirable or acceptable social end or ends" (Burchell et al., 1980, p. 9). As to the permanent or transitory nature of the changes that have been occurring, in their study of the British National Coal Board, Berry et al. (1985) found that:

> Concerns with profitability, financial criteria and economic viability generally is voiced predominantly by those, mainly senior, managers who have recently been put into the Area [i.e., geographical division] from HQ. For the rest, such issues were . . . regarded as transitory, short-term issues, heavily dependent on an ever-changing political climate and the fluctuations of the market. (pp. 12-13)

While there were hints of this in the New Zealand hospital system, the changeover in personnel seems to have been much more complete (see proposition 6); no one believed that things would revert to the way they had been, nor did they want them to. However, the policy choice of organisations striving to be successful businesses was still controversial in 1994, and {Central HQ Manager RG}) for one doubted its sustainability (see proposition 18). One other point on sustainability stems from Mintzberg (1989)'s discussion on professional organisations. When these organisations are faced with a crisis the professional people seem willing to defer to leadership, but in normal circumstances they are best suited to working collegially (see p. 92 of this thesis). This is contrary to operating vertically (Hopwood, 1983) through a chain of accountability formed by individuals in superior-subordinate relationships (see proposition 18).

PROPOSITION 11

OPERATING VERTICALLY, ACCOUNTING WAS A TWO EDGED SWORD. IT HAD THE POTENTIAL BOTH TO CURB INEFFICIENT PRACTICES AND MAKE MONEY GO FURTHER, AND TO CURB THE DISCRETION OF PROFESSIONALS AND REDUCE THE PROFICIENCY AND EFFECTIVENESS OF HOSPITAL ORGANISATIONS. MANY OF THE UNDESIRABLE ASPECTS OF THIS DICHOTOMY WERE AVOIDED BY THE MEDIATION OF SERVICE MANAGERS AND THE USE OF LOOSE COUPLING BETWEEN THE OPERATING CORE AND SUPPORT SERVICES, AND THE MANAGEMENT ZONE.

The way in which accounting operated meant that professionals were being shackled "by encircling expert judgement within the discourse of budgetary calculation" (Miller & Rose quoted in Humphrey et al., 1993, p. 17). Certainly this was happening to the nurses and other health professionals, but the situation with the doctors was ambiguous. They had a great deal of discretion over whether to be involved in rationing spending, and managers were reluctant to force the issue (see pp. 405-407). But decisions taken about other basic units (e.g., closing wards) and manipulations of patient episodes (e.g., reducing the intake of elective patients and the provision of preventative treatment) affected how much doctors caused money to be spent. Even so, admissions increased. The use of loose coupling by service managers in particular to curb undesirable aspects

of budgets, spending control and other accounting aspects are dealt with in chapters 8 and 11 (see pp. 233-235 and 400-408).

PROPOSITION 12

IN THE ABSENCE OF RELEVANT OPERATING DATA FROM CENTRAL SYSTEMS, AND WITH POTENTIAL COMPETITION ARISING FROM OUTSIDE THEIR ORGANISATIONS, SOME RESPONSIBILITY MANAGERS WERE DEVELOPING THEIR OWN DATA SYSTEMS. THEY OBTAINED LITTLE SUPPORT IN THIS FROM ACCOUNTANTS AND MANAGERS AT THE INSTITUTION LEVEL, WHO WERE BUSILY EXPANDING THEIR OWN CENTRALISED SYSTEMS.

The concerns of people at the central authority level and institution level managers have tended to be operationalised in policing total expenditures and putting off spending, rather than controlling individual patient care costs, evaluating cost-effectiveness, or examining value-for-money (see pp. 174, 178-179, 399-400). This was reflected in central accounting systems which attracted widespread criticism from people in hospitals over accuracy, completeness, comprehensiveness, timeliness and other aspects of quality (see pp. 339-340, 343, 402). Similarly, these people were critical of the developing patterns of management as too functional, after the event, and oriented towards spending less in the short term, rather than being service or output oriented and taking a longer term view of costs and benefits (see pp. 397-399). These circumstances prompted more and more responsibility centre managers to develop their own local data systems to ensure that they could have relevant information when they needed it, and to check the central data.

In contrast to the way in which accountants were available to develop and maintain institution level data systems, no such support was available to basic units; indeed local data was frowned on by some accountants (see pp. 402-403). That accounting was siding with the central authorities and institution level managers, and the conventional economic values and beliefs they operated at the expense of the interests of people in the hospitals, seems consistent with the researcher's view of mainstream accounting (see

p. 38). It brought criticisms from doctors, in particular on two counts. First, {Chairman P}, {Doctor QC} and {Doctor QP} could not obtain patient data classified in a clinically meaningful way. They believed their needs were straightforward and acquiring systems to generate them would be inexpensive. {Doctor QP} thought much could be achieved in terms of resource allocation were doctors given some basic support to work in more ad hoc groups aimed at deducing where resources were being spent, and how resources could be shifted from one area to another. These sentiments echoed what Hospital and Related Services Taskforce (1988) said about doctors being given data that they would find useful (see pp. 48-49 of this thesis).

Second, these doctors doubted the worth of the large amounts of money their hospital organisation managers had spent on central systems (e.g., RUS, general ledger) and were preparing to spend on purchasing and operating other elaborate costing systems. {RHA Official R} echoed the concerns of these doctors in referring to several hospital organisations who had bought or intended to buy very sophisticated and expensive systems purported to give universal coverage of activities and costs. Referring to what was needed in the run up to the hospital enterprise period, he differentiated between relatively small costing systems essential for contracting and pricing purposes, and fully fledged systems for managerial purposes of doubtful current value.

Despite the cost of purchasing "new and improved" central information systems, and the efforts put into them by accountants and institution level managers, there was little in what interviewees at the basic unit level said to indicate that their development could be explained in terms of technical-rational purposes. For example, these systems did not address problems experienced by the intended information recipients at the basic unit level, they were not preceded by identification of user needs, and they did not facilitate efficient allocation of resources. However, if one considers their purchase from socio-political motives of gaining power for their sponsors and influencing the behaviour of others, matters become clearer (Ansari & Euske, 1987).

Undoubtedly that sort of socio-political motive was behind some system acquisitions or proposed acquisitions about which the doctors referred to above complained. Many

accountants and institution level managers overlooked or were not bothered about the potential for simple, local, customised information in the operating core and support services, partly because that would be seen as supporting rather than subordinating the people there. Moreover, they were puzzled by the beliefs and values held by the people working there, and unfamiliar with how activities and tasks were carried out. Perhaps they tried to compensate for or disguise these deficiencies by reaching for prepackaged management accounting solutions looking for problems, and that entailed buying sophisticated and expensive systems developed for hospitals in the USA, even though there was no internally generated evidence that they were needed, or that they were likely to work. The result was that new systems were often dumped onto responsibility centre managers with little warning. {Financial Controller P} reported that many staff had become used to "just being told about the implementation of a system either on the same day it was happening or only a few days beforehand." New systems had often been "just chucked at people without much testing and leaving them exposed to a lot of problems with which they had to deal."

PROPOSITION 13

DESPITE A CHANGE IN GOVERNMENT IN 1990, THE GENERAL DIRECTION OF POLICY DID NOT CHANGE; INDEED THERE SEEMED TO BE MORE RESOLVE ON THE ISSUE OF BUSINESSLIKE PRACTICES. A SECOND RESTRUCTURING OF THE HOSPITAL SYSTEM WAS ANNOUNCED IN 1991 AND OCCURRED OFFICIALLY IN 1993. IT WAS BASED ON THE PRINCIPLE OF A MARKET BETWEEN HOSPITAL ENTERPRISES SELLING SERVICES AND HEALTH AUTHORITIES BUYING SERVICES. PRIVATE SELLERS AND BUYERS WERE ALSO ENVISAGED AS ABLE TO JOIN IN THIS MARKET.

In the second iteration of reforms (Upton, 1991) a model compatible with the rest of the public sector reforms was adopted. In contrast with the first model (see proposition 4), this relied on competition through politics; that is, through "conflict and confrontation" (Mintzberg, 1991, p. 65), and naturally, it was controversial (e.g., see Feek & Carter, 1992). It was implemented through the Department of the Prime Minister and Cabinet and was used "to promote necessary organizational change blocked by the legitimate

systems of influence" (Mintzberg, 1985, p. 149). In the case of the health system these systems of influence were the existing Department of Health, the doctors and other health professionals in their role as patients' advocates and agents (Coombs, 1987; Eisenberg, 1986), and communities faced with service cuts and hospital closures (see pp. 190-199, 254, 256). This notion and its implications are developed under propositions 15 and 16.

PROPOSITION 14

THE INTEREST AMONG HOSPITAL ORGANISATIONS' ACCOUNTANTS IN COSTING PRODUCTS RECEIVED AN EXTERNAL STIMULUS WHEN THE CENTRAL AUTHORITIES INSTITUTED A MARKET FOR TRADING OF HEALTH PRODUCTS BETWEEN PURCHASERS AND PROVIDERS TO TAKE EFFECT FROM 1993. THIS BOOSTED THE CASE FOR PUTTING THE HORIZONTAL RELATIONS AMONG THE BASIC UNITS ON AN INTERNAL MARKET FOOTING BY INSTITUTING TRANSFER PRICE MECHANISMS.

This second iteration of official order changes went ahead in 1993. The central authorities were restructured and regional health authorities established. At the time of writing the structures and processes involved in the new system are still more a matter of intention and speculation than reality. However, it appears that allocations to hospital organisations based on the previous population-based, contract funding system are being replaced quite rapidly by one in which hospital organisations, along with other providers, are paid for individual treatments carried out at prospective prices per treatment subject to contractual limits on volumes[7]. In order to overcome the lack of a system of "products" which can be traded in order to establish a market, people in the central authorities are examining work done in the USA and Australia on DRGs. They envisage that accounting can provide the technical expertise to cost and price these "products", and similar expectations have arisen at the institution level including in relation to

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7 This kind of case-mix funding approach had been mentioned as early as 1980 (Advisory Committee on Hospital Board Funding, 1980), and was portrayed as a provider-funder link with competition by Health Benefits Review (1986), and as a buyer-provider split by Hospital and Related Services Taskforce (1988).

internal transfers of goods and services (see pp. 179-190, 377-379; see also proposition 8c).

Reflecting on the Roles of Accounting 1984-1993

Having attempted to make sense of the past, and the conditions of possibility then, the next part of the theory is the consequence of reflecting on the roles which accounting played to 1993 and of addressing the situation as it prevails at the time of writing. Two propositions are put forward about these roles. First, proposition 15 is from the perspective of: Who within the system has used accounting? How have they espoused its use? And how have they gained or lost vis-à-vis others in the system? Second, proposition 16 is from the perspective of the system as a contaminated configuration of forces (see proposition 3) in the process of conversion, and addresses the issue of accounting's role in this conversion process.

In chapter 3, the work of several writers (Ansari & Euske, 1987; Boland & Pondy, 1983; Burchell et al., 1980; Kelly & Pratt, 1992) on the question of roles or purposes of accounting is outlined (see pp. 53, 55-56). Reference is also made to accounting's constitutive capacities (Burchell et al., 1985; Chua, 1995; Loft, 1986; Roberts & Scapens, 1985), in addition to its reflective ones. That is to say, "accounting [not only] reflecting the wider society in which it exists" (Loft, p. 167); but also accounting "as an instrument for social management and change" (Burchell et al., 1985, p. 381); that is, one that "has a power to influence its own context" (p. 385). Reflexing between these ideas from the literature and the analysis from the field, a case can be made for ascribing a myriad of interacting roles to the situated practice of accounting in hospital organisations during the Study period. In turn, each of these can be fitted into one or other of the cells in the Ansari & Euske (1987) matrix such that all four cells[8] would be occupied. In tracing the development of the use of accounting ideas and techniques during this period, the impression is that those who were championing them from the Treasury and the Ministry or Department of Health (e.g., Caygill, 1988; Hospital and

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[8] The four cells are, respectively, "measuring technical efficiency", "resource allocations", "behavior changes" and "gaining legitimacy" (see p. 55 of this thesis).

Related Services Taskforce, 1988; McCulloch & Ball, 1992; National Interim Provider Board, 1992; G. Scott, Bushnell & Sallee, 1990; G. Scott & Gorringe, 1989; Treasury, 1989, 1990; Upton, 1991) tended to stress the roles associated with the technical-rational cells (i.e., measuring technical efficiency and resource allocation). They attributed to these accounting ideas and techniques such outcomes as better decisions, greater efficiency, increased effectiveness and improved accountability, all of which are portrayed as advantageous. In essence, this is the espoused theory (Argyris & Schon, 1974, Patton, 1990) of accounting, to which hospital organisations and the system in general give their official allegiance because of the prominent place it has had in justifications of health reforms.

