The Role of Management Accounting in New Public Management Reforms: Implications in a Socio-Political Health Care Context
The Role of Management Accounting in New Public Management Reforms

Implications in a Socio-Political Health Care Context.

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Afhandlingsens forsknings tilgang fokuserer på økonomistyring som en social videnskab fremfor naturvidenskab. Symbolsk diskurs og social konstruktion er den ontologiske synsvinkel hvor virkeligheden opfattes som en integreret del af meninger og normer skabt igennem individuel erfaring og delt i socialt rum. Afhandlingen tager dermed et kritisk fremfor en traditionel tilgang hvor dannelse af et holistisk billede er tilstræbt.


som illustrerende et passende service kvalitets niveau. Disse kvantitative termer har rod i økonomistyringens terminologi igennem stærke rationelle argumenter, hvor tal bliver fremhævet og beskrevet som faktuel data hvilket besværliggør en diskussion. Dette setter sundhedspersonalet i et dilemma, hvor læger for eksempel til tider er i konflikt med lægeløftet, og de trækker sig fra den offentlige debat. Til gengæld adopterer de på sigt en tilsvarende økonomistyrings diskurs i deres egen debat i blandt andet tidsskrifter som ’Ugeskrift for læger’. Det er dermed demonstreret hvorledes økonomistyrings terminologi bliver et centralt element i den offentlige sundhedsdebat omkring Struktur Reformen i Danmark.

Ved gennemgang af fire forskellige studier med fire forskellige tilgange og belysninger af økonomistyringens rolle i udviklingen af NPM sundhedsreformer, står det klart at økonomistyring spiller en intensiverende og bæredygtig central rolle som kommer til udtryk i retorikken omkring den offentlige sundhed, i implementerede teknikker hvorved det offentlige sundhedsvæsen udøves, og i den sociale forståelse af hvad et godt sundhedsvæsen indeholder. I de fire studier er der gentagne interessante emner, så som økonomistyringens paradoksale rolle i sundhedssektoren hvor det simplificerer og forstærker budskaber, men dermed også reducerer den bagvedliggende abstrakte viden. Dermed opstår der til tider spændinger imellem professioner som økonomer, politikere og sundhedspersonale. Et andet element er de kulturelle 'overraskelser' som opstår ved forskellen imellem NPM reformers implementeringsprocessor i forskellige nationale kontekster hvilket resulterer i forskellige udfald og en tilførende kompleks forståelse af hvad offentligt sundhedsvæsen er og bør være. I sammenhæng med dette er den historiske vinkel som afslører afbrydelser og linearitet som ikke er umiddelbar i en nuværende og afskåret analyse af økonomistyring i sundhedsvæsenet. En essentiel deltagere i økonomistyringens udvikling er for eksempel verdenssundhedsorganisationen (WHO). I WHO’s perspektiv spiller økonomistyring en væsentlig rolle i udviklingen af et velfærdssamfund, og analyse af WHO’s dokumenter frembringer et alternativ til dette struktureret og til tider overdimensionerede velfærdssamfund som findes i udviklings- og overgangslandene hvor korruption, fattigdom og krig er de centrale elementer. Det er dog vigtigt at forstå økonomistyringens terminologiens magt i velfærdssamfundene. Økonomistyringsterminologien er blevet adopteret af adskillige andre professioner, og i et social politisk NPM sundhedsreform kontekst er det ikke selve økonomistyringens profession som er dominerende, men dets teknikker og begreber. Disse teknikker og begreber har overlevelt NPM markedsbølgen. New Zealand illustrerer et eksempel hvor økonomistyringsbegreberne og teknikkerne består selv ved økonomisk tabu. Dermed kan det konkluderes at
økonomistyringsteknikker og terminologi i form af ranking, målstyring, DRG omkostningsudregninger, og budgetter er vedvarende essentielle i sundhedsvæsenet. Disse bringer struktur, klarhed og simplicitet som belæg for beslutningstagning. Konsekvenserne ved denne dominans bør dog i større grad inddrages og diskuteres i den fremtidige udvikling af sundhedsvæsenet.

The theme of this dissertation is the role of management accounting through health care reforms in a socio-political perspective. The starting point is the international theory and philosophy New Public Management (NPM). NPM illustrates a hybrid of management accounting concepts and techniques with public health strategies and initiatives. The main elements in NPM are decentralization, accountability, transparency, and efficiency. This has through reforms been implemented in several nations by intensifying market mechanisms and accounting information. In Denmark, NPM was intensified through a recent Structural Reform, and Denmark thereby form an illustrative case example in this dissertation. The dissertation will through four studies answer the research question *What is the role of management accounting in the development of public health care through NPM reforms?*

The research approach focuses on management accounting as a social science rather than natural science. Symbolic discourse and social construction are the ontological perspective where reality is perceived as an integrated part of opinions and norms created through individual experience and shared in social space. The dissertation thereby takes upon a critical rather than traditional approach with the aim of pursuing a holistic picture and framework.

The first study is entitled “*The historical development of management accounting discursive role in NPM reforms.*” This paper investigates the historical and discursive development of management accounting in health care through general history, organisational and national documents along with academic literature. The framework is informed by the governmentality concept described by Miller and O’Leary (1987) and this is used to reflect on developments in the past century including the
role of discursive formation and practice. It is found that, after the Second World War, the World Health Organisation (WHO) along with the Anglo-American nations play a major role in the formation of NPM reforms and the integrated development of management accounting. In particular the Alma-Ata declaration in 1978 has a specific integrated management accounting description of the process to achieve better health care. This is followed by multiple NPM reforms during the 1980s and 1990s. Management accounting themes of performance measures and Diagnosis-Related group costing method become vital techniques in the health care improvement, and these techniques sustain the dismissal of market reforms in later 1990s. The current health care theme of quality, also integrated in WHO documents, is supported by performance indicators, stemming from management accounting. An additional finding is the various national stages and roles where the meaning of management accounting techniques and NPM reforms differs, but it is found specifically vital in the formation of health care systems in developing and transitional nations. Despite type of reform, public health care level, and national influences and changes, management accounting techniques play a dominant and prevailing role.

The second study is entitled “Demonstration of economic arguments in the public health care debate – a case from Denmark.” This study uses discourse theory to investigate the role of management accounting terminology, stemming from neoclassic economics, in the public health care debate after a Structural Reform was introduced in Denmark. The purpose is to examine the importance of management accounting in the NPM discourse and its influence on the initial aim of the reform which was to promote a focus on service quality. 88 newspaper articles and 18 medical profession articles are analysed from 2002 to 2008, using critical discourse analysis. The analysis shows that the management accounting discourse becomes an ideology which is embedded in the social practice of health care. This creates a phantom phenomenon involving the negative
consequences of the reform being blamed on the system. The health care profession is also victimised. As a result service quality in the sense of the patients’ well-being does not exist. On the contrary, service quality is identified with quantitative measurements rooted in the management accounting tradition through strong rationalised arguments. This puts the profession in a dilemma where the physicians withdraw from the general public debate, but adopt management accounting terms in their own professional debate over the years. The study therefore demonstrates how management accounting terminology becomes a central aspect of the debate on health service purpose and development in Denmark.

The third study is entitled “The interplay of management accounting research and NPM health initiatives.” This paper investigates the development of management accounting research in the context of New Public Management (NPM) initiatives in health care. Drawing on concepts from diffusion theory and earlier literature reviews, the paper examines the interplay between management accounting research and health care reforms in relation to country of origin, development, theoretical approach, research method and topic. The study thus establishes a different focus; namely the interrelationship between the development of management accounting research and practical socio-political NPM innovations. 190 management accounting papers are analysed, over a period of 30 years, and related to 23 health initiatives in an established diffusion analytical framework. The study shows that management accounting techniques are increasingly adopted in governmental health reforms and diffused across nations, themes and initiatives through time with the result that wider social practices become more and more integrated in management accounting research themes. Additionally, The role of management accounting research and the impact of increased NPM health care legislations show how research is driven by governmental issues. Thus management accounting research takes upon a reactive role.
The fourth study is entitled "Riding the waves of NPM – from New Zealand to Denmark." This study compares New Public Management (NPM) implementation in New Zealand and Denmark. New Zealand implemented NPM a decade or more before it was introduced in Denmark. The purpose is to illustrate how different national set-ups, history and assumptions of health care along with timing have an effect on the impact of NPM and role of management accounting. Drawing on a developed contingency model, similarities and differences within initiatives, contexts, processes and contents are identified. The model is applied in a flexible way by adding a time dimension in order to compare NPM implementations in New Zealand and Denmark despite their time lags. Health initiatives are studied from a historical perspective and interviews are made in both countries on the managerial level in order to capture specific current mechanisms. A reason for the time difference in NPM adaption can be found in the history of the institutions and the cultures of the two countries. New Zealand’s rapid reform changes display flexibility and willingness to adapt whereas Denmark’s history with a strong medical profession results in a slower decision making process. Additionally, the modes of implementation differ greatly; New Zealand, during its NPM transition, focused on competitive elements along with performance measures whereas Denmark focused primarily on work productivity and funding sanctions and rewards. This study contributes to the understanding of differences in NPM outcomes across nations and illustrates the importance of bearing a health care’s set-up, background and assumptions in mind when implementing a management control system at a practical level. Finally, a flexible contingency model is developed by adding a time dimension which has not been done in earlier studies.

The four studies have analysed the role of management accounting in NPM reforms through four different approaches. It is clear that management accounting play a central and intensifying role which is expressed through the rhetorical use of reforms and documents in health care. In the four
Studies some reoccurring themes are evident. These are the paradox of management accounting in health care where the messages are simplified by the use of management accounting terms; tensions between professions; cultural surprises emerging due to national differences in background, health care set up and implementation processes; historical discontinuities and linarites; the power of management accounting terminology and techniques through manifestation of descriptive facts; the influence of management accountants versus management accounting on this development; and finally the distinction between definitions of accounting and economics.
Chapter 1

Introduction

“...the possibilities for new accountings, let alone the practices of today, are shaped by socio-political values, legal presumptions, modes of bargaining, statutes and governmental regulations and a whole array of other institutional practices and bodies of knowledge that tie accounting to the contexts in which it operates.”

Anthony G. Hopwood, 1992, p.128
Health care expenses have tripled across the OECD countries during the past 30 years (OECD 2011) stimulating a focus on economy (Ashton 2001; Bates and Brignall 1993; Bourn and Ezzamel 1986; Covaleski and Dirsmith 1983; Groot 1999; Lowe 2000; Preston et al. 1992) often with a management accounting orientation stressing efficiency, cost control, budgeting and management control types (Hood 1995; Jackson and Lapsley 2003; Lapsley and Wright 2004; Pettersen 2001, 2004). At the same time, general living standards and the patients’ information level have increased resulting in greater demands and participation in decision making at various levels (Vrangbæk 2006). This has caused a trend towards commercialisation in the public sector (Walker et al. 2011). As a result policy makers have constantly pursued better managerial solutions for the public health care sector and have turned their attention towards the New Public Management (NPM) philosophy (Christensen 2007; Groot and Budding 2008; Hood 1995; Whitcombe 2008; World Health Organization 2000).