The beneficiaries of (more) accounting were referred to in these justifications using such emotively charged social constructs as society, New Zealand and patients. In contrast the proponents of the reforms made little reference to the gains they themselves would make. That such gains were accruing seems evident, and could have been predicted. That is, at frequent intervals "new pattern[s] of organization visibility" have developed from the computational practices introduced by accountants and these were "significantly chang[ing] organizational participants' perceptions of the problematic and the possible" (Burchell et al., 1980, p. 16). These "computational developments" have provided "the conditions for the reorganization of the enterprise and the changing locus of power and influence" (p. 16) from the doctors, other health professionals and patients in the micro-oriented, proficiency driven operating core, towards the institution level managers and central authority officials.

This gain in power and importance among people who have taken management positions, and the corresponding shackling of power experienced by professionals, is a significant consequence of the system operating more vertically under the influence of the situated practice of accounting (Colignon & Covaleski, 1988; Covaleski & Dirsmith, 1988; Hopwood, 1983; Michelman, 1988). In general, the power of people involved in administration seemed to increase vis-à-vis health professionals after the mid-1980s because a greater emphasis was put on overall resource concerns compared with

individual care concerns (see propositions 1 and 3). Operating more and more vertically through the chain of accountability has reinforced this shift in power.

PROPOSITION 15

ALTHOUGH THEY WERE ESPOUSED AS OBJECTIVE, TECHNICAL AND RATIONAL, THE ACCOUNTING COMPUTATIONAL MEASURES INTRODUCED BROUGHT ABOUT POLITICAL, ECONOMIC AND SOCIAL CHANGES WHICH WERE SUBJECTIVE. THAT IS, CHANGES OF AN ACCOUNTING NATURE, INCLUDING THOSE TO FUNDING, PROCEEDED WITHIN THE OVERALL IDEOLOGY AND POLICIES OF THE PEOPLE CHAMPIONING THE MEASURES.

The measures begun in 1984 in the economy in general and the public sector in particular, and since about 1988 in the health sector (e.g., Caygill, 1988; Health and Disability Services Act of 1993; State Sector Act of 1988; Upton, 1991), were intended to change the hospital system to match "the extrinsic requirements on [*inter alia*, health] of the economy and society at large" (Becher & Kogan, 1980, p. 15) as interpreted by certain politicians (e.g., Roger Douglas, David Lange) and officials in particular departments (e.g., Treasury, Reserve Bank, State Services Commission, Audit Office). These people were concerned with public spending, financial management of government, and management of government organisations (see propositions 1, 2 and 4). Thereafter, the environment in which hospital staff in the operating core and support services pursued cultural mores concerning care for individual patients and similar medical principles (see chapters 5 and 8 in particular) was disturbed by the actions of people at the central authority and institution levels of the hospital system (see chapters 6, 7 and 8 in particular).

Accounting was part of these dynamics both giving force to them and being shaped by them (Roberts & Scapens, 1985). In addition to the politicians and officials referred to above, those who had become involved included the new managers at the central authority level of the hospital system. Some were either accountants, or people with faith in accounting ideas, and it was they who in the name of "the state came to act on

accounting in the name of both accountability and the furtherance of organizational and social efficiency" (Burchell et al., 1980, p. 9; see also Miller, 1990).

Also, accountants were bought in at the institution level of the hospital system at various times during the Study period (see propositions 5 and 9). Not only did they respond to what was demanded of them by various interested parties (e.g., improvements to systems for cash management and annual reporting in about 1988), but, having secured certain bridgeheads, they searched for opportunities "for the expansion of accounting practice" (Burchell et al., p. 8). In their advance across the system, they espoused the relevancy of their activities to "improving organizational efficiency and the maintenance of organizational control" (Burchell et al., 1980, p. 9), and became more powerful managerially as a professional group (Armstrong, 1985).

The measures in which accounting was implicated (see propositions 5 to 11 and 14) entailed changes in the operational mode at each level of the system. At the central authority level, changes ensued to the system of funding and monitoring, and funding for existing activities was reduced. At the institution level, several regulatory items (e.g., NZSA, 1987, which was "sponsored" by the Audit Office; Area Health Boards Act of 1983 as amended; Public Finance Act of 1989; and Minister of Health, 1990) contributed progressively (see Figure 11.1) to hospital organisations being obliged to budget, account and report on a business basis. From 1987, planned and actual expenditures (and later expenses) were increasingly matched expressly against revenue (i.e., government allocations) in, first, annual and, later, monthly periods. In addition, from about 1992, assets were compared with liabilities[9], and the changing net worth of the government's investment was measured on the basis of business accounting standards. By 1994 these measures had culminated in the requirement for hospital organisations to be successful and efficient businesses under the Health and Disability Services Act of 1993 (see also Department of the Prime Minister and Cabinet, 1993).

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[9] Earlier attempts at balance sheets did not seem to be taken that seriously by the central authorities or the hospital organisations ({Government Analyst}, {Central HQ RA}).

In relation to the basic unit level, the accountants, whose offices and the places they frequented were somewhat removed from the daily trauma, set up control structures and processes that affected people inside the hospitals. Predictably, these clashed with the nature of the work done among the staff there (Mintzberg, 1989; W. R. Scott, 1982). They gave rise to frustration, exasperation, anger, demotivation, resignations and strikes, which were ameliorated only by the commitment of health professionals and other staff to the patients, and their inclination to become the patients' agents and defenders against the encroachment of harmful managerial practices (see pp. 89-98, 392-400).

Among these staff, accounting is perceived as connected with softer rationalities of economic efficiency, and rationalities that are different from an owner's perspective of economic efficiency (Bryman, 1984; D. J. Cooper et al., 1981). Indeed, many of accounting's symbolic, ceremonial, mythical, repressive and legitimising roles or purposes (Ansari & Euske, 1987; Burchell et al., 1980; Chua cited in Kelly & Pratt, 1992) were evident from the within-case analyses and can be discerned in several places in the thick descriptions and interpretations in chapters 5 and 8 to 11. Similarly, it was apparent that hospital organisations and the hospital system are "composed of interest groups each with its own form of rationality and each competing for space in the problem solving and strategy formulation processes [therein]" (Pettigrew cited in Bryman, 1984, p. 397).

For their part, most of the accountants and managers interviewed seemed sincere in believing that accounting involved computational decision making and accountability, and served technical-rational purposes (Ansari & Euske, 1987; Morgan, 1988). They felt that many of the accounting systems and processes had been problematic and dysfunctional, particularly when they were first introduced and exhibited technical teething troubles. But they also felt that given time these problems had been and/or could be put right. Implicit in this was a belief of working towards an "overarching rationality" (Bryman, 1984, p. 398) of economic efficiency from the perspective of the government initially as the funder and then, in time, as both the provider of capital seeking a secure return (Armstrong, 1985, also cited by Colignon & Covaleski, 1988) and as agent of the taxpayer.

Somewhat in contrast, other interviewees were more politically adroit, and may have knowingly exploited accounting for natural, socio-political purposes (Ansari & Euske, 1987; Burchell et al., 1980; Kelly & Pratt, 1992). For example: {Central HQ RC} stated that providing a profit and loss account on a monthly basis "is the quickest way to change the culture." Similarly, some of the people whose power had been curtailed, and whose values were compromised, appeared to blame this on accounting, accountants and other managerial developments. For example: {Chairman P} saw the budget process as "the major part in a public relations exercise designed to fool staff", and that the figures in it "were obtained without any consideration for reality." He also pointed out the divergence between how the budgeting process was espoused in the official documentation as rational and participatory, and how it was practised as political and imposed (see p. 282-284) (for a discussion of these aspects of budgeting, see Covaleski & Dirsmith, 1988). {Charge Nurse QB} objected to "the concept of money driving absolutely everything," and {Charge Nurse QA} had a feeling of "being sold down . . . the river" (see pp. 351, 353-354).

The quotes in the previous paragraph typify the tension within the hospital system, and between interested parties on its fringe (see pp. 190-199). This tension derives from the competing perspectives of micro (patient care and provision of facilities) and macro (resource allocation, funding and the extent of government involvement) (W. R. Scott, 1982). However, although people such as those quoted were diametrically opposed to the efficacy of the changes which they were going through, they tended to agree that in hindsight the macro picture of an effective hospital system had been lost sight of, and events at the micro-level were stifled by inertia in the professional bureaucracy of the triumvirate structure of the mid-1980s (see propositions 2 and 3).

By 1993, this inertia had gone, and power was moving away from the doctors and other health professionals towards the now macro-oriented, efficiency (i.e., spending reduction) driven institution level managers and central authority officials. These managers and officials appeared driven by an equivocal mix of spending less, cost containment and efficiency, and a need for order, measurement and product specification (see pp. 171-190

of this thesis; Department of Health, 1993b; Department of the Prime Minister and Cabinet, 1993).

PROPOSITION 16

OF THE MYRIAD OF TECHNICAL-RATIONAL AND NATURAL ROLES THAT MIGHT BE ASCRIBED TO ACCOUNTING IN NEW ZEALAND HOSPITALS DURING THE STUDY PERIOD, THE MOST POTENT ONE HAS BEEN TO ACT AS A POLITICAL FORCE OR SOURCE OF CONFLICT. AS SUCH, ACCOUNTING PRACTICES HAVE PROMOTED CHANGE THAT WAS BLOCKED BY LEGITIMATE SYSTEMS OF INFLUENCE AT ALL LEVELS OF THE HOSPITAL SYSTEM.

Given the political will of the Government to change hospital organisations, and the adoption of competition, conflict and confrontation as the strategy to effect this change, accounting was an obvious weapon to deploy. However, it is unclear to what extent the deployment of accounting as a political force (Mintzberg, 1985, 1991; see pp. 96-98 of this thesis) was either premeditated or unintentional, and it is even doubtful several years on whether most people in the hospital system have come to perceive accounting in this role. But it had already been used in other parts of the public sector in ways which both seemed to fit with Governments' image of effectiveness and efficiency (McCulloch & Ball, 1992; G. Scott & Gorringe, 1989; Treasury, 1990), and with its need for asset sales revenue (e.g., the transformation and privatisation of Telecom New Zealand), or limits on spending funded from taxation (e.g., financial management reform of core government departments - see Treasury, 1989, 1990).

As a political force, accounting practice came to challenge the status quo of the system starting in the mid-1980s (see proposition 5), but more particularly after 1991 (see proposition 9) when conditions of possibility were more favourable. These conditions were described in relation to proposition 13. They included the second iteration of reforms (Upton, 1991) which comprised a model that relied on "conflict and confrontation" (Mintzberg, 1991, p. 65), "to promote necessary organizational change blocked by the legitimate systems of influence" (Mintzberg, 1985, p. 149); that is, the

old Department of Health, the doctors and other health professionals and communities. The manner in which changes were extorted by government reformers from the hospital system involved accounting intruding vertically down the chain of individualised accountability. It had been constitutive in the setting up of this chain, initially into the workings of the Department of Health (see propositions 1 and 4), and then in turn into the institution, basic unit and individual levels of the hospital system (see propositions 6, 8 and 10). The means by which this intrusion was effected included tighter funding and monitoring through contracts and budgets (see propositions 7 and 8), internal charging (see propositions 8 and 14), the purchaser-provider split and criteria for hospital organisations to operate as successful and efficient businesses (see proposition 14) (for a similar scenario in the USA healthcare sector, see Michelman, 1988).

According to Mintzberg (1991), conversions are periods of contradiction, particularly if the competitive force of politics is invoked. This force relies on conflict and confrontation, and is ostensibly destructive because it encourages people to pursue their own ends. But the force of politics can be beneficial in pulling the organisation apart to ensure people address fundamental change, and it "may be the only force capable of stimulating the change" (p. 65) (see pp. 96-98 of this thesis).

Certainly the circumstances in the hospital system since the mid-1980s fit with Mintzberg's description, and accounting has been used to confront the established structures and processes and the power relationships within them. Intrusions by accounting and accountants were and continue to be controversial, especially in relation to doctors and health professionals generally (see Flynn, 1992, for a description of corresponding events in Britain). This can be because accounting had not been part of the conventional ideology of hospital organisations. Moreover, the systems, processes and interactions associated with accounting did not correspond to the distribution of power, the dominant organisational power and culture, or the goals and technology found in the operating core (Markus & Pfeffer, 1983).

Nonetheless, these trappings have "trickled down" certainly to the basic unit level and, to a lesser extent, the individual level, and caused many people to revise the way they

see their workplace and the activities that go on there. It does not matter too much that if viewed through technical-rational eyes computational practices have been flawed (see the frequent criticisms contained in chapter 9 to 11). It is enough that accounting has given rise to conflict within the operating core (e.g., over budgets and internal charging); highlighted the macro and micro dichotomy; and forced people to pull their organisations apart and address the issue of fundamental change. In this fashion, accounting and accountants are part of a conversion of the hospital system from the pre-reform combination contaminated by a mixture of proficiency, consensus and concentration (see Table 12.1), to some, as yet immature, combination (Mintzberg, 1991). Organizational participants' views of what is important are shaped by what is accounted for. "The categories of dominant economic discourse and organizational functioning that are implicit within the accounting framework [are helping] to create a particular conception of organizational reality" (Burchell et al., 1980, p. 5).

Future Speculation

The third and final part of the theory moves from explaining and reflecting on occurrences to date, to speculation on the consequences that have ensued and what might occur next. The three propositions in this section are a mix of conjectures about the future (i.e., what the researcher anticipates might happen) and policy suggestions (i.e., the measures which the researcher thinks should be sponsored by the government and by people within the hospital system).

Mintzberg (1989) argues that, unchecked, a formal management control discipline such as accounting is incompatible in the longer term with the operation of professional organisations, and that it stifles their proficiency and sooner or later makes them ineffective. Similarly, he argues that although politics can facilitate change, and can render an organisation more effective, its more likely longer term effect is to generate internal competition, conflict and confrontation, which would normally be destructive, thus rendering the organisation less effective from a technical-rational perspective (Mintzberg, 1985, 1991). Thus, despite the possibly beneficial effect which accounting as a political force has had on the New Zealand hospital system (Mintzberg, 1991;

Burchell et al., 1980), there is little prospect of a public health service which caters promptly for allcomers (see articulation of personal values, p. 38).

At the time of writing, the onward march of accounting in the name of greater efficiency continues unabated. After several years of agonizing, during which various battles occurred (e.g., over the underlying philosophy of the system, its formal structure and financial basis, hospital closures, nurses' pay, doctors' hours, patient access), the conversion process still proceeds in the hospital system. Stable, legitimate and effective combinations have not yet been established overall, or at any level of the system, or within any of the organisations of which it is comprised (Mintzberg, 1985, 1991). Thus, the future is an opportunity for making choices, and it can be argued that depending on those choices the immediate consequences of accounting in the hospital system and the health service will be either:

(a) tighter encircling of the daily routines of doctors and other health professionals through further imposition of formal management controls, such as standard costs (Miller & O'Leary, 1987; Young & Saltman, 1983); or,

(b) greater empowerment of professionals by decoupling accounting practices at the micro-level from those at the macro-level, and providing support for professional staff at the individual and basic unit levels in devising their own data systems and other computational aspects of their work.

Continuing in the present direction with the situated practice and theory-in-use as they have emerged would lead thus:

PROPOSITION 17

COUPLED WITH THE PROSPECTS FOR SICK PEOPLE BEING TRANSLATED INTO PRODUCTS COMPRISED OF PATIENT TYPES, AND HOSPITAL ORGANISATIONS BEING PORTRAYED AS FACTORIES (SEE PROPOSITION 14) AND MULTI-PRODUCT FIRMS (SEE PROPOSITION 15), STANDARD COSTING IS EMERGING AS A MEANS BY WHICH HOSPITAL ENTERPRISE MANAGERS CAN RESTRICT SPENDING BY INDIVIDUAL DOCTORS.

This proposition was induced from the field data (see pp. 406-407); and industry level studies of DRGs in Australia, Sweden and the USA (Chua, 1995; Chua & Degeling, 1993; Coombs, 1987; Preston, 1992), and of standard costing and budgeting (Miller & O'Leary, 1987; Miller & Rose cited in Humphrey et al., 1993; Young & Saltman, 1983). DRGs are beginning to feature as surrogate products to be traded in contracts between regional health authorities and Crown health enterprises (see proposition 14). As categories of products, they are susceptible to manufacturing based standard costing techniques, including flexible budgets and variance analysis. According to espoused theory these techniques "render visible the inefficiencies of the individual person within the enterprise" (Miller & O'Leary, 1987, p. 241) and are a means to improve efficiency. Thus, the imposition of these techniques among doctors and other health professionals is consistent with the pattern of change so far; that is, of measures implemented between the central authority and institution levels of the system giving rise to analogous measures between the institution level and the operating core. But standard costing was developed in mass production manufacturing organisations in which the tasks of devising and developing technology were divorced from the operation of the technology.

Mintzberg (1989) has incorporated this latter phenomenon in his organisation structuring work by reference to the size and role of the technostructure and operating core. A key feature of professional organisations is that the technical experts (e.g., doctors) both develop the technology and use their expertise in operating it. This arises because problems of ambiguity, non-measurability, uncertainty of outcome and non-repetitiveness of activities are rife in the tasks performed in the operating core. The decisions and actions inherent in these tasks are best made by resorting to expert judgmental and intuitive control, rather than the routine control implicit in standard costing (Hofstede, 1981). Thus, in this kind of organisation structure, the technostructure is relatively undeveloped because its function is incorporated into tasks performed in the operating core.

Under this scenario, decisions and actions about admitting and caring for patient types and individual patients and the application of standard costing seem to be quite far removed from one another. Standard costing could, by this interpretation, be a tangible

expression of the unlikely presumption of accountants knowing better than doctors what types of decisions and behaviours are necessary when faced with a patient (W. R. Scott, 1982; see p. 94 of this thesis). From a soft-rationality, organisational control perspective, the imposition of standard costing is likely to reduce the opportunity for loose coupling between the macro-concerns of the management zone and the micro-concerns and task technology of the operating core (Preston, 1992; Mintzberg, 1989). Therefore it would be disruptive and impose distractions on the latter, for example, by increasing the administrative burden on professionals by requiring them to provide answers and explanations about so-called exceptions that have occurred in the recent past in formal reports to managers who would not be qualified to understand them. Professionals would thus move more towards being reporting machines (Gray & Jenkins, 1993) at the beck and call of managers, rather than individuals dealing with patients within the loosely structured order of their departments. The likely consequences of this are an escalation of the conflict between people at the micro- and macro-levels of the hospital system, and contamination of the organisational configurations emerging from the fundamental changes which the system is going through.

By contrast with proposition 17, altering course and adopting a new theory-in-use is worth consideration because of the following widely held opinion about the context in which accounting is being practised:

PROPOSITION 18

"THE CURRENT IDEOLOGY BASED ON THE NOTION THAT BUSINESS SOMEHOW HAS A MAGIC WAND WHICH WILL TRANSFORM HEALTH IS UNSUSTAINABLE" ({CENTRAL HQ MANAGER RG}). HAVING USED THE FORCE OF POLITICS TO ADVANTAGE, A MORE SUSTAINABLE COMBINATION SHOULD BE SOUGHT ALONG THE LINES OF A CONJOINT PROFESSIONAL ORGANISATIONAL FORM.

Seen as a political force which is pulling the hospital system apart to ensure that people address fundamental change, the present situated practice of accounting is useful in the short term, but only if organisational forces rise from the situation and are combined in

a new and relatively stable configuration that is not contaminated. Seen as technically-rational, aligned with the force of efficiency or diversification, and with a longer term future as part of some new configuration, it is likely that the present situated practice of accounting will have detrimental economic and social consequences for many people. This is because the practice will continue to provoke internal competition, conflict and confrontation (see chapters 9 to 11), which in the longer term will encourage people to act destructively from motives of selfishness and self-preservation rather than one of service, self-sacrifice and caring for one's fellow beings.

From a pluralist perspective of "survival, the prevention of system breakdown and negative entropy" (Hopper & Powell, 1985, p. 445), the task that lies ahead for the various parties referred to in proposition 2 is to resolve the conflicts in the hospital system that are evident in the thick descriptions and interpretations in chapters 5 to 8. In addition, the task that lies ahead in relation to the situated practice of accounting involves contributing to the resolution of conflict by changing the nature of that practice, its scope and the sites at which it is located. In particular this will entail withdrawing vertically operating control systems to a safe distance from the operating core. In addition, accountants among others need to ascertain by inquiries in the field what kind of situated practice, if any, can be aligned to the various forces which will emerge as the new stable configuration of the hospital system.

Unless these matters are attended to quickly, the present conflict "may get drawn out. . . . and that can . . . be viewed as dysfunctional in terms of the use of society's resources" (Mintzberg, 1985, p. 151). A significant step in the process of synthesising a new configuration will be to get the various interested parties to recognise the legitimacy of the traditional tension or conflict between the macro-concerns of the central authorities and hospital organisation managers, and the micro-concerns of people in the operating core and in the community. Davies (cited in Flynn, 1992, p. 41) was able to dismiss the bureaucratic-professional conflict thesis as empirically inadequate in the British national health service, so this conflict may not be as inherent as is often portrayed (see also Coombs, 1987). In any case, such recognition would lay a foundation for hospital professionals and managers "to coexist in a state of

interdependence and mutual influence" (W. R. Scott, 1982, p. 230). From this beginning, deliberate steps could be taken towards a system configuration in which proficiency, ideology, competition, concentration and efficiency are combined in a suitable way to minimise contamination.

If it is to be effective, this combination is likely to see proficiency be prominent again because of the task structure inherent in hospital work (see pp. 90, 92, 93-95, 112-117). However, one would envisage the configuration to be a partnership between professionals and managers, both driven by the forces of efficiency and diversification as well as proficiency (Coombs, 1987). Health professionals could and should put more effort into the way they are organised, and into macro-aspects of the hospital organisations, in addition to the more obvious interest in these matters which managers take. For their part, the managers could take greater responsibility for caring for the community, and for the repercussions of their actions for individual patients and staff.

W. R. Scott (1982) refers to configurations of this type as *conjoint* (see p. 95 of this thesis). Similarly, Becher and Kogan (1980) write of a system in dynamic equilibrium, either in harmony or in a state of balanced tension, "as long as the normative and operational modes are in phase with one another" (p. 17) (see pp. 98-101 of this thesis). They infer that to achieve this more stable balance requires the force of cooperation or ideology (Mintzberg, 1991), which would facilitate a common set of basic values being established and maintained across the system.

At present, as a result of the force of politics exerted by the situated accounting practice in particular, values conflict both vertically and horizontally. Indeed, the very imposition of a vertical dimension in the system (e.g., through profit and standard expense responsibility centres, individualising of so-called managerial responsibility and answerability, devolved budgeting and (potentially) standard costing) is a major source of conflict. It is one of the main aspects which now need addressing. In particular, more cognisance should be taken by accountants and others of the basic assumptions and values inherent in these particular concepts. Indeed, recognition and understanding by accountants of the social and political side to their craft (Ansari & Euske, 1987; Kelly

& Pratt, 1992; Miller, 1990) would be a major step in the direction being called for here. More focused studies than the present one into each aspect of that craft under headings such as those just enumerated (i.e., profit and standard expense responsibility centres, etc.) would be worthwhile.

Assuming that proficiency is to be promoted as a major force in a reconfigured hospital system, the question arises as to what kind of situated accounting practice can be aligned to it. Thus:

PROPOSITION 19

ACCOUNTING HAS THE POTENTIAL TO TAKE AN IMPORTANT SUPPORTING ROLE AS A SYSTEM OF INFORMATION, LEARNING AND FORMATIVE EVALUATION (SCRIVEN, 1973; STUFFLEBEAM, 1983) FOR PROFESSIONAL AND OTHER OPERATING CORE AND SUPPORT SERVICE STAFF, INCLUDING THOSE WITH SOME MANAGERIAL RESPONSIBILITY AT BASIC UNIT LEVEL. SIMILARLY, ACCOUNTANTS COULD "DEVELOP THE ART OF 'READING' AND PROBING SITUATIONS TO CREATE INTELLIGENT, ACTIONABLE INSIGHTS" (MORGAN, 1988, P. 484) IN THE CONTEXT OF THE WORK OF HEALTH PROFESSIONALS AND CARING FOR PATIENTS.