Likewise, the role of management accounting is increasingly expanded and diversified (Baldvinsdottir et al. 2009; Baldvinsdottir et al. 2010; Jeacle 2008; Pierce and O'Dea 2003). Traditionally, management accountants have played an objective and detached role, analysing numbers in comprehensive and logical ways (Jeacle 2008). Similarly, accounting research used to focus on technical aspects of accountings past concentrating on good planning, costing practices and reporting (Hopwood 1987). But now, in practice, it is no longer enough to prepare the quarterly balance sheets, register the data and do the financial reporting. There is a growing demand for innovative accounting, non-financial performance measures, organisational strategies and behavioural considerations in the functions of the management accountant (Baldvinsdottir et al. 2010; Juhani 1999). Likewise, management accounting research includes increasingly more studies on the underlying processes of accounting, and organizational and social transformations coupled with accounting change (Baxter and Chua Wai 2003; Broadbent and Guthrie 2008; Hopwood
Concurrently with the spread of management accounting techniques to the public sector, pressures for quality of care combined with costs containment in order to ensure sustainability and excellence within a specific budget are present (Carolyn J 1999; Llewellyn 1993). The social action of management accounting has become more urgent and evolve through social practice rationality rather than technical rationality (Hopwood 1987, 2007; Jones 1992; Miller 1994).

The focal point of this PhD dissertation lies in the interface between governmental reforms, the health care sector and management accounting. As illustrated in figure 1, it is the common zone of these three areas which is studied. The idea is to explore the combined development of the three themes paying specific attention to the role and shape of management accounting in the health care sector through the discursive distribution channel of governmental reforms. This type of formation is also referred to as hybridisation (Kurunmäki 2008; Miller et al. 2008), where “hybrids are defined as new phenomena produced out of two or more elements, normally found separately.” (Miller et al. 2008, p.943).

Figure 1:
The New Public Management philosophy is an illustration of such a hybrid, and NPM covers part of the conceptual combination shown in figure 1. Using a range of research approaches this PhD dissertation aims to investigate the diffusion of management accounting ideas and fractions through NPM reforms in the socio-political health care context with the purpose of improving the understanding of the discursive role of management accounting and its influence on the wider social practice of health care. Four different studies are made. First, the role of management accounting through the development of NPM in a historical context is studied with the aim of providing an outline of the development and assessing the path of NPM in the current diversified and cross-national discourses of NPM. This study lays a holistic foundation for the second study which is more specific. The second study is a national case study of Denmark investigating the specific discursive role of management accounting in the public and professional media debates on NPM reform. The third paper is an extension of the first study with a specific focus on the diffusion of management accounting through academic research and health care initiatives, providing further insights into the findings in the second study as well. Based on the two historical and holistic studies and the case study of Denmark, the fourth study provides a comparative study of the historical development of the specific health care reform settings of New Zealand and Denmark. Overall, the four studies outline the historical development and combination of the role of management accounting and the development of NPM in health care through governmental reform settings. The role of management accounting is studied through communication and is thereby discursive in two different ways; first, it is concerned with the written representation of management accounting terms through governmental reforms, management accounting literature and media. This type of linguistic discourse refers to the work of Fairclough (Fairclough 1992, 1995). Second, it is the specifying socio-historical elements as in discursive formation. Discourse
formation consists of rules for the formation of ‘concepts’ and ‘strategies’ constituted by prior elements which, in combination, makes discourse a social practice (Fairclough 1992; Foucault 1972). Drawing on Foucault’s work, it is the idea to capture the present by analysing the historical background. In other words, each of the four studies seek to capture the present state of the role of management accounting at the socio-political level by studying the historical development and spreading through different methods.

Thus, taking a socio-ideological perspective, the objective of this study is to investigate different aspects of the role of management accounting in the socio-political settings of health care influenced by NPM reforms. The aim is to examine the development and the emergent paradoxes and consequences of using management accounting and NPM in a social service like health care. The general research question is:

**What is the role of management accounting in the development of public health care through NPM reforms?**

A longitudinal and holistic approach is applied in all papers where development over time plays a central role. Using a discursive approach in two studies, a diffusion approach in the third and a contingency approach in the last paper, the dissertation will look at the different dualities, power relations and influence of management accounting on health care. A common focus for all studies is the development of the role of management accounting and NPM, its spreading and different types of discursive manifestations.

As background and justification for the studies, an introduction is provided to explain the nature of NPM and briefly examine previous research literature to identify prior research focuses and new research opportunities. Extensive research literature is integrated in the first and third study. The remainder of the introduction will be structured as follows; (1) the NPM concept is explained, (2)
NPM implications and studies are highlighted, (3) the specific Danish setting and situation is described, (4) the identified research gaps leading to the four different focal points are provided.

**New Public Management**

NPM has become a well-known world-wide phenomenon. It became an international trend in the public sector within the OECD countries during the 1980s and 1990s with some late adopters after 2000 (Brorstrøm and Nilsson 2008; Cook 2004; Groot and Budding 2008; Pettersen 2004; World Health Organization 2000). Most researchers view NPM as being in the mature stage (Broadbent and Guthrie 2008; Hood and Peters 2004; van Helden 2005), others see a phase of post NPM (Christensen 2007) and some are even speaking of the death of NPM (Dunleavy et al. 2005). But large parts of the management accounting aspects of NPM are still very central and relevant, especially that of performance measures (Dunleavy et al. 2005; Lapsley and Wright 2004). Jacobs (2012) calls for continuous emphasis on research of NPM, but also calls for the development of theoretical frameworks to enhance our understanding of the role of accounting in the public sector. Likewise Miller *et al.* (2008, p.962) states that “we need to know more about the ways in which accounting interacts with, and at times hybridizes, as a result of encounters with other types of expertise”. And finally, Kurunmäki (2008) identifies three gaps in management accounting literature on NPM which are the different roles of management accounting versus accountant, identification of beneficiaries of managerial reforms within the accounting profession, and the future of management accounting expertise. Within the future of management accounting, Kurunmäki (2008) lays an emphasis on accounting language and accounting’s transferability to other groups of experts. These identified gaps within the literature of NPM will be partially or fully addressed in this dissertation. They all illustrate the continuous importance of research within NPM.
Originally, NPM is a specific management philosophy adopted by governments. It is a concept used to describe several organisational control systems originating in the private sector. A major part of NPM is constituted by management accounting ideas and fractions such as efficiency and accountability in order to control costs, becoming market-oriented to meet patients’ needs and holding public institutions accountable for their measured work performance and increasingly basing resource allocation on performance. Thus, one of the core issues of NPM is performance measurement which is still highly relevant (Dunleavy et al. 2005). Performance measures are implemented in various governmental reforms to encourage public institutions to become more productive and efficient. Financial and qualitative results are used to make the performance more transparent, comparable and measurable (Danish Ministry of Health 2004; Lee 2008; Linneberg et al. 2009; Pettersen 2004; Whitcombe 2008). This PhD dissertation focuses on the management accounting aspects of NPM such as efficiency and accountability through the means of specific management accounting techniques such as budgets, costing methods and performance measures.

Health care is one of the major governmental sectors that have faced numerous changes due to implementation of NPM. The public health care sector differs in structure, availability and governmental influences across nations. However, the overall aim of public health care is to ensure good medical treatment to the public. The implementation of NPM in public health care has revealed several differences in perception, application, usage and knowledge, which has resulted in various dilemmas and paradoxes of NPM, particularly the conflicts between opposing core values such as service quality treatment and financial objectives. The consequences and effects of introducing NPM vary depending on the context and setting in which the health care system operates. One of the main arguments against the introduction of NPM in the health sector is the emphasis on economic discursive ways of thinking and the neglecting of social relations (Glennerster 1994; Linneberg et al. 2009; Llewellyn and Northcott 2005; Samuel et al. 2005).
Nevertheless, worldwide increases in health care costs along with the increasing demand forecasts caused by ageing populations force health care managers to constantly review procedures and organisation. The set-up of public health care systems is often very complex since political aspects play a major role in it. Furthermore, the line of authority and command is distinctively long, with various layers of decision-making and with a great distance between top political decision-making and actual daily working experience. Therefore, the initial intentions of the politicians often change as they are translated through the hierarchy and this can result in different outcomes than those initially anticipated by policy makers. This dissertation focuses on the political level of decision-making through reforms and very little on institutional outcomes. It does, however, include rhetorical responses to the outcomes in academic research, media and readjustments of political initiatives.

Management accounting studies of New Public Management

This section provides a framework for management accounting studies on NPM describing earlier studies and addressing and identifying gaps in the literature leading to study opportunities. The introduction of NPM has been widely studied and discussed at a scientific level during the past 25 years and seems to be clustered around specific themes such as the commercialisation of health, the social context, the profession and socio-political issues. Within each of these themes challenges exist and progress in different ways. However, a common issue of duality seems to prevail where the initial aim of a theme creates other problems associated with this aim. This is what Hood and Peters (2004) refer to as the Mertonian unintended effects where unanticipated consequences always follow social action. Hood and Peters set up a natural framework for the development of NPM consisting of three areas; (1) the Mertonian unintended effects; (2) cultural surprises; and (3)
system discontinuities and non-linearities. According to their study, NPM has, at the time of their study in 2004, just barely begun its middle age and studies fully developing insights into cultural surprises and system discontinuities are preliminary. Even the Mertonian effects such as NPM paradoxes are not fully studied.

It is, however, exactly the Mertonian effects that are studied in management accounting literature and have been identified as the paradoxes of management accounting techniques in the social setting of health care. The paradoxes studied have included the implementation of market reforms in a social public setting, the ignorance of the social setting in management accounting techniques and the qualitative aim and procedures of the health care profession versus the economic issues. A description of studies within each of these areas is given below.

Commercialisation

Studies on introducing commercialisation in health care have shown increasing challenges with the increased focal point on financial indicators, which have not been the main focus in public organisations historically (Jacobs et al. 2004; Jansen 2008; Kurunmäki et al. 2003; Talbot 1999). The patients are the important users of the health care system and therefore patients’ experiences are vital in order to evaluate the health care. NPM has had various consequences for the patients. This is particularly due to the standardisation but also to the implementation of management control systems as budgets, costs analysis and so forth. A particularly critical research aspect has been the connotations of putting prices on patients (Samuel et al. 2005) where the treatment of patients becomes a commodity. A dilemma of meeting the demands of the users, patients or potential patients by introducing standards, measures, free choice and cost control (Eldenburg et al. 2010; Pina and Torres 1996; Vrangbæk 2006) with the result of treating patients like products and
creating ethical dilemmas in specific situations (Cordery et al. 2010; Fischbacher-Smith and Fischbacher-Smith 2009; Hill et al. 2001; Samuel et al. 2005). It is a debatable issue, but in the literature it is still not as debatable as that of the profession, maybe due to its complexity, distance to patients and complex links between cause and effects.

**Social context**

Social context and relations are highlighted themes in especially critical studies on NPM. The specific aspect of implementing performance measures (PM) has been widely criticised for ignoring social relations and not understanding social behaviours resulting in lack of motivation among employees (Agrizzi 2008; Arnold et al. 1994; Ballentine et al. 1998; Brunsson et al. 1998; Cordery et al. 2010; Glennerster 1994; Kurunmäki 2008; Kurunmäki et al. 2003; Lawrence et al. 1994; Llewellyn 1993; Miller et al. 2008; Miller and O'Leary 1987; Preston et al. 1992; Whitcombe 2008). The studies show difficulties in combining accounting methods with the initial aims of health care. Part of the reason is that as an integrated management tool PM is static and uniform and thereby lacks the ability to differentiate between people but rather categorises them in inappropriate manners (Baker and Hayes 1995; Kurunmäki and Miller 2006; Llewellyn and Northcott 2005; Miller and O'Leary 1987; Scarparo 2011). Moreover, it is found that NPM ignores the fact that public employees are not trained in the economic discursive way of thinking presumed by several aspects of NPM (Linneberg et al. 2009). Additionally, the implementation of NPM in the Nordic health institutions has led to a large increase in administrative work and is a massive obstacle for the employees (Pettersen 2004). Frequently, performance measurements are assumed to measure predictable links, causes and effects. However, human beings can act powerfully and unintentionally (Walthers and Williams 2003), which is not an integrated factor of the PM. This is
one reason why economic development and outcome of planned social interventions can end up being powerful compositions of control which may never have been intended, illustrating the Mertonian unintended effects of social action (Hood and Peters 2004). The management accounting literature shows that when financial and non-financial measures are implemented to solve transparency and costing problems, other conflicts occur. In New Zealand, the experience with NPM is long and has led to several dilemmas such as control versus flexibility (Boston et al. 1996). NPM consists of several control elements but at the same time, NPM calls for more individual responsibility and decentralisation. Another dilemma is diversity versus uniformity (Boston et al. 1996). Performance measures constitute uniformity through standards, but the public demands distinction and the ability to choose the best.