The soft economic rationality (Bryman, 1984) underlying the conjoint kind of configuration would justify the existence of the accounting craft (D. J. Cooper et al., 1981), and so "provide rationales for continued accounting action" (Burchell et al., 1980, p. 10). However in 1994, with few exceptions, accountants still have far to go before they gain the respect of one of the two major partners in this kind of configuration, the health professionals. The reasons for this are that accountants are identified with practices (e.g., the general ledger systems, the encircling of professional practices with spending limits, the budget structures and processes) that have been a source of aggravation, frustration and stress (see proposition 15; see also Weick, 1983).

If accounting is to play something other than a destructive political role in the future, it will need to be changed both in how it is espoused and in how it is practised. Given

moves towards a conjoint configuration, in which the force of proficiency and professionals will have a prominent place (see proposition 18), the potential for accounting is to address the computational practice needs of both "health care practitioners specializ[ing] in the delivery of micro patient care, and administrators and medical managers attend[ing] to the delivery of macro care" (W. R. Scott, 1982, p. 231) in order to "complement, [but] not replace, the exercise of human judgement" (Burchell et al., 1980, p. 15). This is something which has not yet been achieved in New Zealand hospitals, or in professional organisations generally. It is an area in which accounting knowledge is sparse save for studies like the present one which examine the repercussions of importing computational means that may be useful in machine bureaucracies and divisionalised organisations (see Broadbent & Guthrie, 1992; Ferreira & Merchant, 1992), or publications which describe, and by implication inspire, such importation in the first place (e.g., Anthony & Young, 1994; Healthcare Financial Management; R. Jones & Pendlebury, 1992; T. Jones & Prowle, 1984; Levy, 1985; Perrin, 1988).

Some evidence for the notion of accounting ideas, skills and techniques being useful in supporting staff to develop data came out of several interviews, and some of it is related in conjunction with proposition 12. One matter developed there is the propensity of institution level managers and accountants to purchase centralised systems from socio-political motives, and to overlook the potential for more localised, less costly, information systems because that would be seen as supporting the professionals. If accountants and other people located at the institution level offices would spend more time visiting wards and other operating core sites and observing, listening to and conversing with people there, they could begin to understand more about the beliefs and values which drive those people, and become more familiar with how activities and tasks are carried out.

Of the accountants interviewed, {Financial Controller P} was the most enlightened in these respects, primarily because of his own health professional education and experience. He had the respect of the health professionals he came into contact with, even if they might not have agreed with some of the things in which he was engaged.

In 1993 he was "working on improving the reporting packages" which staff in various parts of the hospital were receiving and "getting some management and financial integrity into the information" which was flowing between managers. He was extremely critical of past episodes when systems had been "dumped" on Site P from the hospital organisation's remote central headquarters (see proposition 12). Despite these experiences he believed that accounting data and processes could be improved given time. He also thought that people's awareness of data could be raised through education and training, and that it might still be possible for accountants to gain the respect of these people.

What is being suggested here is that by frequently experiencing life in the operating core, and regularly listening to people, accountants might learn to put aside their preconceived ideas of accounting as objective (Morgan, 1988) and their presumptions that "the specification, design and use of accounting systems precedes decision making, [and] that the roles played by accounting systems in decision making can be invariate across a multitude of different decision situations" (Burchell et al., 1980, p. 13). Accountants need to understand the micro culture and ideology inherent in hospital activities (Bourn & Ezzamel, 1986b; Coombs, 1987), and build their systems and processes around these to improve their chances of acceptance by doctors and other health professionals (Markus & Pfeffer, 1983). Also: "In practice, accounting systems function in a diversity of ways, intertwined with institutional political processes and the operation of other forms of organizational and calculative practice" (Burchell et al., 1980, p. 13). Accountants, and other users of accounting, need to appreciate what these are, and to evaluate their outcomes.

They need help in this from researchers willing to go into hospitals to ask how things are done and to find the outcomes from both a micro perspective, and a macro one. For the industry as a whole, instrumental, moral-practical and aesthetic areas (Chua & Degeling, 1993) need to be examined, including the financial effects of the new prospective payments systems emerging between regional health authorities and Crown health enterprises, and its effects on the quality of care. A related matter is the need for accountants to develop and refine the criteria by which hospital enterprises are

evaluated. The rhetoric of the phrase *successful and efficient businesses,* and mere measurement of revenue and spending, and frequent revaluing of fixed assets, are hardly valid in such a complex, ambiguous and emotive area.

At the same time, the data that seem to be of interest in hospitals are those about physical quantities and quality, rather than about dollars, partly because the dollar is not much use as a unit of measurement to staff fathoming operational relationships, interactions and events day-by-day. This area would also make a challenging one for accounting researchers willing to derive concepts, processes and techniques relevant to professional people operating at the micro-level. Data are also of interest to interested groups in the community, and accountants who withhold information under the guise of commercial (and political) sensitivity (see p. 256) might want to examine the ethics of this and their responsibilities as professionals to society at large.

The Government may also wish to reflect on whether competition based on restricting financial (and possibly professional and technological) information flows is contrary to generating healthy business competition or to desirable clinical practices. Another issue for the Government is that its own budget process is a major restriction to long term financial planning in the hospital system. The time at which Parliament receives the current year's budgets should be the time they receive the following year's budgets

A Summing Up

In order to illuminate the subject matter, to facilitate its understanding among interested parties, and to extrapolate about what has been occurring and about the future, this Study has addressed the questions:

> How is accounting practised among people working in, or involved with, the hospital system in New Zealand? And, what roles has it come to play during a period of reform?

The picture which emerges, and which has been articulated as a theory-in-use, comprises four aspects:

(a) a hospital system subjected to macro-level disturbances that have caused a mixture of effects in terms of structures, processes, interactions and outcomes;

(b) an emergence of accounting since the mid-1980s in multiple roles, which are reflective and constitutive of organisational and social practices developing in the system;

(c) qualified success for the situated accounting practice in the role of a political force in converting hospitals to a more effective form of organisation; and

(d) accounting practice at a fork in the road ahead, one way leading to its contamination of hospitals by inappropriate forces and forms based on production management; and the other to its emergence as an important support in a hospital system founded on a more conjoint organisational configuration in which professionals and managers apply their craft cooperatively for the joint and several benefit of patients.

In the previous section the researcher has argued for a further wave of measures that will lead along this latter fork, and take advantage of the fundamental changes that have occurred already. However, at the moment the signs of this happening are not encouraging.

Concluding Remarks

Reflections on Methodology

This Study appears to have broken new ground in accounting research by virtue of the strategy of control and design which was employed. Despite the difficulties which the researcher faced in knowing what to do each step of the way, and in not being surrounded by colleagues who had been there before, the use of this strategy was rewarding as an innovative experience per se, and for the data and analysis which it has provided. The biggest problems in order of magnitude were:

(a) getting on top of the mountain of quotational data;

(b) the "agony of omitting" descriptions from this thesis;

(c) obtaining acceptance for the necessity to report in detail on methods used and to report the data so thickly in descriptions and interpretations;

(d) obtaining acceptance of theoretical consistency, reliability and validity of the Study; and

(e) obtaining access to sites.

As far as the researcher is concerned, the amount he has learnt by conversing with people in the field about their work has been phenomenal. The reader must judge whether these efforts were worth it from his/her perspective.

Situating the Study in the Accounting Literature

In terms of the accounting literature, the Study might be classified under what Broadbent and Guthrie term "Explicitly alternative approaches: Contextually technical accounting" (1992, p. 16). These authors cite several other studies of public health services institutional systems in Britain, USA and Australia which have also been cited in this thesis (e.g., Bourn & Ezzamel, 1986a, 1986b; Broadbent, 1992; Chua, 1995; Chua & Degeling, 1993). By comparison with the work reviewed by Broadbent and Guthrie, the Study has dealt with New Zealand, and so adds to the international evidence available on the subject. It has also attempted a rare *rapprochement* between the micro-organisational and industry levels of analysis (Chua & Degeling, 1993; Silverman, 1985). It claims like most, but not all, the studies reviewed, to have evidence of accounting as a "force of change" (p. 23), but follows a different analysis from those in the studies reviewed, in particular by relying on the forces and forms model of Mintzberg (1991). The Study also emphasises the importance of context in studying the way accounting operates (e.g., in the naturalistic methodology; in aiming to study the situated practice; in the use of thick description and interpretation to report on the Study; and in devising a map of the Study context to focus the data and articulate the theory-in-use). In addition, the focus of the Study is on illumination, understanding and extrapolation, which are along similar lines to the "question[ing] and understand[ing] . . . . [and] critical evaluation of the processes which have been implemented" referred to by Broadbent and Guthrie (p. 23).

Compared with findings summarised in Broadbent and Guthrie (1992), the Study raises the issue of accountants and others promoting accounting practices neglecting, disregarding or not appreciating the social and subjective nature of these practices. It also points to differences in what is important to health professionals and communities compared to accountants and managers, and to the inevitable clash of accounting's underlying assumptions with the culture of hospital organisations in particular when attempts are made "to try to give visibility to particular activities within the system . . . . [using] 'new' accountings" (pp. 23-24). However, the Study seems novel in suggesting that this conflict has actually had some benefit through pulling the system apart to ensure that the people within it address fundamental change (Mintzberg, 1991). The researcher suggests nothing new in advocating further research into an area where there is "little evidence that pilot studies are being used to evaluate changes prior to their wider implementation" (Broadbent & Guthrie, 1992, p. 23).

Future Research Topics

Several suggestions have been made about areas for future research in this chapter and elsewhere in the thesis. It would be fruitful to develop the function and values framework as a map of the system context, including keeping it up to date as further changes in values and functions ensue. Similarly, the situated practice of accounting, and its many aspects (see proposition 19), in the hospital system and elsewhere in the New Zealand public sector would also be useful areas of study. In particular, the theory-in-use proposed in this thesis could be further refined by more in-depth analyses of different aspects of accounting at new Crown health enterprise and other provider sites, and among the new organisations which comprise the central authority level. In designing such analyses, deliberate attempts should be made to look for negative cases, and to capture changes in conditions and participants' attitudes due to historical and maturational factors (Denzin, 1989b). Furthermore, in the light of the findings of this Study of one part of the New Zealand public sector, it seems pertinent to look at all other parts of the sector because, having been through similar changes, the theory espoused for accounting in them is also very likely to be false. One further useful line of inquiry might be to monitor changes in espoused theory, including quality

supplementing efficiency as a justification for vertical intervention by central authorities in the operations of hospital organisations.

Reflections on the Researcher's Personal Journey

In relation to proposition 19 (see pp. 453-454), accountants are urged to spend more time conversing with people on their operating core sites, so they can understand more about the beliefs and values which drive those people, and familiarise themselves with how activities and tasks are carried out. By doing this it is suggested that accountants might learn to put aside their preconceived ideas and presumptions about accounting, and appreciate its natural side in addition to its technical-rational one.

In essence, this is what the researcher has done since 1987, and the experience has been both enlightening and fulfilling. Not only does he feel more informed about the Study area, but he is also more aware of how to study other areas, and why they should be studied: to illuminate, understand and extrapolate different contexts and the accounting or other practices which go on there. The researcher also feels more cognisant of the incongruity between his personal beliefs about the world being made a better place for society's underdogs, and engaging in "fixing" organisations using functionalist or any other techniques without articulating the assumptions underlying the techniques, or the reasons the organisations may appear to be in need of fixing. Finally, the researcher has come to appreciate that in guiding students in their study of accounting he needs to encourage them to reflect on both the natural and technical-rational roles of accounting in the particular context in which it is practised.

REFERENCES

Abernethy, M. A., & Stoelwinder, J. U. (1990). Physicians and resource management in hospitals: An empirical investigation. Financial Accountability & Management, 6, 17-31.

Abernethy, M. A., & Stoelwinder, J. U. (1991). Budget use, task uncertainty, system goal orientation and subunit performance: A test of the 'fit' hypothesis in not-for-profit hospitals. Accounting, Organizations and Society, 16, 105-120.

Ackroyd, S., Hughes, J. A., & Soothill, K. (1989). Public sector services and their management. Journal of Management Studies, 26, 603-619.

Advisory Committee on Hospital Board Funding. (1980). The equitable distribution of finance to hospital boards. Wellington: Author.

Akers, R. L., & Quinney, R. (1968). Differential organization of health professions: A comparative analysis. American Sociological Review, 33, 104-121.

Allcorn, S. (1990). Using matrix organization to manage health care delivery organizations. Hospital and Health Services Administration, 35, 575-589.

Ansari, S., & Euske, K. J. (1987). Rational, rationalizing, and reifying uses of accounting data in organizations. Accounting, Organizations and Society, 12, 549-570.

Anthony, R. N., & Young, D. W. (1988). Management control in nonprofit organizations (4th ed.). Homewood, IL: Irwin.

Anthony, R. N., & Young, D. W. (1994). Management control in nonprofit organizations (5th ed.). Burr Ridge, IL: Irwin.

Area Health Boards Act. No. 134 of 1983.

Area Health Boards Amendment Act. No. 21 of 1988.

Argyris, C. (1990). The dilemma of implementing controls: The case of managerial accounting. Accounting, Organizations and Society, 15, 503-511.

Argyris, C., & Schon, D. A. (1974). Theory in practice: Increasing professional effectiveness. San Francisco: Jossey-Bass.

Armstrong, P. (1985). Changing management control strategies: The role of competition between accountancy and other organisational professions. Accounting, Organizations and Society, 10, 129-148.

Arrington, C. E., & Francis, J. R. (1993). Giving economic accounts: Accounting as cultural practice. Accounting, Organizations and Society, 18, 107-124.

Arthur Andersen. (1987). New Zealand Department of Health: Public hospital performance assessment. Wellington: Government Printer.

Austin, R. E. (1989). The changing political economy of hospitals: The emergence of the "business model" hospital. Dissertation Abstracts International, 49, 1430A. (University Microfilms No. 89-17,970).

Ayling, J. (1988). Resource management in New Zealand public hospitals. New Zealand Health Review, 8(2), 32-36.

Bates, W. J. (1991). The public sector accounting standards and the area health boards: A preliminary assessment. Unpublished manuscript: Massey University, Department of Accountancy.

Becher, T., & Kogan, M. (1980). Process and structure in higher education. London: Heinemann.

Becher, T., & Kogan, M. (1992). Process and structure in higher education (2nd ed.). London: Routledge.

Bell, S. (1994, 21 July). Dannevirke hospital may lose surgery. Dominion, p. 1.

Berry, A. J., Capps, T., Cooper, D., Ferguson, P., Hopper, T., & Lowe, E. A. (1985). Management control in an area of the NCB: Rationales of accounting practices in a public enterprise. Accounting, Organizations and Society, 10, 3-28.

Boland, R. J., & Pondy, L. R. (1983). Accounting in organizations: A union of natural and rational perspectives. Accounting, Organizations and Society, 8, 223-234.

Boston, J. (1991). The theoretical underpinnings of public sector restructuring in New Zealand. In J. Boston, J. Martin, J. Pallot, & P. Walsh (Eds.), Reshaping the state: New Zealand's bureaucratic revolution (pp. 1-26). Auckland: Oxford University Press.

Boston, J. (1995). The state under contract. Wellington: Bridget Williams.

Boston, J., Martin, J., Pallot, J., & Walsh, P. (Eds.). (1991). Reshaping the state: New Zealand's bureaucratic revolution. Auckland: Oxford University Press.

Bougen, P. D., Ogden, S. G., & Outram, Q. (1990). The appearance and disappearance of accounting: Wage determination in the U.K. coal industry. Accounting, Organizations and Society, 15, 149- 170.

Bourn, M., & Ezzamel, M. (1986a). Costing and budgeting in the National Health Service. Financial Accountability & Management, 2, 53-71.

Bourn, M., & Ezzamel, M. (1986b). Organisational culture in hospitals in the National Health Service. Financial Accountability & Management, 2, 203-225.

Broadbent, J. (1992). A middle range approach for understanding accounting in organisations: A model and its applications in a case study in the NHS (Discussion Paper No. 92/1). Sheffield: University of Sheffield, Management School.

Broadbent, J., & Guthrie, J. (1992). Changes in the public sector: A review of recent "alternative" accounting research. Accounting, Auditing and Accountability Journal, 5(2), 3-31.

Brown, L. D., Gardner, J. C., & Vasarhelyi. (1987). An analysis of the research contributions of Accounting, Organizations and Society, 1976-1984. Accounting, Organizations and Society, 12, 193-204.

Bryman, A. (1984). Organization studies and the concept of rationality. Journal of Management Studies, 21, 391-408.

Bryman, A. (1988). Quantity and quality in social research. London: Unwin Hyman.

Burchell, S., Clubb, C., & Hopwood, A. G. (1985). Accounting in its social context: Towards a history of value added in the United Kingdom. Accounting, Organizations and Society, 10, 381- 413.

Burchell, S., Clubb, C., Hopwood, A., Hughes, J., & Nahapiet, J. (1980). The roles of accounting in organizations and society. Accounting, Organizations and Society, 5, 5-27.

Burgh, J. G. (1994). Cost and management accounting: A modern approach. St Paul, MN: West.

Burrell, G., & Morgan, G. (1979). Sociological paradigms and organisational analysis. London: Heinemann.

Caygill, D. (1988). Health: A prescription for change. Wellington: Government Printer.

Caygill, D., & Salmond, G. (1989). Managing the health changes: The official view. Wellington: New Zealand Institute of Health Management.

CHE business plans issued to public. (1994, 11 May). Dominion, p. 2.

Chua, W. F. (1986). Radical developments in accounting thought. Accounting Review, 61, 601-632.

Chua, W. F. (1988). Interpretive sociology and management accounting research: A critical review. Accounting, Auditing and Accountability Journal, 1(2), 59-79.

Chua, W. F. (1995). Experts, networks, and inscriptions in the fabrication of accounting images: A story of the representation of three public hospitals. Accounting Organizations and Society, 20, 111-145.

Chua, W. F., & Clegg, S. (1989). Contradictory couplings: Professional ideology in the organizational locales of nurse training. Journal of Management Studies, 26, 103-127.

Chua, W. F., & Degeling, P. (1993). Interrogating an accounting-based intervention on three axes: Instrumental, moral and aesthetic. Accounting, Organizations and Society, 18, 291-318.

Clark, H. (1989). New Zealand health charter. Wellington: Minister of Health.

Colignon, R., & Covaleski, M. (1988). An examination of managerial accounting practices as a process of mutual adjustment. Accounting, Organizations and Society, 13, 559-579.

Comments on 'Unshackling the Hospitals'. (1988). New Zealand Hospital, 40(3), 5-8.

Coney, S. (1988, 15 May). The Gibbs health cure: More faith than foresight. Dominion, p. 10.

Controller and Auditor-General. (1978). Financial management and control in administrative government departments (B. 1 [PT.IV]). Wellington: Government Printer.

Controller and Auditor-General. (1994). Second report for 1994 (B. 29[94b]). Wellington: Government Printer.

Coombs, R. W. (1987). Accounting for the control of doctors: Management information systems in hospitals. Accounting, Organizations and Society, 12, 389-404.

Cooper, D. J., Hayes, D., & Wolf, F. (1981). Accounting in organized anarchies: Understanding and designing accounting systems in ambiguous situations. Accounting, Organizations and Society, 6, 175-191.

Cooper, M. H. (1988). Economics of health care: Challenges for the immediate future. New Zealand Medical Journal, 101, 718-720.

Cooper, R., & Kaplan, R. S. (1988). Measure costs right: Make the right decisions. Harvard Business Review, 66(5), 96-103.

Cooper, R., & Kaplan, R. S. (1991). Profit priorities from activity-based costing. Harvard Business Review, 69(3), 130-135.

Coulthurst, N., & Piper, J. (1986, September). The management accounting terminology labyrinth. Management Accounting (UK), 64, 28-30.

Covaleski, M. A., & Dirsmith, M. W. (1983). Budgeting as a means for control and loose coupling. Accounting, Organizations and Society, 8, 323-340.

Covaleski, M. A., & Dirsmith, M. W. (1988). The use of budgetary symbols in the political arena: An historically informed field study. Accounting, Organizations and Society, 13, 1-24.

Covaleski, M. A., & Dirsmith, M. W. (1990). Dialectic tension, double reflexivity and the everyday accounting researcher: On using qualitative methods. Accounting, Organizations and Society, 15, 543-573.

Covaleski, M. A., & Dirsmith, M. W. (1991). The management of legitimacy and politics in public sector administration. Journal of Accounting and Public Policy, 10, 135-156.

Cox, D. (1991). Health service management - a sociological review: Griffiths and the non-negotiated order of the hospital. In J. Gabe, M. Calnan, & M. Bury (Eds.), The sociology of the health service (pp. 89-114). London: Routledge.

Coy, D., Tower, G., & Dixon, K. (1994). Public sector reform in New Zealand: The progress of tertiary education annual reports, 1990-92. Financial Accountability & Management, 10, 253-261.

Davis, P. (1974). An occupational prestige ranking scale for New Zealand. (Research Report No. 24). Christchurch: University of Canterbury, Department of Psychology and Sociology.

Davis, P. (1981). Health and health care in New Zealand. Auckland: Longman Paul.

Davis, S. W., Menon, K., & Morgan, G. (1982). The images that have shaped accounting theory. Accounting, Organizations and Society, 7, 307-318.

Denzin, N. K. (1989a). Interpretive interactionism. Newbury Park, CA: Sage.

Denzin, N. K. (1989b). The research act: A theoretical introduction to sociological methods (3rd ed.). Englewood Cliffs, NJ: Prentice-Hall.

Department of Health. (1969). A review of hospital and health related services in New Zealand. Wellington: Author.

Department of Health. (1989a). Briefing notes for the Minister of Health. Wellington: Author.

Department of Health. (1989b). The public health: Report of the Department of Health for the year ended 31 March 1989 (E. 10). Wellington: Government Printer.

Department of Health. (1991a). Patient throughput statistics for quarter ended 31 March 1991 (amended). Wellington: Department of Health, Health Statistical Services.

Department of Health. (1991b).The public health: Report of the Department of Health for the year ended 30 June 1991 (E. 10). Wellington: By order of the House of Representatives.

Department of Health. (1993a). Annual report of the Department of Health for the year ended 30 June 1993 (E. 10). Wellington: Government Printer.

Department of Health. (1993b). RHA monitoring framework. Wellington: Author.

Department of the Prime Minister and Cabinet. (1993). Crown health enterprise performance reporting measures. Wellington: Author.

Dirsmith, M. W. (1986). Discussion of "Social environments and organizational accounting". Accounting, Organizations and Society, 11, 357-367.

Dixon, K. (1987). Application to the Health Workforce Development Fund: Facilitating the development of the financial management of hospitals. Unpublished document, Massey University, Department of Accountancy.

Dixon, K. (1989). Chartered accountants in the New Zealand public sector: Population, education and training, and related matters (Discussion Paper No. 90). Palmerston North: Massey University, Department of Accountancy.

Dixon, K. (1991). Information about fixed assets for internal management and external reporting purposes in the "Anonymous" Area Health Board. Unpublished manuscript, Massey University, Department of Accountancy, Palmerston North.

Dixon, K. (1992). The finance function in healthcare organisations: A preliminary survey of New Zealand area health boards (Discussion Paper No. 126). Palmerston North: Massey University, Department of Accountancy.

Dixon, K., Coy, D., & Tower, G. (in-press). Perceptions and experiences of annual report preparers. Higher Education.

The Dominion. (1994, 1 July). On the right track at last. Dominion, p. 10.

Drummond, M. (1989). How should claims for clinical developments be presented? In R. Akehurst, & M. Drummond (Eds.), Clinicians and the management of health care resources (pp. 45-56). Bristol: NHS Training Authority.

Eisenberg, J. M. (1986). Doctors' decisions and the cost of medical care. Ann Arbor, MI: Health Administration Press Perspectives.

Eisenhardt, K. M. (1989). Building theories from case study research. Academy of Management Review, 14, 532-550.

Elston, M. A. (1991). The politics of professional power: Medicine in a changing health service. In J. Gabe, M. Calnan, & M. Bury (Eds.), The sociology of the health service (pp. 58-88). London: Routledge.

Feek, C. M., & Carter, J. (1992). Look before you leap; Your health and the public health. State or market? New Zealand Medical Journal, 105, 294-296.

Ferreira, L. D., & Merchant, K. A. (1992). Field research in management accounting and control: A review and evaluation. Accounting, Auditing and Accountability Journal, 5(4), 3-34.

Fetter, R. B., Shin, Y., Freeman, J. L., Averill, R. F., & Thompson, J. D. (1980). Case mix definition by diagnostic related groups. Medical Care, 18(2, Supplement), 1-53.

Financial statements of the Government of New Zealand for the year ended 30 June 1993. (1993). Wellington: Treasury.

Flynn, R. (1992). Structures of control in health management. London: Routledge.

Forde, R. (1994, 10 March). Petition backing Pugmire launched. Evening Standard, p. 1.

Gillespie, W. J. (1983). A prospect for change. New Zealand Medical Journal, 96, 336-337.