The health care profession, in particular the physicians, raises even further dilemmas in research studies. The strong health care profession generally resists changes when being challenged (Brorstrøm and Nilsson 2008; Jespersen et al. 2002; Kirkpatrick 2011). In restructuring health sectors in several European countries, physicians are being highly challenged due to a tendency of a power switch away from physicians to administration (Jones 1999; Kurunmäki 1999). The physicians’ profession and basic assumptions about their purpose are identified as being highly opposed by this restructuring since within PM part of their basic purpose as physicians is ignored. Physicians’ basic assumptions of their profession are qualitative results rather than quantitative results. A Danish study by Strandberg-Larsen et al. (2007b) finds that primarily economic measurements are used and the focus has moved from quality to financial performance. Even though a refocus on quality in recent years is seen, this refocus is on quality performance indicators.
which again become standards without acknowledging the ambiguity of quality treatments (Blomgren and Sahlin 2007). Moving the focus from qualitative diversity to performance indicators challenges the basic philosophy and purpose of physicians. Moreover, collective rewards for the health care profession contribute more to the learning organisation than financial rewards (Evans et al. 2010; Modell 2000; Pizzini 2010). This might be explained by the different basic assumption and ideologies of people working with social outcomes compared to the private sector, which focuses on competition, changing environments and financial outcomes. A few studies have shown that physicians would like and need more stability, less administration and closer contacts to patient and colleagues (Brorstrøm and Nilsson 2008; Jones 1999; New Zealand's Minister of Health 2000), a fact that conflicts with implementing new models and specifically performance measurements and earned autonomy (Brorstrøm and Nilsson 2008; Mannion et al. 2007). This is supported by a study done by Mannion et al. (2007) in the UK that shows that chief executives and directors in health care are not motivated by financial rewards and personal reputation, but rather more responsive service to patients, opportunity to increase staff’s work ethics and increased quality of results. Furthermore, a study done in Norway by Østergren (2006) shows how performance measurements are de-motivating for the staff because of time spent on registration and because of the focus on goals rather than quality. The staff thereby becomes passive and responsive. Another study by Chang (2006) in the UK also shows decoupling between national targets and local needs and that performance measurements are seldom all incorporated locally. They are merely used for survival and legitimisation. Therefore, to be able to still fulfill their core duties and basic professional assumptions, physicians tend to only adopt PM because of obligation and legitimisation (Chang 2006; Kurunmäki et al. 2003) or in other words, to keep the pressure at a distance so they can focus on their primary duties. One of the major consequences of the focus on PM is manipulation of numbers e.g. in the UK where widespread manipulation of waiting list data was revealed in 2003.
(Chang 2006). This makes the usefulness of the registered measures and numbers questionable. Jansen (2008) made a study of three hospitals in Holland. He found that in most cases politicians were unable to use the performance information received from the hospitals since they were too standardised. Furthermore GASP-NAPA 1997 reports that local governments in the US do not use outcome measures (Lee 2008). In Australia a study was done by Lee (2008) on performance information which showed that qualitative measures are highly undeveloped, yet rated very important among public sector managers.

**Comparative studies**

Though a general resistance exists, how the profession reacts to implementation of NPM seems to differ between nationalities which brings us to the second area of natural NPM development issues of Hood and Peters (2004); cultural surprises. According to Kragh Jespersen et al. (2002) four characteristics vary across countries; constellations, competition, political-administrative structure and power relations, which makes the outcome of NPM differ both among professions but also at the political level depending on nationalities. Several studies within management accounting have started to look upon specific national cases and some are even comparative studies. A case study done by Liisa Kurunmäki (1999) on three different Finnish hospitals shows how physicians are forced to use economic rationality when arguing for their needs; otherwise they would not be heard. The study describes the implications of different health acts and reforms implemented in Finland in the 1990’s. Kurunmäki uses Bordieu¹ to analyse the power influences of implementing aspects of NPM with strong emphasis on accounting in the Finnish health care sector. The study shows how accounting tools affect physicians. When medical staff are not familiar with accounting, those tools become instructions and thereby a power device. Another study on the profession is made by Liisa
Kurunmäki together with Lapsley and Melia (2003) on “Accountingization versus legitimation: a comparative study of the use of accounting information in intensive care”. This is a comparative study of intensive care units in the UK and Finland. The study focuses on the global NPM trend versus the national perceptions and management techniques. In both countries they find a decoupling between health care and administration which seems to provide mechanisms for legitimisation. Kurunmäki has furthermore published an article in AOS (2004) on the differences between Finland and the UK. In this interpretive study, she seeks to understand the acceptance of NPM reforms by medical professionals in Finland and the changes during the late 1980s and through the 1990s. A study done by Jacobs, Marcona and Witt (2004) comparing cost and performance information for physicians in the UK, Italy and Germany found further decoupling between clinical staff and administration; clinical staff, in general, do not have access to cost and activity information even if they are interested in them. This seems to be a highly critical issue. The differences however, between the UK, Italy and Germany, were similar to those found in Kurunmäki et al’s (2003) study; the UK seems to have more experience with accounting and cost tools in health care and is now drifting away from market reforms because of their negative experience with them, whereas in Germany and Italy these types of reforms with more focus on costs and accounting are rather new and the two countries are therefore still open towards the process of adaption. These studies have just started to explore the cultural surprises and differences and there are still countries which are not represented in the management accounting literature despite their NPM implementation and governmental refocus on management accounting issues. Denmark is one of those countries, despite a Nordic comparison done by Pettersson (2004). This study discusses context and behaviour in order to explain the reform processes in these countries. It is found that management accounting plays a significant role in the terminology used by practitioners. It is further found that there are similarities in the centrally driven reform process and
the gradual introduction of commercialised rationality but with various differences in pricing of hospital services, motivation for the reforms and the directions of change.

To sum up, the paradoxical nature of management accounting techniques aimed at standardising the complex social environment and practice of healthcare has been clearly described. Less clear, however, is our understanding of the role of management accounting in the societal development and across nations (Hood and Peters 2004; Jacobs 2012; Kurunmäki 2008; Miller et al. 2008). We lack a focus on system discontinuities and nonlinearities. Hood and Peters (2004) explain this phenomenon as a supplement to the previous two areas. It demands a more longitudinal and holistic approach than the previous management accounting studies. No study has been made of the development of this phenomenon over time, assessing the actual changes and effects that are all too often dismissed at some point due to inconsistencies and unanticipated results. Existing research has this large gap and to close it would require multiple studies over a longer period of time. The present dissertation seeks to address parts of this gap. Additionally, this dissertation addresses the call made by Miller et al. (2008) and Kurunmäki (2008) on increasing knowledge on the different ways accounting language, or financial literacy, diffuses and hybridizes when entering the healthcare context. The dissertation further adds to the body of literature beyond the Anglo-American context by using Denmark as a case study.

Two of the studies use Denmark as the cultural setting where one study is a comparative study of Denmark and New Zealand. These two studies address the cultural surprise effect described by Hood and Peters (2004), and the comparative study some of the system discontinuity issues. The fact that Denmark has not been used as a case study in any previous management accounting studies of NPM supports this choice. Using Denmark as a case contributes to the diversified understanding of the development of NPM across nations and enables cross national studies in the pursuit of
understanding and capturing differences, why do they exist and how do they influence the outcome. Therefore a brief description of the Danish health care setting and recent reform development is relevant.

**Setting the Danish scene**

In 2004 the Danish government decided to make profound changes in the Danish health system through a structural reform which became effective in 2007. The traditional issues of increased costs, lack of transparency, a strong profession and a wish to offer the citizens free choices forced the Danish government into action. The structure of the Danish health system has several layers: Government/Ministry of Health, regional level and municipal level (Danish Ministry of Health 2004; Strandberg-Larsen et al. 2007b). In order to understand the specific development of NPM in Danish health care, a brief analysis of the latest Danish health reforms is given below. Moreover, some Danish studies made at the Center of Health Management, Copenhagen Business School are reviewed in order to understand more in-depth issues.

**The Danish Health Reforms**

In the 1970s counties, i.e. small communities, were introduced in the Danish society. Although Denmark had had a mutual benefit health system funded by the state since 1892 (Krasnik and Vallgårda 1997), the development of the counties laid the foundation for a far more integrated and profound health care system in the 1970s. The counties took care of several local services including health service. Various attempts to optimise the health care system were made during the 1980s and 1990s; e.g. the Trojkan model (one nurse, one doctor and one administrator in the management team), engaging hospital managers in budgets and implementing contracts between communities
and the state. However, a more recent reform, the Structural Reform of 2004, led to the largest turnaround in the Danish health care sector. This reform’s core premise was to merge all counties into 5 large regions. The main argument for this restructure was the link between size and productivity. The larger a region or area, the better facilities and expertise could be drawn upon (Borum 2006a; Danish Ministry of Health 2004). The quantity – quality relation was the foundation for the restructure of the Danish health care sector (Borum 2006a). As of 1 January 2007, these regions were responsible for health care. However, municipalities within the regions still have some responsibilities as regards homecare and prevention of illness. Moreover, the Danish State is responsible for the coordinating and specialised health care.

**Figure 2: The structure of the Danish health system**

The above figure is based on WHO’s Danish health report from 2007 (Strandberg-Larsen et al. 2007a) and the Structural Reform (Danish Ministry of Health 2004). In the reports, the private owners include primary care. Even though primary care is ‘privately’ run by practitioners in Denmark, it is part of the public health sector as the costs are covered by the state and a visit to a
general practitioner in Denmark is free of charge. The private hospitals are run as fully private entities which is a new phenomenon in Denmark following the Structural Reform (2004). The different responsibilities are divided as follows (Danish Ministry of Health 2004):

**The State:** Coordinates specialised treatments, sets standards for quality and IT systems in health care, makes demands and standards for the municipalities and regions.

**Regions:** Are responsible for hospitals, psychiatry and physicians, receive finances according to objectives met, receive finances from the municipalities according to population size and number of admissions and have to cooperate with the municipalities as regards treatment, preventions and post treatment (home care).

**Municipalities:** Have the responsibility for rehabilitation and home care, have to prevent illness and to encourage communities to be proactive in this area. They have to pay a fixed amount of DKK 3.000,- per admission to the regions (this figure has increased to DKK 4.000,- in later years).

Whether this is a correct and/or fair division of assignments and responsibilities is an open question. However, it is obvious that this type of division may lead to various complications. One problem is that the state coordinates and sets demands and standards without involving municipalities and regions, which makes this a top-down controlled reform. Another problem is the division of the responsibility between the municipalities and regions where a grey zone could very likely occur when patients are sent home from the hospitals. Moreover, in order to prevent illnesses a very large and long time frame is needed since most illnesses cannot be prevented overnight. This could create some imbalance in those regions that have a large amount of elderly and psychiatric patients. The second study analyses some of these implications. The reform itself and the Danish health care
system and set-up will be further discussed and compared with the New Zealand system in the fourth study.