The glib report. (1988, May). Public Eyes, pp. 1-5.

Gluck, F., Kaufman, S., & Walleck, A. S. (1982). The four phases of strategic management. Journal of Business Strategy, 2(3), 9-21.

Gray, A., & Jenkins, B. (1993). Codes of accountability in the new public sector. Accounting, Auditing and Accountability Journal, 6(3), 52-67.

Griffiths, R. (1983). National Health Service management inquiry: Letter to the Secretary of State for Social Services. London: Department of Health and Social Security.

Guba E. G., & Lincoln, Y. S. (1983). Epistemological and methodological bases of naturalistic inquiry. In G. F. Madaus, M. Scriven, & D. L. Stufflebeam (Eds.), Evaluation models: Viewpoints on educational and human service evaluation, (pp. 311-332). Boston, MA: Kluwer-Nijhoff.

Guba E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin, & Y. S. Lincoln (Eds.), Handbook of qualitative research (pp. 105-117). Thousand Oaks, CA: Sage.

Hay, D. (1992). Public sector accounting in New Zealand: An update and clarification. Financial Accountability & Management, 8, 1-6.

Health and Disability Services Act. No. 22 of 1993.

Health Benefits Review. (1986). Choices for health care. Wellington: Government Printer.

A Health Service for New Zealand. (1975). Wellington: Government Printer.

Hofstede, G. (1981). Management control of public and not-for- profit activities. Accounting, Organizations and Society, 6, 193- 211.

Hood, C. (1995). The "new public management" in the 1980s: Variations on a theme. Accounting, Organizations and Society, 20, 93-109.

Hopper, T., & Powell, A. (1985). Making sense of research into the organizational and social aspects of management accounting: A review of its underlying assumptions. Journal of Management Studies, 22, 429-465.

Hopwood, A. (1976). Accounting and human behaviour. Englewood Cliffs, NJ: Prentice-Hall.

Hopwood, A. G. (1983). On trying to study accounting in the contexts in which it operates. Accounting, Organizations and Society, 8, 287-305.

Hopwood, A. (1984). Accounting and the pursuit of efficiency. In A. Hopwood, & C. Tomkins (Eds.), Issues in public sector accounting, (pp. 167-187). Oxford: Philip Allan.

Horngren, C. T., Foster, G., Datar, S. M. (1994). Cost accounting: A managerial emphasis (8th ed.). Englewood Cliffs, NJ: Prentice-Hall.

Hospital and Related Services Taskforce. (1988). Unshackling the hospitals. Wellington: Author.

Hospitals Act. No. 40 of 1957.

Hospitals Amendment Act. No. 22 of 1988.

Humphrey, C., Miller, P., & Scapens, R. W. (1993). Accountability and accountable management in the UK public sector. Accounting, Auditing and Accountability Journal, 6(3), 7-29.

James, C. (1986). The quiet revolution: Turbulence and transition in contemporary New Zealand. Wellington: Allen & Unwin, and Port Nicholson.

Janger, A. R. (1979). Matrix organization of complex businesses (Conference Board No. 763). Amsterdam: Elsevier.

Johnson, H. T., & Kaplan, R. S. (1987). Relevance lost: The rise and fall of management accounting. Boston, MA: Harvard Business School.

Jones, R., & Pendlebury, M. (1992). Public sector accounting (3rd ed.). London: Pitman.

Jones, T., & Prowle, M. (1984). Health service finance: An introduction (3rd ed.). London: Certified Accountants Educational Trust.

Judson, J. A. (1985). Trauma management. New Zealand Medical Journal, 98, 8-9.

Kaplan, R. S. (1984). The evolution of management accounting. Accounting Review, 59, 390-418.

Kelly, M., & Pratt, M. (1992). Purposes and paradigms of management accounting: Beyond economic reductionism. Accounting Education, 1, 225-246.

Kilmann, R. H. (1989). Managing beyond the quick fix. San Francisco, CA: Jossey-Bass.

Kilroy, S. (1994, 30 May). Government signals more hospital cuts. Dominion, p. 1.

Lapsley, I. (1994). Responsibility accounting revived? Market reforms and budgetary control in health care. Management Accounting Research, 5, 337-352.

Laughlin, R. (1992). Empirical research in accounting: A case for middle range thinking. Unpublished manuscript: University of Sheffield, School of Management.

Laughlin, R. C., & Lowe, E. A. (1990). A critical analysis of accounting thought: Prognosis and prospects for understanding and changing accounting systems design. In D. Cooper, & T. M. Hopper (Eds.), Critical accounts (pp. 15-43). London: Macmillan.

Lawrence, S., & Dumble, P. (1991). Integrating financial accounts and information systems in the health sector. Accountants' Journal, 70(10), 65-67.

Levy, V. M. (1985). Financial management of hospitals (3rd ed.). Sydney: Law Book.

Lipsky, M. (1978). The assault on human services: Street-level bureaucrats, accountability and the fiscal crisis. In S. Greer, R. D. Hedlund, & J. L. Gibson (Eds.), Accountability in urban society: Public agencies under fire, (pp. 15-38). Beverly Hills, CA: Sage.

Loft, A. (1986). Towards a critical understanding of accounting: The case of cost accounting in the U.K., 1914-1925. Accounting, Organizations and Society, 11, 137-169.

Logan, R. L. (1993). Prescription for increasing cooperation between clinicians and managers in public hospitals. New Zealand Medical Journal, 106, 304-305.

Malcolm, L. A. (1984). Service development groups. New Zealand Medical Journal, 97, 183-184.

Markus, M. L., & Pfeffer, J. (1983). Power and the design and implementation of accounting and control systems. Accounting, Organizations and Society, 8, 205-218.

Marris, R. (1967). The economic theory of "managerial" capitalism. London: Macmillan.

Marwick, J. (1987). Quality and accountability. New Zealand Medical Journal, 100, 528-530.

McCulloch, B. W., & Ball, I. (1992). Accounting in the context of public sector management reform. Financial Accountability & Management, 8, 7-12.

McKean, W. I. (1985). The high cost of medicine: Decision Time. New Zealand Medical Journal, 98, 545-548.

McKinlay, P. (1990). Health sector reform. In P. McKinlay (Ed.), Redistribution of power? Devolution in New Zealand, (pp. 116-139). Wellington: Institute of Policy Studies.

McKinnon, J. (1988). Reliability and validity in field research: Some strategies and tactics. Accounting, Auditing and Accountability Journal, 1(1), 34-54.

McMahon, L. F., Fetter, R. B., Freeman, J. L., & Thompson, J. D. (1986). Hospital matrix management and DRG-based prospective payment. Hospital and Health Services Administration, 31(1), 62-74.

Meyer, J. W., & Rowan, B. (1983). Institutionalised organizations: Formal structure as myth and ceremony. In J. W. Meyer, & W. R. Scott (Eds.), Organizational environments: Ritual and rationality, (pp. 21-44). Beverly Hills, CA: Sage.

Michelman, J. E. (1988). The development and uses of accounting information for managerial reporting and control: In a healthcare setting. Dissertation Abstracts International, 48, 2382A. (University Microfilms No. 87-14,735).

Midcentral considers hospital closures. (1994, 26 May). Dominion, p. 1.

Miller, P. (1990). On the interrelations between accounting and the state. Accounting, Organizations and Society, 15, 315-338.

Miller, P., & O'Leary, T. (1987). Accounting and the construction of the governable person. Accounting, Organizations and Society, 12, 235-265.

Minister emphasises need to concentrate on health. (1989). New Zealand Health and Hospital, 41(3), p. 27.

Minister of Health. (1989). A contract for area health boards. Wellington: Department of Health.

Minister of Health. (1990). Area health boards standardised accounting formats. Wellington: Author.

Minister of Health. (1992). Directions for health and independence. Wellington: Author.

Ministry of Health. (1993a). Post election briefing (Vol. I). Wellington: Author.

Ministry of Health. (1993b). Post election briefing (Vol. II). Wellington: Author.

Mintzberg, H. (1979a). An emerging strategy of "direct" research. Administrative Science Quarterly, 24, 582-589.

Mintzberg, H. (1979b). The structuring of organizations. Englewood Cliffs, NJ: Prentice-Hall.

Mintzberg, H. (1985). The organization as political arena. Journal of Management Studies, 22, 133-154.

Mintzberg, H. (1987). Crafting strategy. Harvard Business Review, 87(4), 66-75.

Mintzberg, H. (1989). Mintzberg on management: Inside our strange world of organizations. New York: Free Press.

Mintzberg, H. (1991). The effective organization: Forces and forms. Sloan Management Review, 33(2), 54-67.

Mitroff, I. I. (1985). Why our old pictures of the world do not work anymore. In E. E. Lawler III, A. M. Mohrman, Jr., S. A. Mohrman, G. E. Ledford, Jr., & T. G. Cummings (Eds.), Doing research that is useful for theory and practice (pp. 18-36). San Francisco, CA: Jossey-Bass.

Morgan, G. (1984). Opportunities arising from paradigm diversity. Administration and Society, 16, 306-327.

Morgan, G. (1988). Accounting as reality construction: Towards a new epistemology for accounting practice. Accounting, Organizations and Society, 13, 477-485.

Morgan, G., & Smircich, L. (1980). The case for qualitative research. Academy of Management Review, 5, 491-500.

Morrison, A. (1993, 31 October). Big drop in pay drives nurses to strike. Sunday Times, p. 1.

Munro, M. (1994a, 1 July). Back in the black. Dominion, p. 1.

Munro, M. (1994b, 14 July). The legacy of Rogernomics. Dominion, p. 9.

National Advisory Committee on Core Health and Disability Support Services. (1992). Core services 1993/94. Wellington: Author.

National Interim Provider Board. (1992). Providing better health care for New Zealanders: Report to the government and the New Zealand public. Wellington: Author.

New Zealand Medical Association 1886-1986 Centennial Meeting Auckland 17-21 May 1987. (1988). New Zealand Medical Journal, 101, 287-358.

New Zealand Society of Accountants. (1987). Statement of public sector accounting concepts. Wellington: Author.

New Zealand Society of Accountants. (1990). Body of knowledge. Wellington: Author.

NHS\DHSS Steering Group on Health Services Information. (1984). A report on the collection and use of financial information in the National Health Service (Sixth report to the Secretary of State). London: HMSO.

Owen, F. (1983). A report on an investigation of hospital board budgeting in New Zealand hospital boards. Palmerston North: Massey University.

Pallot, J. (1991a). Accounting, auditing and accountability. In J. Boston, J. Martin, J. Pallot, & P. Walsh (Eds.), Reshaping the state: New Zealand's bureaucratic revolution (pp. 198-232). Auckland: Oxford University Press.

Pallot, J. (1991b). Financial management reform. In J. Boston, J. Martin, J. Pallot, & P. Walsh (Eds.), Reshaping the state: New Zealand's bureaucratic revolution (pp. 166-197). Auckland: Oxford University Press.

Patton, M. Q. (1990). Qualitative evaluation and research methods (2nd ed.). Newbury Park, CA: Sage.

Perrin, J. (1988). Resource management in the National Health Service. Wokingham, Bucks: Van Nostrand Reinhold.

Peters, T. (1988). Thriving on chaos. London: MacMillan.

Peters, T. (1992). Liberation management. London: Macmillan.

Pettigrew, A. M. (1985). Contextualist research: A natural way to link theory and practice. In E. E. Lawler III, A. M. Mohrman, Jr., S. A. Mohrman, G. E. Ledford, Jr., & T. G. Cummings (Eds.), Doing research that is useful for theory and practice (pp. 222-248). San Francisco, CA: Jossey-Bass.

Population trends and health. (1984). New Zealand Medical Journal, 97, 261-262.

Preston, A. (1986). Interactions and arrangements in the process of informing. Accounting, Organizations and Society, 11, 521-540.

Preston, A. M. (1992). The birth of clinical accounting: A study of the emergence and transformations of discourses on costs and practices of accounting in U.S. hospitals. Accounting, Organizations and Society, 17, 63-100.

Public accounts for the year ended 31 March 1987. (1987). Wellington: Government Printer.

Public Finance Act. No. 44 of 1989.

Reinken, J. (1988). In Report of the Royal Commission on Social Policy: Social perspectives (April Report No. 4) (pp. 41-87). Wellington: Royal Commission on Social Policy.

Roberts, J., & Scapens, R. (1985). Accounting systems and systems of accountability: Understanding accounting practices in their organisational contexts. Accounting, Organizations and Society, 10, 443-456.