The Structural Reform is supplemented with yearly financial reports that set the standards and demands for the health care. These financial reports have intensified tremendously from being loose and brief in the end of the 1990s (around ½ page) to becoming very specific with increasing demands (up to 3-4 pages the later years) (Salomonson 2004). These are also integrated in the analysis in chapter 4.

**Results from the Structural Reform**

Some studies have been made on the effects of the Danish Structural Reform, but none within the area of management accounting. At Copenhagen Business School, Centre for Health Management, a so-called baseline survey of the health sector’s organisation and management before and after the structural reform has been made. This survey focuses on measuring the general outcomes and changes due to the health reform, not on the implications and how it is integrated in the hospitals at a practical level.

The baseline survey concludes that primarily economic measurements are being used and that the focus has moved from quality to financial performance as duty (Strandberg-Larsen et al. 2007b). Furthermore, the survey concludes that the hospitals now have more latitude for their daily operation (Bech 2006) as long as they live up to the external standards. So on the one hand the important decisions on how to implement the reform rest with the hospital management, but on the other hand the external standards and pressures limit their freedom of action. This is one of the issues raised in chapter 6 as well.
Furthermore, in his paper “The justification of the administrative reform” Borum (2006b) explains that health centres have been promoted to become more client-orientated. Moreover, the study explains how, since the 1990s, the government has had various commissions studying the optimal service size; that is the optimal size of population for a hospital. Based on a patient / population size and service quality, the government has set up a standard for the size of population needed for having an efficient hospital, using this argument for closing several small hospitals. The study shows a shift from the commission under the previous government (the social democrats in the 1990s) to the commission under the current government (the Liberals since 2002). The commission under the Social Democrats concluded that an optimal population size for internal medicine at a hospital is 200-250,000 people, whereas the new commission came to the conclusion that a population size of 400-700,000 is the optimal size for internal medicine. This shift in size shows various relations to NPM and the increasing need for centralisation and efficiency. According to Borum’s (2006b) study it has become legitimised that increased quantity equals increased quality. However, the study also shows opposing opinions. The politicians claim that the commission’s report is the optimal solutions whereas the medical society opposes and claims that the quantities are too large.

Finally, a study by Tanggaard Andersen and Jensen, from the Department of Health Promotion Research, University of Southern Denmark, (2010) on the Structural reform criticises the exact points made above. They raise issues such as the division of labour between municipalities and regions, the lack of binding agreement and patient and citizen orientation, lack of follow-up indicators and missing descriptions and information. They further claim that the reform has been driven by rational considerations underestimating the other links and areas. These issues are supported by Morten Dige, a Danish philosopher, who has written about the commoditised patient (2007). He emphasises the risk of the new reform with heavy economic rationality. He tries to
define the difference between the concepts of a patient and a consumer. The concept of patient has fundamental values such as the respect for the individual, involvement and solidarity whereas the concept of consumer forces the “patient” to become more active rather than passive which creates the danger that the strong consumer wins and the weak ones may get neglected. Moreover, he stresses quantity versus quality; when the patients/consumers complain about quality the answer they receive is based on statistics. He views the management accounting logic behind this fact as rather problematic. These issues are those raised and studied in chapter 4.

The Quality Model

To counter some of the issues and to improve quality, a Quality Model was introduced in 2007. This model, however, is characterised as a strategy and it has never been discussed much at the governmental or the operational level (Kjellberg 2007). The idea is to get better quality for the same resources with a focus on less administration. Implementing this reform in procedures of the regions and hospitals has taken several years. In 2010, the Health Ministry published a document aiming a documenting the changes created by the Structural Reform. Among these are quality aspects focusing on indicators such as patient’s satisfaction, hospital ratings and percentage of patients with a specific contact person in the hospital system (Sundhedsministeriet 2010). In 2011, the Danish regions published a document called ‘Quality in Health’ with the specific aims of decreasing mistakes in treatments, decreasing mortality and increasing patient’s satisfaction (Regioner 2011). But it is still in its implementation period and few quantitative quality indicators have been implemented and no results have yet been presented.
The Danish medical profession

The Danish medical profession has also been studied by various authors, both from the above mentioned baseline study, but also by economists. The Danish profession is seen as a strong and powerful profession which has been highly challenged by the Structural Reform. Borum’s (2006c) “Revitalising a dormant institution? Contestation and innovation around health centres in the reshaping of a national health care system” shows the opposition by physicians towards the reform whereas nurses see an opportunity to increase influence and consequently set up several professional commissions in order to constructively work with the new reform and its possibilities and thereby end up with a larger number of health centres. They try to legitimise themselves pragmatically by being proactive whereas the physicians seem to be more hesitant. They are simply against the model and health centres. This is in line with studies by Kragh Jespersen (Jespersen et al. 2002; Kirkpatrick 2011) where the Danish profession stands strong and is used to gaining power by either opposing strongly until a proposition fades out or takes ownership of managerial and administrative tasks. However, this is greatly challenged by the Structural Reform where more non-clinical management is seen.

The future

A recent report on the strengths and weaknesses of the Danish health care system was prepared by Kjeld Møller Pedersen, Mickael Bech and Karsten Vrangbæk (2011). They take a look at the future and conclude that the main challenge for the Danish health sector is the demographic development with the increase in elderly patients resulting in increasing expenditures, lack of manpower and lack of financing. These are the exact issues raised by health economists. The Danish case shows that NPM is not dead, but has just been implemented in larger scale. The Danish case may add to
cultural surprises showing a different and slow absorption of NPM, described as a tortoise by Hood and Peters (2004). The Danish studies show some of the Mertonion effects occurring when implementing NPM. This scene setting has added to the importance of research within the area and it has further showed some of the possible implications in a Danish social context and health care practice.

**Focused opportunities of study**

This dissertation focuses on the role of management accounting in public health care through NPM reforms and specifically on the management control challenges and paradoxes in this socio-political setting. The specific angle of management accounting in NPM reforms adds to a study of development and spreading of these techniques that constantly reform and transform the public sector. It provides an opportunity to study rudiments of the NPM movement, the reason behind it and the role of management accounting within the public sphere. The dissertation will investigate the discursive manifestations of management accounting through governmental reforms addressing the cultural surprise and system discontinuities and nonlinearity of the development of management accounting in NPM reforms. Building on earlier institutional studies, the study seeks a holistic depiction of the institutional developments that derive from the governmental level. Using multiple longitudinal theories addressing the formation of the specific issues in management accounting is pursued to explain and make sense of social practice of reform development.

- The first paper investigates the historical development and outcome of NPM in a historical and cross-national context at the socio-political level. It lays the foundation for the next three papers and captures the complete holistic view of the development where the following three papers address parts of this holistic development and explain more narrow
elements. The longitudinal development of management accounting through NPM reforms is investigated addressing the nonlinearity area and development depicted by Hood and Peters (2004). In Chapter 3 the discursive role of management accounting in the construction and development of a governable health care pursued through reform making will be discussed using Foucault’s concept of governmentality addressing the societal concerns of Miller and O’Leary (1987).

The second paper takes a different approach and addresses a narrow specific case study setting that builds on Danish media data to map the influence of management accounting terms on the changing public opinion on NPM in Denmark. Management accountings discursive influence on the ideology of the health care profession is analysed and addresses the large group of profession institutionalised studies. This paper is different, however, as its purpose is to identify the role of management accounting terms in the public debate following the Danish Structural Reform. It thereby addresses the call for studies on the interaction of management accounting terminology made by Miller et al. (2008), and partially the study discusses the issues of expert groups adopting accounting language raised by Kurunmäki (2008). Chapter 4.

The third paper also takes a step back, but differently than in the first study. It analyses the research environment and its interrelation with developed NPM reforms over the past three decades, the role of management accounting and its interplay with NPM academic research and reforms, and it addresses both diffusion theory of management accounting in public reforms by Lapsley and Wright (2004) and the nonlinearity focus on the development of management accounting described by Hood and Peters (2004). Additionally, it briefly touches the discussion on the role of management accounting versus management accountant, raised by Kurunmäki (2008). Chapter 5.
The fourth paper takes another narrow aspect and investigates the difference in NPM adoption between New Zealand and Denmark in order to illustrate the differences and the impacts of different national set-ups, history and health care background. It reviews the socio-political challenges and differences between Denmark and New Zealand and addresses the cultural surprise area of Hood and Peters (2004) but also the call for comparative studies by Petterson (2004) using a contingent framework for comparing reform changes. Chapter 6.

These four papers combine historical development, academic research, public opinion, the health care profession, reform developments and national differences with the aim of identifying the role that management accounting has played through NPM reforms in health care and how this role is manifested in our understanding of management accounting in the public sector today.

These issues lead to four complementary research questions which will create the foundation for the four studies in this dissertation.
Dissertation Research Question: What is the role of management accounting in the development of public health care where social NPM reforms are apparent?

Chapter 3 (Paper 1):
Title: The historical development of management accounting discursive role in NPM reforms
Research Questions: What constitutes the historical development of NPM health reforms? What role does management accounting play in this development?

Chapter 4 (Paper 2):
Title: Demonstration of economic arguments in the public health care debate – a case from Denmark
Research Questions: What is the role of management accounting presented in the media in the development of NPM through the Danish Structural Reform? How does the introduction of the Structural Reform influence the perception and use of the terminology of service quality in the media?

Chapter 5 (Paper 3):
Title: The interplay of management accounting research and NPM health initiatives
Research Questions: How is management accounting constituted through NPM health initiatives? And how are these NPM initiatives represented in the management accounting literature?

Chapter 6 (Paper 4):
Title: Riding the waves of NPM – from New Zealand to Denmark
Research Questions: How does NPM implementation differ in initiative and contextual outcome in Denmark compared to New Zealand? What role does the time difference play in this respect? How do these differences affect the process and outcome in each of the countries?
Chapter 2

Methodology
The research approach along with justifications for theories and methods chosen will be explained in this chapter. The aim is to make the assumptions and approach of the dissertation clear and to create the foundation on which the dissertations’ overall analytical frame is based.

**Research approach**

One research approach is not necessarily more definitively true or false than another. However, a given paradigm can be more useful for some purposes than others. The dissertation is centered on management accounting as a social science rather than natural science. According to Morgan and Smircich’s six ontological approaches (Ryan et al. 2002, p.36), two approaches are particularly relevant for this PhD dissertation; they are “symbolic discourse” and “social construction”. Especially given the dissertation’s use of discourse theory and analysis it is relevant to set a focus on a reality of common meanings and norms where “as such, reality is not a set of rules per se, but is embedded in the meanings and norms which are created through individual experiences of events and situations, and then shared through social interaction. Although these meanings and norms can be changed at any time, they can also be quite stable over time and thereby come to structure social activity.” (ibid., p. 37). Chapters 3, 4 and 5 look at themes and discourses and their changes over a specific period of time. Chapter 3 investigates the historical discursive development of management accounting through NPM reforms. Chapter 4 observes newspaper and professional articles in a given period, and chapter 5 observes the changing themes in research articles and their interplay with health care reforms. Observing without interacting does not imply a foundation based on concrete construction, nor a foundation resting solely on explaining actions and understanding social order, but rather a foundation based on critical observations within an analytically descriptive approach. It is important to define what is meant by the term “critical”. Critical research is often related to Marxism but that is not the intention of this research. According to Ryan, Scapens and
Theobold (2002) accounting research can be divided into three categories; mainstream, interpretive and critical. Mainstream accounting uses quantitative methods and believes that empirical reality is objective. Mainstream accounting uses mechanical management models with little distinction between physical and social phenomena (Jakobsen et al. 2011). Interpretive accounting is explanatory and subjective and believes that reality is socially created. Critical accounting research takes a step further and believes that “criteria for judging theories are always temporal and context bound. Social objects can only be understood through a study of their historical development and change within the totality of relations” (ibid, p.43). Furthermore “Empirical reality is characterized by objective, real relations, but is transformed and reproduced through subjective interpretation”. Thus critical research is broad in one sense and it is not related to a particular political standpoint. Rather it incorporates an actor’s approach with the belief that humans possess a free will and that accounting models are integrated in social contexts which influence the use of the models and vice versa. Various philosophers such as Marx, Foucault and Habermass exist within critical theory and their contributions create differences in approach. Laughlin, 1995 (Ryan et al. 2002) describes the differences between these approaches more clearly. He distinguishes between level of prior theorisation, level of theorisation in method and level of emphasis given to critique of the status quo and the need for change. For example, according to Laughlin’s classifications of social research (Ryan et al. 2002) Marxism is low on methodology choice and high on theory and change choice whereas for example German critical theory is medium in all of the above. In other words, the term “critical research” is not an area of researchers with a specific political standpoint, but rather a specific way of believing in knowledge which can approach research in several ways.

According to Laughlin’s classifications (Ryan et al. 2002), this dissertation uses critical research with medium emphasis on theory, methodology and change. This type of research allows the
researcher to both observe and interpret with the possibility of making loose generalisations. It allows the researcher to derive from prior theory and to have theorisation in the methods used without, however, being tightly dependent on them (Ryan et al. 2002, pp.46-47). It gives the possibility for research to be located in the middle range of subjectivism and objectivism. Ontologically, the symbolic discourse approach to reality allows the researcher to interpret how the human actors, who are represented in the articles, make sense of their reality and which meanings and norms they connect to specific situations which could e.g. be the implementation of performance measures in health care. In contrast, social construction allows the researcher to describe the individual sense-making of the actor. Drawing on both these approaches therefore seems relevant for this dissertation. Even though chapters 5 and 6 differ from chapters 3 and 4 they are still within this research approach. The aim of chapter 6 is to illustrate the historical development of NPM and performance measures in New Zealand and Denmark. The critical approach allows the article to be both objective in terms of methodology, but also somewhat subjective in understanding the effect that the rules and performance measures have upon the actors. Three different methods and approaches were chosen in the four studies but all based on critical research, where chapters 3 and 5 are related to the interpretive approach, describing and explaining various trends and the historical development. Nørreklit and Israelsen (2011) describe, within actor management discourse, the difference between conceptual realism and mechanical discourse. They find that conceptual realism believes that things belong to the same concept if they are similar in nature and well defined borders are needed for concepts to apply. However, opposed to mechanical discourse, it is believed that these concepts should be integrated and may or may not be changed according to the social context in which they are incorporated. Conceptual realism is referred to here as part of the critical research paradigm. It is an important part of this dissertation because it also combines some elements from the mainstream approach, e.g. that of structure and concept
definitions. Thereby, it opens up for the possibility of integrating diffusion theory in chapter 5 and contingency method in chapter 6.

Having defined the ontological assumptions as drawing on symbolic discourse and social constructivism and the critical research approach as the overall taxonomy using theories from social science such as discourse analysis, the relevancy of this standpoint will now be explained.

To make a research frame capable of incorporating both parts of management accounting and the social context of health care, their interactions and influences upon each other, the above assumptions and the critical perspective are relevant. Taking a mainstream perspective would limit this study to a mere evaluation of the management accounting tools, proving what works and what does not according to numbers, categorisations and isolations. An interpretive perspective allows the researcher to describe various social impacts and situations, which is also done, but it would not allow the researcher to question and reflect on these impacts and situations. This dissertation seeks to reflect on some of the implications and difficulties of the impacts of NPM in the health sector in order to create awareness and knowledge of what seems to be economically beneficial and efficient. Sound economic efficiency is beneficial in many cases since it creates a foundation for a welfare society. However, when dealing with social services, other factors interfere with these types of solutions. Economic solutions have limitations in relation to social services and when based on the traditional mechanical accounting models. Economic efficiency lacks the ability to predict behaviour and to understand human rationale. In order to be able to emphasise on the problematic issues of implementing NPM and particularly performance measures in the social context of public health care, a critical approach therefore seems highly relevant and useful.
The four papers have different theoretical approaches which according to Jacobs (2012) is necessary in order to capture the role of accounting in the complex social practice of public services. The method of the first study is a historical literature review. The study provides an in-depth review of health care issues within management accounting. The historical review lays the foundation for the next three papers and discovers further issues along with knowledge usable in the rest of the dissertation. However, in order to link this historical review to the critical perspective approach and to enable critical questioning along with discussions, the theoretical approach is inspired by the paper of Miller and O’Leary (1987) “Accounting and the construction of the governable person” which draws on Foucault. However, according to Jacobs (2012) the issue of governmentality of Miller and O’Leary’s paper is at such an early stage that it is valid as a pre-stage development of theoretical approaches grounded in the accounting setting. It is further complemented by governmentality and the discourse theory of Foucault which is used to explain the development of management accounting through history and its discursive manifestations.

The method of the second study is systematically drawn on the critical discourse analysis by Norman Fairclough (1992). The data is alternative in that newspaper articles are used. In this paper discourse analysis is closely linked to the theoretical framework of discourse theory combined with rationality and power where Foucault (Simons 1995) and Flyvbjerg (1998) have valuable views which adequately add to the discursive discussion. This study is also a longitudinal study that looks into changes in the Danish public debate over a period of eight years.

The third paper uses a different approach but also differs in aim and nature. It is a literature review combined with a health care reform review and the interrelation through diffusion theory. The similarity to the other studies is the longitudinal focus on management accounting transformation
through public health care reforms where diffusion theory is another theory that seeks to explain this development.

The last paper is a comparative study, comparing reform changes and implementation of NPM in New Zealand and Denmark. Reforms are studied and verified by interviews made both in New Zealand and Denmark, which adds to an in-depth case study. Contingency theory is used as a method since it enables us to capture the structure of a theme that is diffuse and difficult theme due to the time dimension. Contingency theory also describes links of the past in order to capture the present.

All four papers are similar in their longitudinal approach and it is at this point that the theories supplement each other. Discursive formation, diffusion over time and contingent links and interrelations over time all illustrate different types of historical transformations, spreading, links and manifestations of management accounting. They all seek to capture the present by analysing the historical background bit by bit as prescribed by the work of Foucault (Foucault 1972; Simons 1995). Figure 3 illustrates the similarities and differences of the four studies.
Figure 3:

**Common elements:**
- Management accounting
- Health care sector
- Governmental reforms

**Paper 1:** through Miller and O’Leary (1987) and Foucault (1972)

**Paper 2:** through critical discourse analysis (Fairclough, 1992)

**Paper 3:** through diffusion theory (Bjørnenak 1997, Bjørnenak and Mitchell, 2002)

**Paper 4:** through contingency theory (Pettersen, 2004)

**Present state**
- New Public Management
- Social practice of management accounting

**Development over time**
References


Borum, F. 2006a. Forskning i sygehus under forandring.


OECD. 2011. Health: spending continues to outpace economic growth in most OECD countries.


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1 A French Sociologist, 1930-2002, who worked with habitus, field and symbolic violence focusing on how specific symbols are used as dominance in order to achieve and maintain power.

2 http://www.cbs.dk/forskning/institutter_centre/institutter/chm
Chapter 3

The historical development of management accounting discursive role in NPM reforms

Abstract

Much research has focused on the role and limitations that management accounting techniques have had in the development of New Public Management (NPM) reforms during the past 30 years. However, research of the origin of NPM, the reason for NPM reforms consumed with the role of management accounting from a historical perspective is limited. This paper investigates the historical and discursive development of management accounting in health care through general history, organisational and national documents along with academic literature. The framework is informed by the governmentality concept described by Miller and O’Leary (1987) and this is used to reflect on developments in the past century including the role of discursive formation and practice. It is found that, after the Second World War, the World Health Organisation (WHO) along with the Anglo-American nations play a major role in the formation of NPM reforms and the integrated development of management accounting. In particular the Alma-Ata declaration in 1978 has a specific integrated management accounting description of the process to achieve better health care. This is followed by multiple NPM reforms during the 1980s and 1990s. Management accounting themes of performance measures and Diagnosis-Related group costing method become vital techniques in the health care improvement, and these techniques sustain the dismissal of market reforms in later 1990s. The current health care theme of quality, also integrated in WHO documents, is supported by performance indicators, stemming from management accounting. An additional finding is the various national stages and roles where the meaning of management accounting techniques and NPM reforms differs, but it is found specifically vital in the formation of health care systems in developing and transitional nations. Despite type of reform, public health care level, and national influences and changes, management accounting techniques play a dominant and prevailing role.

Keywords: Governmentality, discourses, management accounting, New Public Management, health care systems, World Health Organisation, accounting history

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1. Introduction

The historic development of management accounting in relation to NPM can be linked to a specific rationale of a national society placing the responsibility of the individual and his/hers interests in the hands of the government. The role of management accounting within this phenomenon of governmentality (Miller & O'Leary, 1987, Simons, 1995) has many interesting connotations. The study by Miller and O’Leary (1987) on the history of accounting shows how accounting may contribute to the categorisation and construction of public society. Other studies investigate the history and trends evident in NPM (Bach and Bordogna 2011; Groot and Budding 2008; Gruening 2001; Hood and Peters 2004). This study pursues a historical investigation of the development of management accounting in relation to NPM with a specific focus on the health care system. The paper is closely related to the framework of ‘new accounting history’ (Gomes et al. 2011; Miller et al. 1991) where ‘new accounting history’ addresses accounting as a social practice and studies the implications that changes in accounting procedures have had on the organizational and social functioning (Gomes et al. 2011). Implementing management accounting techniques, based on an economic rationale, in the social context of health care, where social results are generated raises several conflicting issues relating to the construction and control of health care systems.

NPM methods are closely related to management accounting methods and tools, especially performance measures and the focus on management control. The theory of NPM is founded on several theoretical microeconomic frameworks such as public choice theory, principal agent theory, transaction cost theory, technical rational theory and institutional theory (Boston et al. 1996; den Heyer 2011). Originally, NPM was accused of displaying Tayloristic characteristics by promoting the optimal solutions that will solve everything (Bach and Bordogna 2011; Savoie 2012). These traits of profit maximisation and rational choice are integrated with neoclassic economics and play
an essential role in the development of management accounting (Johnson 1983; Ryan et al. 2002). But not only the origin of NPM and management accounting display similarities, management accounting techniques and innovations such as costing, budgeting and performance measurement tools are vital instruments in NPM reform making, especially within the health care sector (Lapsley and Wright 2004; Pettersen 2001).