Rose, N., & Miller, P. (1992). Political power beyond the state: Problematics of government. British Journal of Sociology, 43, 173-205.

Roslender, R. (1990). Sociology and management accounting research. British Accounting Review, 22, 351-372.

Ross, F. (1993, 17 December). Health papers point to hospital closures. Dominion, p. 1.

Ross, F. (1994a, 2 March). 100 job losses feared for hospital workers. Dominion, p. 3.

Ross, F. (1994b, 4 March). Health restructuring needed despite bailout, say CHEs. Dominion, p. 2.

Ross, F. (1994c, 15 June). Patients wait as rush goes on. Dominion, p. 1.

Ross, F. (1994d, 18 August). Rural GPs key to health package. Dominion, p. 1.

Salmond, G. (1988). Health management strategies: The need for research. New Zealand Medical Journal, 101, 720-722.

Sanderson, H. F. (1982). What's in a waiting list? British Medical Journal, 285, 1368-1369.

Scott, C. (1990). Health sector reform in New Zealand. Conference on Economic and Social Reform (pp. 119-160). London: UK/NZ 1990 Committee.

Scott, G., Bushnell, P., & Sallee, N. (1990). Reform of the core public sector: New Zealand experience. Governance: An International Journal of Policy and Administration, 3(2), 138-167.

Scott, G., & Gorringe, P. (1989). Reform of the core public sector: The New Zealand experience. Australian Journal of Public Administration, 48(1), 81-92.

Scott, W. R. (1977). Effectiveness of organizational effectiveness studies. In P. S. Goodman, & J. M. Pennings (Eds.), New perspectives on organizational effectiveness (pp. 63-95). San Francisco, CA: Jossey-Bass.

Scott, W. R. (1982). Managing professional work: Three models of control for health organizations. Health Services Research, 17, 213-240.

Scriven, M. (1973). The methodology of evaluation. In B. R. Worthen, & J. R. Sanders (Eds.), Educational evaluation: Theory and practice, (pp. 60-106). Belmont, CA: Wadsworth.

Seddon, T. D. S. (1983). Future developments of primary medical care in New Zealand: A view from practice. New Zealand Medical Journal, 96, 132-135.

Seddon, T. D. S. (1988). Addressing the iceberg: The hidden issues of area health boards. New Zealand Medical Journal, 101, 577-579.

Silverman, D. (1985). Qualitative methodology and sociology. Aldershot, Hants: Gower.

Silverman, D., & Gubrium, J. F. (1989). Introduction. In J. F. Gubrium, & D. Silverman (Eds.), The politics of field research: Sociology beyond enlightenment (pp. 1-12). London: Sage.

Social Security Act. No. 7 of 1938.

State Sector Act. (1988). New Zealand Hospital, 40(2), 4-9.

State Sector Act. No. 20 of 1988.

Stufflebeam, D. L. (1983). The CIPP model for program evaluation. In G. F. Madaus, M. Scriven, & D. L. Stufflebeam (Eds.), Evaluation models: Viewpoints on educational and human service evaluation, (pp. 117-141). Boston, MA: Kluwer-Nijhoff.

Swieringa, R. J., & Waterhouse, J. H. (1982). Organizational views of transfer pricing. Accounting, Organizations and Society, 7, 149-165.

Thomas, K. W., & Tymon, W. G. (1982). Necessary properties of relevant research: Lessons from recent criticisms of the organisational sciences. Academy of Management Review, 7, 345-352.

Tinker, A. M. (1985). Paper prophets: A social critique of accounting. London: Holt, Rinehart and Winston.

Tomkins, C., & Groves, R. (1983). The everyday accountant and researching his reality. Accounting, Organizations and Society, 8, 361-374.

Towards the reorganisation of health. (1983). New Zealand Medical Journal, 96, 125-126.

Treasury. (1989). Setting a new course (Video). Wellington: Immediate Creative Services.

Treasury. (1990). Putting it simply: An explanatory guide to financial management reform. Wellington: Government Printing Office.

Turner, R. (1989). Deconstructing the field. In J. F. Gubrium, & D. Silverman (Eds.), The politics of field research: Sociology beyond enlightenment (pp. 13-29). London: Sage.

Tuson, C., & Van Peursem, K. A. (1994). Financial reporting in area health boards 1987-1992 (Working Paper Series No. 19). Hamilton: University of Waikato, Department of Accounting and Finance.

Upton, S. (1991). Your health and the public health. Wellington: Minister of Health.

Van Maanen, J. (1979). The fact of fiction in organizational ethnography. Administrative Science Quarterly, 24, 539-550.

Vidich, A. J., & Lyman, S. M. (1994). Qualitative methods: Their history in sociology and anthropology. In N. K. Denzin, & Y. S. Lincoln (Eds.), Handbook of qualitative research (pp. 23-59). Thousand Oaks, CA: Sage.

Walsh, P. (1991). The State Sector Act 1988. In J. Boston, J. Martin, J. Pallot, & P. Walsh (Eds.), Reshaping the state: New Zealand's bureaucratic revolution (pp. 52-80). Auckland: Oxford University Press.

Weick, K. E. (1983). Stress in accounting systems. Accounting Review. 58, 350-369.

Young, D. W., & Saltman, R. B. (1983). Prospective reimbursement and the hospital power equilibrium: A matrix-based management control system. Inquiry, 20, 20-33.

Young, D. W., & Saltman, R. B. (1985). The hospital power equilibrium: Physician behavior and cost control. Baltimore, MD: John Hopkins University Press.

APPENDICES

Appendix A

A Synthesis of the Interviews with Commissioners and Senior Managers of Five Area Health Boards 1991

This synthesis comprises descriptions, explanations and opinions as expressed by the eight interviewees. The researcher has made a conscious effort to capture these faithfully and without drawing conclusions. Key words and phrases used by the interviewees have been put in speech marks without attributing them to particular interviewees.

According to the interviewees, hospital organisations used to operate on the dual premise that there were limits to the need for medical intervention as decided by doctors, and there was "an abundant supply of resources and dollars to deliver services". Accounting and economics were irrelevant because of "the lack of a perception that there was an optimisation problem." Capital was obtained by "pleading", and once procured was "free". Funding used to be entirely input oriented, and once physical resources were in the organisation, there was little accounting for how they were used. Costing was not required as an aid to allocating scarce resources since "resources were not scarce". Indeed, accounting systems were perceived as faulty and were little used. Costs could not be isolated to particular departments within a large single institution, or even an entire hospital organisation. However, in reality, a rationing problem did exist, and it was dealt with according to the availability of staff and facilities. The outcome was "rationing by the ability of people to wait."

In the 1980s, the recognition that there was a rationing problem was hastened by "reductions" in the funding which hospital organisations received from central government. Rationing was allied with such ideas as efficiency and cost-effectiveness. These were coupled with activities such as budgeting and costing. The change began after 1987 when accounting standards (NZSA, 1987) placed a non-statutory obligation on public sector organisations to improve annual reporting. The standards increased "the

dependence of hospital organisations on accounting data" and prompted the start of the recruitment of professional accountants. They also led to an increase in the number of people involved in reporting from among staff generally. From these beginnings things snowballed. The obligation to report was strengthened by legislation and ministerial directive (Area Health Boards Act 1983 as amended, Public Finance Act 1989, Minister of Health, 1990). Included in these changes was a requirement for hospital organisations to submit annual estimates to the Minister, and for general managers to make monthly reports to the Department outlining how spending compared with the amounts provided in these estimates. Out of this, the Department of Health's contract negotiating and monitoring process eventuated (see below). The concept of "*living within one's income*" (i.e., one's budget) gained prominence, and budget setting and control were introduced within hospital organisations.

The introduction of budgeting systems was accompanied by the establishment of responsibility centre structures. Each centre had a financial as well as a service orientation. These blended well with service management structures which had been introduced as part of general management after 1988[1]. More staff in both clinical and non-clinical areas started to receive, utilise, and be answerable on the basis of accounting data. There was a growth of "consciousness among clinical and non-clinical managers over costs, resource usage and the need to work within budgets." Similarly, staff realised they were "accountable" for the resources they were granted and for the way these were consumed.

By 1991 the picture which emerged was one of "very dynamic organisations", both in terms of formal processes and structures, and of people and the ways things were being done. It was a picture in which "learning" featured significantly, along with growth in

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[1]This coincided with the passing of the State Sector Act of 1988. This Act was consistent with the principle of introducing business management into government organisations (Walsh, 1991). It enabled the establishment of hierarchical structures, formal chains of responsibility, command and accountability (Treasury, 1990) and the image of unity of corporate purpose in the public sector as a whole. In the health sector, this led to the appointments of general managers at the helm (Treasury, 1989, used the analogy of a Cook Strait ferry captain to make its point) of each hospital organisation, and the creation of formal service management structures and processes.

several aspects. There were formal requirements for clear, quantified and temporal statements of missions and goals. "Planning had increased out of all recognition", and monitoring had been improved giving rise to "information flows about patterns of demand for services and costs". Internally, many more people were responsible and answerable for decisions related to resources, and the form of external accountability was "much more focused." There was a general recognition that the problem of scarce resources and the rationing process had become more explicit. The interviewees felt that this process was "infinitely superior" and the outcome "more optimal" in the sense of "maximising the value obtained from the dollars spent on healthcare services from the public purse." Even so, the process still involved "making controversial judgments which had political undertones."

Annual operating contracts between the Department of Health and each hospital organisation were a primary impetus to planning within hospital organisations. These contracts were also associated with accountability in that officials were answerable for "achieving everything that was set out in [their organisations'] contracts." Financially, this accountability encompassed capital and debt, as well as operational expenditures. However, the latter were the main feature of the contracts, and the budgets for them showed "the intended distributions of the funds" that were granted, and allowed spending to be "monitored" by the Department's analysts.

Annual operating contracts were instituted for the 1990-91 financial year. Initially, these contracts were limited to a broad description of services and the amounts to be spent on each one. The corresponding contracts for 1991-92 contained "much more specific agreements about service volumes and costs." People at commissioner and senior management level were involved in negotiating each year's contracts with Department of Health officials. The perception of the general outcome of the negotiations was that "service level targets [were] being raised," and probably more responsibilities were being put onto organisations "without extra money to fulfil these." Indeed, if anything, funding was seen as being cut. Although the contracts were supposed to be negotiated between "equal partners at arms length," the Department was perceived as having the "upper hand" because it determined the total amount of each organisation's annual

operating grant and it was the Minister who eventually arbitrated in cases of failure to agree. Even so, these negotiations were taken seriously by the hospital organisations and revolved around what each organisation should do with the total grant it was to receive.

The determination of the amount of grant was based on a population-based funding formula which, although it had been applied for some years, was still gave rise to adjustments in funding allocations compared with the period before the formula was used (Advisory Committee on Hospital Board Funding, 1980; Health Benefits Review, 1986). Thus, some of the funding cuts which imposed on hospital organisations across the board were due to adjustments towards bringing historical based funding into line with the formula. In any case, the formula was controversial because it "assumed a linear relationship between population and health costs throughout New Zealand," whereas the interviewees were unanimous that size, population density, geography and demography, and the historical distribution of facilities and services, all confounded this assumption. They all made points about the idiosyncrasies of their areas and the people residing there, not only from a health perspective, but also economically, socially and culturally. Nevertheless, the organisations' negotiators found it "very difficult to persuade the Department officials" that the costs of providing services behaved differently from the standards implied by the formula.

The general perception of accounting as a discipline was that by 1991 it was playing a significant, even "vital", role in hospital organisations. The size and shape of this role were "relatively new and still emerging." Basically, accounting information was "dual purpose" in that not only was it disseminated internally as part of planning and monitoring, but it was also part of externally accountability processes, including through published financial reports. It was "the obligation to report externally" that had acted as the "original stimulus" to accounting's emergence in hospital organisations in the period 1988 to 1991. However, the main factor in its continuing rise was "the realisation that the resources available to healthcare are scarce." This drove the demand for data throughout hospitals and other operating facilities, as well as in central administration. The job of gathering, processing, monitoring and reporting on the

financial outcome of actual events compared with the budget fell to accountants and the central finance function because of their particular skills. However, both staff and external parties needed to believe that the data being produced by accountants and accounting systems were of "reasonable quality and relevant to making decisions" before they would use the new systems. The interviewees felt that this had generally been achieved, and attributed this to "increased professionalism" shown by the accountants, many of whom were recent recruits to the organisations. This professionalism included the meeting of NZSA (1987) standards in preparing annual reports.