The health care sector is of specific concern to society due to its increasing costs and operational complexities. However, it remains a necessary social entity. In order to address its complexities, NPM methods have been adopted in the health care systems of most OECD countries with the initial idea of avoiding discrimination and injustice and controlling costs (Gruening 2001). In addition they are used to obtain transparency to provide a choice, efficiency and development and to deal with distrust (Blomgren and Sahlin 2007). In addressing the issue of transparency, the health care profession is highly involved and the originally strong power structures of the profession (Daniels 1984; Dich 1973; Fairclough 1992) are challenged (Jones 1999; Kurunmäki 1999). The two historical factors of a powerful profession and continuously increasing health costs play important roles in the implementation of NPM methods in the health care sector. The aim of this paper is to investigate the historical development of management accounting in health care in relation to NPM reforms across nations during the last century. Drawing on Foucault’s concept of governmentality, Miller and O’Leary (1987) author a historical paper where they relate accounting techniques such as standard costing, budgeting and especially the development of statistical methods to the entire structure of society. This provides a theoretical framework (Jacobs 2012) which will be combined with the meta discursive manifestations of Fairclough (1992). This combination will contribute to the presentation of the development and meaning of the role of management accounting in health care. The following research questions will
be addressed; **What constitutes the historical development of NPM health care reforms? What role does management accounting play in this development?** The aim is to research a neglected perspective of NPM which is that of system discontinuities and non-linearities (see e.g. Hood and Peters (2004)). The system discontinuities and non-linearities address long term effects where change may produce favourable results up to a certain point where after unanticipated problems surface through surprises and paradoxes (Hood and Peters 2004). Paradoxes and unanticipated problems in the NPM development have been observed (Ashton 2001; Boden et al. 1998; Groot and Budding 2008; Hill et al. 2001; Hood and Peters 2004; Lawrence et al. 1994; Whitcombe 2008), but no study has analysed the development of the problems in a historical perspective. Thus this analysis will investigate the development of NPM and seek to explain some of the discontinuities that have become observable during later years and discuss the reasons for these discontinuities along with national differences. From a historical research, it will also use and investigate the specific societal role of governmentality described by Foucault (Foucault 1994; Raffnsøe et al. 2008; Simons 1995) and Miller and O’Leary (1987).

The remainder of the paper will be structured as follows: (1) first, the conceptual framework for the paper will be explained; within this framework the method of historical accounting investigation will be addressed, (2) next, the historical development is investigated and divided into the natural stages of NPM’s development; prior to NPM, the rise of NPM, the globalisation of NPM, national variations of NPM and post NPM, and (3) finally this historical examination will be discussed.

2. **Conceptual framework**

Governmentality refers to the mentality of structuring the nation through public provided services. NPM reforms are in this relation a tool for managing public institutions. Governmentality assists in explaining and understanding the shaping and circumstances of health care reforms, and is thereby a
suitable theoretical approach. This section sets up a theoretical framework for examining the history of management accountings role in NPM. It describes the pre-stage theoretical framework of Miller and O’Leary (1987) tied to the governmentality and discursive formation of Foucault (1972). Discursive formation through discourse theory is a relevant extension of governmentality since it refers to the understanding of how the mentality of structuring health care through health reforms is embedded in social practice. Additionally, it is a suitable framework in the analysis of the linguistic development in health care reforms. Discourse theory is explained in relation to Foucault below (Fairclough 1992; Foucault 1994) and specifically with a focus on Fairclough’s (1992) meta discourses. Finally, the method of historical accounting research used in this paper will be explained and reflected upon.

**Governmentality**

Governmentality is a concept developed and explored by Michel Foucault in the 1970s and 1980s (Raffnsøe et al. 2008). According to Foucault (1994) governmentality is the encounter between the technologies of domination of others and of oneself. It is the ‘conduct of conduct’ which according to Bevir (2010) “*captures the way governments and other actors draw on knowledge to make policies that regulate and create subjectivities.*” Governmentality draws on disciplinary rationality and sets up programmes of government, among these health care, that act as frameworks for the perception and evaluation of things (Simons 1995). By governmental history Foucault understands three things; (1) the connection between procedures, analysis and reflections, calculations and tactics that allows execution of very specific and complex forms of power, (2) the tendency of governmentality taking control over sovereignty and discipline and (3) the developing process through which the constitutional state becomes an administrative state which slowly becomes governmentalised (Raffnsøe et al. 2008, pp. 286-287).
Using the concept of governmentality, Miller and O’Leary (1987) take an alternative approach to explain accounting practices by linking the historical development of accounting to this type of governmentality and to other social practices. Based on a specific accounting event, namely the construction of standard costing and budgeting in 1900-30, Miller and O’Leary (1987) explore the social development within the last century. “We are concerned with the emergence of standard costing and budgeting in the early decades of this century and the way this can be related to other social practices” (Miller and O’Leary 1987, p. 236). They relate standard costing, budgeting and especially the development of statistical methods to the entire structure of society. Miller and O’Leary (1987) find that these accounting and quantitative methods are used as a means of management gaining power by constructing individuals, quantitatively and financially, in order to make them more manageable and efficient. The concept of standard costing is related to general standardisation and the ability to classify standards. Standard costing and budgeting make it possible to observe and monitor and, thereby, to identify the contributions of each employee. It is this connection between management accounting and governmentality that facilitates this type of historical paper on the development of management accounting in relation to NPM reforms.

The problematic interplay between accounting and the state identified by Miller and O’Leary (1987) has been discussed in management accounting NPM literature over the past decades. For instance the issues of standards which define averages and force society to conformity (Llewellyn and Northcott 2005) which Miller and O’Leary (1987) compare to waste caused by inadequate human action. Social organizations or individuals can thereby be eliminated through standards and norms. Programmes are created to prevent specific types of deviations or variances, i.e. departures from the norm. Standards and statistical methods are used to produce results as efficiently as possible. Improved and controllable physical and mental health is seen as an increase in efficiency leading to improved results. When drawing these historical connections between standard costing
and society, Miller and O’Leary (1987) apply the concepts of rationality and efficiency to the present time and identify a conflict between these concepts and the introduction of behavioural science into accounting. “One issue which interests us particularly in this continuity of concerns, coupled with a redefinition of terms and objectives, is the introduction of the notion of the “behavioural” into accounting (Miller and O’Leary, 1987, pp. 255-256). Behaviourism is used as a general term that characterises the free will of the individual and his ability to choose. However, rationality plays a dominating role in the constructing of health and behaviour where rationality is defined as regularities, logic, strategy, self-evidence and ‘reason’ (Simons 1995). Rationality is the raison d’être of governmentality. It answers the liberal critique of questioning why in fact one must govern? (Foucault 1994). According to Foucault “liberalism resonates with the principle: ‘one always governs too much’ – or at any rate, one always must suspect that one governs too much. Governmentality should not be exercised without a ‘critique’ far more radical than a test of optimization. It should inquire not just as to the best (or least costly) means of achieving its effects but also for concerning the possibility and even the lawfulness of its scheme for achieving effects. (Foucault 1994, p.74). NPM is the tool of optimisation of the public sector which can be criticised from the perspective of Foucault’s framework. One component of NPM is the set of accounting methods that has been adopted from the private sector and transferred to the public sector (Froud et al. 1998; Hood 1995; Lapsley and Llewellyn 1992; Marriott and Mellett 1995; Mayston 1999; Newberry and Pallot 2004; Shaoul 1998). NPM has therefore led to a strong “accountingisation” perception of the world where we focus on rationalisation that turns citizens into consumers and services into products (Watkins and Arrington 2007, p.43). This is similar to the standard costing and budgeting issues discussed by Miller and O’Leary (1987). Thus, governmentality proves to be an interesting framework for the investigation of the development of NPM. In order to fully
understand the means of management accounting in this context, governmentality is supplemented by the identification of discursive practice.

**Discursive practice**

According to Foucault “the discursive description constitutes a range of already existing linguistic utterances which are put into relations in different ways until it becomes possible to recognise an overall pattern in these utterances.” (Raffnsøe et al. 2008). Foucault uses this to describe discursive formation where regularity is revealed by placing arguments in relations to one another, thereby constituting discursive practice. Foucault’s discourse approach is far more abstract than that of Fairclough’s (1992) critical discourse. But Foucault’s discourse approach builds on a longitudinal work with multiple integrated concepts and thoughts such as governmentality which makes it different but also necessary in this type of study. However, Fairclough’s (1992) discourse approach contributes to this historical analysis by the identified meta discourses. Fairclough (1992) relates the discursive social practice to that of social change. He claims “I shall identify certain broad tendencies in discursive change affecting the societal order of discourse, and relate these tendencies to more general directions of social and cultural change. The sort of change I shall be referring to has a partly international or at least transnational character……’, and he continues ‘I shall discuss three major tendencies: democratization, commodification, and technologization of discourse. The first two relate to substantive changes in discourse practices, whereas the third suggests that conscious intervention in discourse practices is in increasingly important factor in bringing change about.’ (Fairclough 1992, p.200).

The meta discourses are applicable in this historic study. They describe some general international trends occurring simultaneously to the NPM development enabling to highlight important key matters in the analysis. Fairclough (1992) describes democratisation as the removal of inequalities
and asymmetries in society and groups of people. The powers of information and knowledge that the professions used to have are being challenged. However, removing these overt power markers, as Fairclough (1992) calls it, seems only to be transferring the power to the administration and accounting (Covaleski and Dirsmith 1991). The meta discourse of commodisation is where the service industry becomes increasingly similar to the enterprise culture of businesses that produce goods, which is closely related to the market approach of the health sector at the end of 1980s (Lapsley 1994; Lawrence et al. 1994). Patients become consumers and hospitals become producers. Technology is the third meta discourse that Fairclough (1992) mentions as a general discourse change in society. Technology is a core factor enabling the increase of registration since the registration is technology based. Furthermore technology has increased information availability, giving ordinary people more knowledge and power. This has resulted in revolutionary changes in organisational structures. The global increase of knowledge and power to the public puts pressure on organisations. It is therefore important for organisations, both private and public, to incorporate externally legitimated structures (Meyer and Rowan 1977).

These three meta discourses along with Fairclough and Foucault’s discursive practice establish a foundation for identifying the present built on the historical parts and elements of governmentality. Together, social change through discursive practice and governmentality bring out the meaning and influence of management accounting in the development of NPM as a governmentality framework.

**Accounting history**

According to Foucault the present is built on pieces of the past and can only be understood through the examination of history (Raffnsøe et al. 2008). This idea of the importance of history is shared by Miller et al. (1991) and Burchell et al. (1980). With a focus on accounting history, they identify a new arena of accounting history which integrates other disciplines and draws on social science in its
historical examination. They identify the importance of this type of accounting history as follows:

‘One aspect of the distinctiveness of the new accounting history is its focus on shifts in the forms of knowledge or expertise that typifies accounting at a particular moment in time and in a certain social context’. Moreover, they encourage further similar accounting history studies in order to enrich the discipline of accounting and to manifest the newly acquired impetus of accounting especially within a, at that time, new area of management accounting (Miller et al. 1991). This is supported by Gomes et al. (2011) who encourage accounting historians to function as ‘change agents’ in shaping public opinion and public policy decisions. Napier (2006) points to the use of Foucault’s work in exploring this ‘new accounting history’ which in accordance with Foucault ‘attempts to identify (or construct) networks of people, principles and practices (‘accounting constellations’) and to show how accounting can be ‘caught’ in such networks’ (Napier 2006, p.462). Additionally, Jacobs (2012) finds a need for exploring new areas of accounting due to social change in which accounting plays an increasing role. This requires new types of accounting theory and research in order to understand the social context in which accounting operates. Gomes et al. (2011) further emphasise the importance of accounting history studies since they often reveal how accounting emerges, its impacts on society and its social setting. These are important elements in the further development of accounting techniques and especially the nuances of accounting techniques which need further attention. They call for accounting history studies with informative and engaging alternatives which will attract a broader audience. This, they suggest, is done by illustrating accounting history in a non-typical setting of the everyday life which people may be able to relate to and which thereby inspires questions and enquiries on accounting development. This paper uses the health care setting as social context. The health care setting relates to everyday life and we are all interested in this setting since we are all part of the setting, some more actively than others. The paper explores the development of accounting in this social setting, thereby
following the approaches of Miller et al. (1991) and Jacobs (2012) by implementing social science in order to capture the specific accounting development in the social setting of health care. It sets out to identify the role of management accounting in the development of NPM through the practices of governmentality and discourse. It, thus, adds to the understanding of the present role of management accounting in health care, not simply at the local level, but also at an international level. This addresses Napier’s (2006) advocacy of this need to investigate accounting development through international governmental and organisational documents assisted by the management accounting research literature and health care history. It identifies world-wide societal change which has influenced micro-level changes.

3. NPM historical roots and definitions

Different perspectives on the origin of NPM exist. Some researchers point to policy makers in the US back in the 1960s (Gruening 2001; Stivers 2008), others point to New Zealand as an initially example of NPM through practical turnarounds (Lawrence et al. 1994; Whitcombe 2008) or to the UK during the Thatcher regime in the 1980s (Boden et al. 1998). But roots can also be traced to the beginning of the 1900s, or earlier, that marked the start of the discussions of what we refer to as NPM themes today.

Prior to NPM (1900 – 1960s/70s)

Even before 1900, in the 18th century, bio politics such as population number, average age of living and so forth became an interest for politicians (Foucault 1994; Krasnik and Vallgårda 1997). From the 18th century until the First World War, health systems expanded as nations changed into modern states in industrialised societies (Klazinga et al. 2001). Hospitals were established in several
nations from the beginning of the 18\textsuperscript{th} century for the military and for people who were less well off (Imhof 1977) and private practitioners became available during the 19\textsuperscript{th} century.

However, it was not until the 20\textsuperscript{th} century that public social services emerge with the willingness to provide universal health care, educations and other social services for citizens in industrialised countries (McKinlay and McKinlay 1987). A special focus on mortality and infections existed during the first half of the 20\textsuperscript{th} century in industrialised countries. Also apparent was an emergent need for structuring the society in manageable systems where ‘deviated’ citizens were assisted in various ways (Miller and O’Leary 1987). This was a basis for creating control and order. During this time cost accounting, sociology and medical systems evolved (Miller and O’Leary 1987). Performance measures have played a major role within the concept of NPM (Ballentine et al. 1998; Glennerster 1994; Modell 2001). However, performance measures and focuses on, for example, hospital costs can be traced to the beginning of the public health systems. Non-financial performance measures were also in focus (Cutler 2010; Klazinga et al. 2001). However, it was after World War II when universal health care emerged in most industrialised countries. Most of the state organised health care systems stemmed from pressure and inspiration from the World Health Organisation (WHO) that was established in 1948. This global health organisation was a result of the formation of the United Nations in 1945 (World Health Organization 2012, p.1). In its constitution all UN nations declare:

\begin{quote}
“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The health of all people is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and the State. The achievement of any State in the promotion of and protection of health is of value to all.

……..

Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.”
\end{quote}
The above declaration reveals two significant concerns; the focus on equality of the users of these health systems and the focus on the responsibility of the States to provide both health and equality. These concerns are similar to what Foucault calls the obligation of the State to ‘run a family’ (Simons 1995, p.37). It is a common interest that the State controls and provides equal access to health care. Another significant statement from a management accounting perspective is the last sentence concerning the responsibility of governments to provide health through social measures. This use of measures marks the beginning of an accounting influence. These measures are of concern to Miller and O’Leary (1987) in the standardisation of health care which results in the categorisation of people through measurement. The ‘adequate health and social measures’ creates a basis for the formation of objects which become knowledge (Fairclough 1992, p.41) and get incorporated in the operation of the State.

Shortly after the WHO was constituted, the British National Health Service (NHS) was established in 1948 (Hatcher 1997) during a period of national health concerns and pressing universal health responsibilities. Additionally, the American President, Harry Truman, unsuccessfully proposed a national insurance program in 1945. Not until 20 years later was Medicare established with the aim of providing health coverage to citizens above 65 years and disabled citizens (MyMedicare.com 2012). The establishment of public health services across UN nations varies significantly, both in coverage, intensification and timing (World Health Organization 2000).

**The rise of NPM (1960s-1970s)**

In the 1960s the ideas of NPM, referred to as Reinventing Government (Pollitt and Boukaert 2011), emerged and developed in the US. Dwight Waldo and others introduced NPM at a conference on future public administration (Gruening 2001; Stivers 2008). They saw a need for a more democratic
structure to avoid discrimination and injustice (Gruening 2001). This concern was ultimately supported and addressed by WHO in 1978 through the Declaration of Alma-Ata that was the result of an international conference on primary health care in the USSR (World Health Organization 1978b). The declaration is concerned with the inequality of health care provided across nations especially the differences between developed and developing nations. The main goal of the declaration is to reach an acceptable and equal level of health by the year 2000. The means to achieve this aim is stated in paragraph VIII: “All Governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country’s resources and to use available external resources rationally.” The declaration urges all UN nations to make plans and strategies, which in some nations were translated into reforms over the succeeding years. Through the Alma-Ata declaration the WHO constitution’s focus on social measures is supported and enhanced through economic rationality. The means to reach these objectives are described in detail in the Primary Health Care report of the international conference in USSR in September 1978. This report was sponsored by WHO and the United Nations Children’s Fund (World Health Organization 1978c). The third chapter of the report, ‘Operational Aspects of Primary Health Care’, incorporates management accounting techniques and issues such as planning, budgeting, decentralisation, control and evaluation. On page 68, the importance of budgets is stated ‘Budgeting at a central level is a key step because it estimates required resources and allocates those available in such a way as to transform an intention into concrete realization of the programme at the various levels of the health system.’. This focus on budgets is further emphasised by a recommendation for allocating costs to decentralised units according to standard costing. The development of standard costing is a great concern to Miller and O’Leary (1987) who note that by standardising you eliminate waste which is
deviation from the norm but which may in fact be a necessary root of social organisation and human action.

Moreover, the WHO report states that these decentralised units such as communities should be given specific financial ceilings combined with the responsibility and authority to spend the allocated money. These methods are detailed means to the universal health aim of equal access and available health care described above. This report is central in the development of NPM and in the development of management accounting through NPM reforms. The governments are urged to set up a structured health care system by means of economically optimized programmes based on standardization of various elements. The standardisation can be seen in the components of the evaluation process stated in part 106 of the report. These components include relevance of activities, analysis of progress, assessment of efficiency 'by comparing the results obtained with the efforts expended, the latter being expressed in terms of people, time, money and health technologies. It includes the measure of the extent to which facilities are actually being used' (World Health Organization 1978c). The statement clearly indicates how management accounting tools such as evaluation measures, effectively performance measures, become an embedded part of the control of universal health care. Thus the nations are encouraged to evaluate the efficiency of health care in relation to people, but to do so through management accounting tools. It further encourages a combined evaluation of people, time, money and health technologies through measures. These are the elements of society that Miller and O’Leary (1987) refer to in their review of constructing people through controlling elements of standard costs, budgets and performance measures and these are the elements that constitute parts of the concept of governmentality where these control devices become tools to be employed by the government to control society. It marks the beginning of the theme of NPM that precisely rests on the elements of decentralisation, transparency and accountability for performance (Groot and Budding 2008; Gruening 2001). In
order to pursue these themes the focal point is adopting market-based models with a strong focus on performance measurements (Brorstrøm and Nilsson 2008; Simonet 2011). Contracts and reforms between the State and the health care institutions emerged through a focus on this accountability and transparency theme (Blomgren and Sahlin 2007; Hood 1991), based on the Alma-Ata declaration (Østergren 2006). The resulting NPM philosophy shows two tendencies or trends, i.e. institutionalisation through contracts and market models. Both include management, organisation, registrations and measuring (Hood 1991). These are the general NPM themes, but different approaches and tools are constituent elements of the concept of NPM e.g. costing, ABC, budgets, balanced scorecards and other management accounting models which are used to enhance the NPM philosophy. The structures of public administration, political reforms and different types of management accounting systems have played a major role in the rise to prominence of NPM (Christensen 2007). Different management accounting tools such as balanced scorecard, ABC and in particular a focus on performance measures have entered the public scene. Moreover, in several cases these performance measures are used as economic incentives (Evans et al. 2010; Glennerster 1994; Ittner et al. 2007).

To explain the emergence of NPM, however, may not be as simple as just referring to the WHO Alma-Ata declaration. The declaration was indeed concerned with the costs of health care and this fact and the unequal access to health were a reason to encourage the structuring and tighter governing of the health care through results measures. But the Alma-Ata declaration actually states that in order to attain an acceptable and healthy economic level within a state, health care access and delivery is crucial; ‘The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.’ (World Health Organization 1978a, § III). According to WHO the initial aim of
establishing structured health care was to promote better economic welfare and world peace. Spending money on health care is seen as a positive attribute in this respect.

The health care profession almost goes unmentioned in the WHO declarations. Just a small part is devoted to the profession and refers to their future role in health with a main focus on responsibilities. However, the power of the profession has also been used as one of the reasons for the implementation of NPM reforms. In 1973, a Danish author, Jørgen S. Dich, published a book ‘The ruling class’ (1973) which argues against the state employing experts such as physicians. The state employed experts, he says, are gaining power at the expense of the working class, who are merely a social and ideological project in the public sector while the organisers and caretakers skim the cream with high salaries or in his words “The humanistic ideology becomes powerful as those who are employed in care taking duty or other health functions substantiate their demands for expansion of the sector to improve patients’ and employees’ state of being. When you put humanism behind your demands, your position is strong because the ideology for the opposition is humanistic too. The opposition becomes weak. The growth becomes big.” (p.16). Dich’s (1973) statement is similar to the concerns of Foucault who declared that the ‘knowledge’ of the state and the economic focus might prevent the tradition of running the state as a family as the elite of managers who provide the care has a totally different position than the individual (Foucault 1994; Simons 1995). ‘At the same time as medical knowledge served government, power also accrued to medicine itself. The ‘surplus of power’ that a political programme of hygiene bestowed on doctors included their ‘frequent role...as programmers of a well-ordered society. Capital and government were dependent on medicine as it provided the programmable model of society as a body’ (Foucault in Simons (1995, p.28)). Without a doubt, the medical knowledge has led to vast professional power but this power differs across nations. The Danish physicians have a strong history of power (Downie et al.
2006; Jespersen et al. 2002). Norman Daniels (1984) describes similar issues in American society in his article “Understanding Physician Power: The social transformation of American medicine”. Daniels (1984) accuses the physicians of self-serving by having complete monopoly of the medical market and paternalism in a doctor-patient relationship. One of Fairclough’s meta discourses, democratisation, has emerged as a global trend in order to remove this power and discrimination. It is aimed at making people, irrespective of social class and profession, more equal (Fairclough 1992). Similarly, the NPM wave has led societies to make reforms in an attempt to gain access to information and thereby to control the profession and hold them accountable (Gendron et al. 2007; Grafton et al. 2011; Kirkpatrick 2011; Kurunmäki 2004; Nyland et al. 2009; Pettersen 2004).