The interviewees saw facilitating "budget setting and budgetary control processes as a key role" of accountants within their organisations. However, the planning and controlling decision-making inherent in these processes was not confined to accountants; it was "a much wider team effort" at senior management level, and involved many people throughout the organisations. Thus, commissioners, general managers and other senior managers met on a regular monthly basis to discuss, among other things, various reports. These emanated usually from the finance managers and included the general managers' monthly reports to the Department.

The establishment of responsibility centres was indicative of moves by hospital organisations towards "decentralisation and devolution." It was generally seen as "very desirable," even "vital," that decisions were made at the "point of service delivery." This was where "the in-depth knowledge" was located as the decision makers were "close to the facts." It was thought that central decisions should be limited to broad policy matters and evaluation of responsibility centres' performance. All these centres had managers and were operating financially either as expense centres or, in a few cases, profit centres. Their managers were "answerable to more senior managers for any material variations" from budgets. For this, it was seen as essential that the parties concerned had "accounting information which was relevant for a variety of purposes." Services and costs were interrelated throughout the organisations and the interviewees generally believed that their organisations were becoming "more cost effective," and that services were being "strengthened in the face of financial stringency."

Data were being generated within organisations and RUS was one system mentioned by the interviewees. However, it was not clear to what extent data were utilised. While people at the centre of hospital organisations might have wished that accounting and other data were used to make decisions about the allocation of resources, there was considerable doubt about whether staff were generally aware of fundamental concepts such as "differential costs, marginal costs, opportunity costs" and similar decision-relevant costs. On the other hand, there was evidence that some people thought of the consequences of one course of action in terms of the number of alternative courses of action foregone. Thus, for example, "the cost of an operation might be expressed in terms of the equivalent number of by-pass operations." In any case, it was thought that there was an ever increasing need for "more sophistication" both in terms of systems and in terms of staff knowledge. In some cases the organisations' operations were "outgrowing their existing computer systems" and new ones were expected to cost significant amounts of time and money.

While it was recognised that information could infiltrate every decision, it was recognised that calculating costs cost money. Hospital organisations could not afford to "know the cost of everything and nobody wanted that anyway." Given some continuous scale between absolutely no data and data saturation, hospital organisations moved towards having more data. The problem was that developing data capacity was like "going into unfamiliar territory without a compass." However, the interviewees were reasonably enthusiastic about "more tailored information flowing to all appropriate levels" of their organisations. As to who should be responsible for that development, they perceived that accountants would be involved, but that the demarcation between accounting and other skills was "fuzzy".

The interviewees reported that as acceptance of, and dependence on, accounting data increased in the way described above, so did the status of accountants. As a consequence, they had become "more visible and more powerful" in the running of hospital organisations. This change was not without some counter reaction from groups, such as elected board members, other administrators, and health professionals. The way the latter viewed accountants was also adversely affected by a traditional, philosophical

tension existing between administrators and health professionals. This was attributed to health professionals perceiving central administrative people in particular as "going about their business in a generally intrusive way."

It was thought that the extent of intrusiveness was perceived by health professionals to increase as more formal managerial positions were created both centrally and at service and responsibility centre level in the period 1989 to 1991. Indeed, initially there was some opposition to this, founded on "an underlying anxiety" among doctors, nurses and other staff in clinical and non-clinical support services functions that information would be used to make changes that would "clobber" them and their services. After a while, the unpopularity and opposition among most staff had "mellowed" because change had been "relatively successful." Probably what had also helped were initiatives such as "bottom-up budgeting" involving those professionals who had been allotted some managerial responsibilities. However, among staff generally there was "still a lot of apathy." They tended to see accounting as "irrelevant or not their concern", and in any case, were "too busy to bother." They were sceptical about the outcome of management intervention, and found such information as the general managers' reports "largely beyond them." Moreover, accounting still had its opponents, and they were using "occasional errors" in order "to try to challenge and undermine the credibility of the whole process."

Appendix B

27 July 1992

Potential Interviewee's Name
Official Title of Position Held
"P" Hospital
Address

Dear Name

Healthcare Budgeting Case Study

I have been given your name as a potential participant in the above case study by [Name of Assistant] in the business manager's office. I understand that she has forewarned you about this approach. I am now writing to acquaint you with the study and to invite you to participate.

The basic purpose of my work is to develop an understanding of the nature, role and influence of accounting in health authorities and this is one of three case studies which I am using to collect data. In connection with this particular case, it is my intention to visit individually with about 15 people who are in a variety of clinical, support service and administrative roles.

Should you agree to participate, then I should like to meet with you when it is mutually convenient during August, September or October. Our meeting would take the form of a semi-structured interview/discussion of between 30 and 75 minutes duration. We would discuss your experiences and perceptions of the budgeting process. I would use a series of topic questions in order to guide our discussion but these would be very open ended so as not to prejudice what you tell me about the way you perceive the process.

Any data I obtain from you will be kept in strict confidence and would not be available to anyone other than myself. Following our meeting I would write to you setting out

a record of the discussion based on my notes and inviting additional thoughts, corrections and comments.

Combining the data available from all people I visit, I would write up the case without prejudicing your anonymity to anyone, or prejudicing the anonymity of the Board to the outside world. The initial and subsequent drafts of the case write up would be passed back to all participants for comment, and only the final version would be generally available. I am sure that in this final form the case study will provide interesting insights into the process for the people involved with it as well as students of the subject.

The case data would then be combined with that from other cases leading to a comprehensive overview paper discussing the nature, role and influence of accounting in health authorities. This I would intend to publish.

I hope that this outline is agreeable to you.

As indicated above, I hope to visit "P" Hospital on various days during August, September and October. I shall contact you in a few days time to find out whether you would like to participate, and if so, to arrange an appointment. If your participation does eventuate, I should be grateful if you would return the enclosed informed consent form at some time in order for me to comply with the University's code on human ethics.

I look forward to meeting you.

Yours sincerely

KEITH DIXON
Research Project Team Leader

The nature, role and influence of accounting in public sector secondary healthcare in New Zealand

PARTICIPANT'S CONSENT FORM

Keith Dixon has explained the reason for his study and the procedures involved in it. I have read the information letter and any questions have been answered to my satisfaction. I understand that I am able to raise issues at any time during the study, and that I am able to withdraw from it at any time. My right to privacy will be respected such that I can divulge as much or as little information as I myself decide. I understand that information collected during the study will be treated in strict confidence and will be known only to the researcher and myself. I will not be identified by name in any material emanating from the study.

I therefore give my consent to take part in this study.

Signed: _____

Name: **Potential Interviewee's Name** (Participant)

Date: _____

Signed: _____

Name: **Keith Dixon** (Researcher)

Date: _____

Appendix C

SITE "P" BUDGET PROCESS INTERVIEW GUIDE

1. How would you describe your job?

2. How long have you been with the Hospital?

3. And, how long in this job?

4. I understand that a budget was recently compiled for the time being. How were you involved in the process of compiling this budget and how did you go about it?

5. From your angle, how was the process of putting this budget together carried out in the organisation?

6. How has what we have just been talking about changed in recent years?

7. How does the present budget feature in your dealings with other people in the organisation?

8. From your angle, how is the budget figuring in the organisation?

9. How do these last two compare with previous years?

10. How do you perceive the present budget?

11. How has this perception changed in recent years?

12. How do you obtain knowledge of the other budgets in the organisation?

13. How does this knowledge figure in what you do?

14. There was a budget for last year I believe. How is the budget for last year figuring in what you are doing at present?

15. How does this compare with previous years?

16. How does the budget figure in what you do as the year progresses?

17. How does this compare with previous years?

18. How do you perceive budgeting figuring in future?

19. How do you feel about budgeting?

20. How have these feelings changed?

21. How much influence do you perceive yourself having in the budgeting process?

22. How important do you find the foregoing?

23. How interesting do you find the foregoing?

24. How do you perceive other people's feelings about the foregoing?

25. How often are you asked your opinion about budgeting?

26. Is there anything else you wish to add?

SITE "Q" COST DATA INTERVIEW GUIDE

1. How would you describe your job?

2. How long have you been with the Hospital?

3. And, how long in this job?

4. I understand that cost data is available to you. How is this data compiled?

5. How is it disseminated?

6. How are you involved in compiling and disseminating this data and how have you gone about it?

7. How does this compare with the previous era?

8. How does cost data figure in what you do?

9. How does this kind of cost data feature in your dealings with other people in the organisation?

10. How do you perceive it figuring in what other people do?

11. How do you perceive it figuring in the organisation as a whole?

12. How does this compare with the previous era?

13. How do you perceive the consequences of cost data?

14. How do you obtain knowledge of costs in other parts of the organisation?

15. How does this knowledge figure in what you do?

16. How do you perceive cost data figuring in the organisation in future?

17. How do you perceive cost data figuring in your job in future?

18. How much influence do you perceive yourself as having in the compiling, disseminating and applying of cost data?

19. How do you perceive cost data affecting you?

20. How do you perceive cost data affecting the organisation?

21. How do you perceive cost data affecting people outside the organisation?

22. How important do you find the foregoing?

23. How interesting do you find the foregoing?

24. How do you perceive other people's feelings about the foregoing?

25. How often are you asked your opinion about cost data?

26. Is there anything else you wish to add?

SITE "R" ANNUAL REPORT INTERVIEW GUIDE
PREPARER VERSION

1. What is your job and how do you carry it out?

2. How long have you been with the Board\hospital?

3. And, how long in this job?

4. I understand that the 1991-92 report has been compiled recently. From your angle, how was this compilation process carried out?

5. How have you been involved in this process and how did you go about this?

6. How does what you have outlined compare with previous years?

7. How were the changes conceived?

8. How surprised were you by what the annual report showed?

9. How many copies of the annual report are being printed?

10. How does this compare with previous years?

11. How do you expect the annual report to be distributed?

12. How does this compare with previous years?

13. How did you deal with press/media reactions when the last report was published/distributed?

14. How did you deal with popular reactions when the last report was published/distributed?

15. How does annual reporting affect you?

16. How does annual reporting affect your part of the organisation?

17. How does annual reporting affect the organisation as a whole?

18. How does annual reporting affect people outside the organisation?

19. How does these effects compare with previous years?

20. How else does annual reporting figure in what you do?

21. How does this compare with previous years?

22. How do you perceive annual reporting figuring in the organisation in future?

23. How do you perceive annual reporting figuring in your job in future?

24. How do you feel personally about the various changes you have talked about?

25. How important do you find the foregoing?

26. How interesting do you find the foregoing?

27. How do you perceive other people's feelings about the foregoing?

28. How often are you asked your opinion about annual reporting?

29. Is there anything else you wish to add?

SITE "R" ANNUAL REPORT INTERVIEW GUIDE
RECIPIENT VERSION

1. How would you describe the organisation with which you are connected?

2. How would you describe your job?

3. How long have you been with the organisation?

4. And, how long in this job?

5. I understand from the [SITE R] Area Health Board that your organisation receives copies of its annual reports each year. How are you interested in the [SITE R] Area Health Board including the hospitals and other facilities/activities with which it is involved?

6. How does this interest figure in your job?

7. In particular, how do the annual reports of the Board figure in your job?

8. How have any of the above changed in recent years?

9. How do you perceive any of them changing in the future?

10. Which was the last Board annual report received? And when?

11. How did this report in particular figure in your job?

12. How did you respond directly to the [SITE R] Area Health Board after receiving this last report?

13. How did any media reports you saw stemming from the last report figure in your job?

14. How do items about the Board other than its annual report figure in your interest in the Board?

15. How does these items figure in your job?

16. How has this changed in recent years?

17. How do you perceive this changing in the future?

18. To your knowledge, how do the [SITE R] Area Health Board's annual reports figure in the work of other people in your organisation?

19. How do these reports figure in the way your organisation behaves?

20. How has this changed in recent years?

21. How do you perceive this changing in the future?

22. How do you perceive other organisations and people being affected by the Board's annual report?

23. How has this changed in recent years?

24. How do you perceive the [SITE R] Area Health Board having changed as a result of changes in its annual report and popular reaction to the affects of those changes?

25. How satisfactory was the form and content of the report?

26. How satisfactory is the timeliness of the report?

27. How should you like to see the report change in the future?

28. How do you expect the report to change in the future?

29. How satisfactory are the form, content and timeliness of other items you obtain about the Board?

30. How should you like these items to change in the future, including additional items?

31. How important do you find the Board's annual reports?

32. How interesting do you find their reports?

33. How do you perceive other people's feelings about the reports?

34. How do you feel personally about the changes which have been made to the reports in recent years?

35. Is there anything else you wish to add?