**The globalisation of NPM (1980s)**

The UK pioneered its NPM government reforms with the action taken during the 1980s under Prime Minister Margaret Thatcher (Groot and Budding 2008). NPM was then adopted in Australia and New Zealand, which historically are closely linked to the UK. New Zealand has implemented the most extensive NPM changes from the mid-80s and through to the 90s. New Zealand is therefore often referred to as the establisher of NPM and in New Zealand it is also called ‘the Great Experiment’ (Blakely 2010; Christensen 2007; Lawrence et al. 1994; Whitcombe 2008). Denmark implemented minor aspects of NPM in the 1980s, but implementation has intensified after 2003. Throughout the 1980s the main focus, in public institutions, was on transparency and responsibility through contracts (Blomgren and Sahlin 2007). Intensified focus on budgets and the administrative aspects through health reforms was seen throughout OECD countries. According to Hood and Peters (2004) early studies of NPM emerged in the 1980s where the concerns were normative and where many of the ideas came from practitioners, for example in New Zealand (Blakely 2010; Hood and Peters 2004). In the UK, the Griffith report (Griffiths 1983) laid the foundation for the
focus on quasi-market methods in the health care sector. It even directly disregards the fact of the health sector being a non-profit organisation: “We have been told that the NHS is different from business in management terms, not least because the NHS is not concerned with the profit motive and must be judged by wider social standards which cannot be measured. These differences can be greatly overstated. The clear similarities between NHS management and business management are much more important.” (Griffiths 1983, note 1). The report then identifies important aspects of the private sector which are relevant for the health sector such as ‘…levels of service, quality of product, meeting budgets, cost improvement, productivity, motivating and rewarding staff, research and development, and the long term viability of the undertaking.’ (Griffiths 1983, note 1).

Commercialisation, which is one of Fairclough’s (1992) global meta discourses, is evident in the ‘quality of product’ term. The private sector techniques meant that patients were now seen as consumers and the services given were seen as products. During the same year, changes were made to the US Medicare with a hospice care, routine mammography and new eligibility for federal employees (MyMedicare.com 2012). Additionally, in 1983 the Prospective Payment System was established in the US health care where treatment was covered through Diagnostic Related Group standards (DRG) rather than cost based payments (Borden 1988; Hwang 1994). The DRG system was originally adopted by the state of New Jersey in 1980. Implementing diagnose related cost standards when allocating money proved to moderate hospital cost inflation (Hsiao et al. 1986). It was therefore later adopted by the US Medicare in 1983. The US Medicare is different from the European public health systems, however, in the sense that it is a basic health insurance with additional coverage available through payments from the individual and it is only available for specific groups of citizens, primarily for elderly citizens aged 65 years or more. It is not universal health coverage. However, the change from cost based payment to standards like DRGs reaffirms the focus on market based techniques where a standard cost is applied, leaving the means of
treatment to the institution that got the possibility of becoming more effective and thereby receiving more money.

This time a reversed order of national and WHO adoption exists. The implementation of DRG in the US spurred WHO to issue the report ‘The application of Diagnosis-Related Groups (DRGs) for hospital budgeting and performance measurement’ (1988). It pursues target 34 from ‘Health for All’ in 1978 handling planning management and resource allocation. The report is further based on a pilot project in Wales, UK. The report describes in detail how DRG may be employed by nations and hospitals. It requires hospital activity data and cost data. The hospital’s cost data is assumed to be summed up per patient. An approach to implement DRG is ‘At a minimum, cost centres will need to be differentiated into medical, non-medical and support cost centres.’ (World Health Organization 1988, p.2). The report describes how these different costs should be allocated. It is further claimed that DRG is suitable for budgeting with inflation and wage increase adjustments. In particular, a large part of the report focuses on DRG in relation to performance measures which should include both admission/discharge measures and clinical and outcome/quality measures. A primary measure of outcome is the mortality rate but a need for more advanced outcome measures is acknowledged (World Health Organization 1988, p.4). In this report WHO recommends a focus on the quality and outcome measures. Moreover an important point in the report is that ‘Training will be required to assist health care professionals in the use, presentation and interpretation of case-mix measures and applications in the health care field.’ (World Health Organization 1988, p.6 point 7). This is an interesting note since it applies measures to the health care personnel without considering the opposite assistance where health care personnel assists in deploying the right data and measures through their abstract field knowledge. This is an example of reversed powers that are in Foucault’s framework. The knowledge of medicine gradually gets replaced by knowledge of cost measures and social measures. These measures represent the ‘truth’. According to Foucault (1994,
self-technology implies a set of truths. ‘Technologies of self-permit by own means and help of others, specific operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality’ (Foucault 1994, p.225). Good standards, reduced costs, appropriately allocated costs and improved efficiency assist this state of perfection. The allocated costs reveal the truth which enables actions to be taken to achieve perfection and happiness. The focus of the State is gradually switching from running a family to the problem of economy (Simons 1995, p.37).

These tendencies were further developed through the real market based reforms which were established at this time in the UK through the ‘Working for Patients’ white paper in 1989 (Ellwood 1996; Heald and Scott David 1996; Levaggi 1995; Mullen Penelope 1990; Northcott and Llewellyn 2001) and in New Zealand through the ‘Your Health and the Public Health’ in 1991 (Ashton 1993; Lawrence et al. 1994; Upton 1991). They had an intensified purchaser provider split. The idea behind this market approach is; ‘Users of the system will benefit because they will be able to choose between different types of health care with more services provided in the community.’ It continues ‘Health professionals and effective managers will find the new environment gives them opportunities to work with greater autonomy, and be recognised and rewarded for delivering better health care.’ (Upton 1991, p.10). Again the patients get translated into the term ‘users’, which indicates commercialisation, and managers are no longer just managers but mentioned as ‘effective’ managers. The market reform era takes the WHO Alma-Ata declaration a step further as it is no longer enough to standardise costs and integrate evaluation measures. In addition, competitive elements from the private market are also implemented in the public health care system. During this time period an academic management accounting concern for behaviouralism and management accounting in a social context evolves as suggested by Miller and O’Leary (1987). Management accounting techniques have gradually entered the social context of health care. Having been
introduced gradually as social measures initially, it then became a key component of entire market reforms that is fully embedded in discursive practice. This, however, provokes a concern for the initial social aims of public health care resulting in criticism by management accounting academics in the form of standardisation and the role of costs in respect of health care quality (Arnold et al. 1994; Chua and Preston 1994; Lawrence et al. 1994; Llewellyn 1993), the control of the profession (Coombs 1987), other concerns with the organisational members (Abernethy and Stoelwinder 1990; Bates and Brignall 1993; Nahapiet 1988; Pinch et al. 1989; Rea 1994) and later on more intense critique as the results of the reforms start to surface. This, however, does not happen until the end of 1990s where the NPM phenomenon and the focus on budgets and performance measures in health have started to be implemented in various nations.

*National variations of NPM (1990s)*

Throughout the 1990s, the NPM philosophy grew stronger across nations but with different themes and ways of implementation (Hood 1995; Hood and Peters 2004). Canada, Holland, Norway, Finland, Germany, Italy, Portugal and Sweden were among the countries who made prominent attempts to adopt New Public Management. However, literature within management accounting is scarce in these countries.

The focus during the 1990s was on cost issues and DRG estimates became increasingly popular due to an increased demand for lowering costs in the public sector. A study by Forgione *et al.* (2005) identifies the adoption of DRG in Australia (93-00), Australia (97), Belgium (95), Denmark (00), Finland (95-01), France (99-04), Hungary (93), Ireland (93), Italy (95), Luxembourg (95), Norway (93), Poland (99), Portugal (90), Spain (91-98), Sweden (90-96), Switzerland (96), UK (92) and the pioneers US and Canada (83). In the 1990s DRG adoption was extremely common.
Another characteristic of this period is the awareness of cross-national differences in NPM implementation and public sector reforms (Hood and Peters 2004). Comparative studies emerged integrating a critical aspect while analysing the consequences of the NPM reforms (Broadbent and Guthrie 2008). In this way socio-political and cultural issues came to play a central role in the different developments and outcomes of NPM (Hood and Peters 2004; Jespersen et al. 2002). Previously, there were no studies of NPM implications in non-English speaking nations. But during the last few years some studies have been conducted across nations; not only industrialised nations, but also developing and transitional countries. These studies will be explored below with a description of the general tendencies in these national contexts and also the apparent differences. The language barrier limits the raw study of reforms in non-English speaking countries.

**Industrialised countries**

Most research studies are conducted within English speaking nations like the US, the UK, Australia and New Zealand. The US differs from the European countries and Australia since its health care system is highly privatised. Therefore, the discussion on health care issues in the US has a different perspective. However, the US perspective reflects the main issues of NPM in health care since NPM draws on market mechanisms and tools. Additionally, DRG originated in the US. One article written by US authors can be found in AOS. That is “Monetized medicine: from the physical to the fiscal” (Samuel et al. 2005). This article criticises market driven health care for having failed to fulfill its intention. The study criticises the way that accounting and costing systems put prices on people’s lives and points to the negative results of, for example, DRG that makes physicians defend quality of commodity rather than quality of care. It questions the ethical implications of transforming medical services into commodities: “For example, engineers warned that “one major obstacle” to a “product line approach to managing hospitals” was the misguided “humanistic concept of service” (Fetter & Freeman, 1986, p.53). Some economists still lament “…the
disquietude many people feel, or think they should feel about the commercialism” of healthcare (Pauly, 1998, p.235). Despite their misgivings, it would seem that the battle against the commodification of medical care is being fought in the shadow of a war already lost. “Providers” and “consumers” have almost completely replaced “doctors” and “patients”, and “care” is increasingly “delivered” to enhance “health status”. The ill-health of people is no longer viewed as a social problem, but increasingly as a “budget deficit problem” (Thurow, in Preston et al., 1997, p.160)”.

The paper, moreover, documents how this market shift in health care has not decreased health costs. They are still increasing steadily. The trend of increased costs despite NPM implementation is further supported by New Zealand studies (Ashton 1996; Easton 2002) and OECD cost statistics (OECD 2011). However, as shown earlier through the WHO documents, this is a desirable intention and necessary to promote good health and it contributes to society as a whole. The critical American literature (Covaleski et al. 1993) is focused on the patients and quality of care rather than on the profession and in this way it differs from European studies. The post market reform critics in English speaking nations shift in the reform focus from service and clinical orientation to monetary, budget and performance measures. This was, however, not the initial intention of the WHO report from 1978 on ‘Health for All’ where the main aim was equal access for all individuals to health services. But in an attempt to successively provide these health services and monitor the outcomes and costs, mechanisms of control and power are implemented and result in unintended consequences. Numbers represent the truth and management accounting tools become very powerful through this belief.

In the UK, New Zealand and Australia, the public health care sector plays a larger role and in these countries, in particular in the UK, the most critical literature can be found. UK and New Zealand
who are the pioneers, adopting market reforms in the early 1990s, turn away from this attempt at the end of 1990s and focus on collaboration instead of competition. In 1997, New Zealand integrates the ‘Coalition Agreement’ (Ashton 2001; The New Zealand National Party 1996) and the UK integrates the white paper ‘The new NHS’ (The UK National Health Service 1997). These Anglo-American countries have been categorised as and are called the NPM marketisers (Lynn 2008; Pollitt and Boukaert 2011).

In the continental European countries the state plays a stronger and more active role (Bach and Bordogna 2011) and they have been called the modernisers or the Neo-Weberian States (Pollitt and Boukaert 2011). Neo-Weberian States refer to states with ‘normalised’ state influence in the sense that citizens do not question its existence and Neo refers to the citizens’ involvement and demands (Lynn 2008). Though no opposition to the role of the state can be found in the management accounting literature, many of these countries are actually regarded as more opposed to NPM adoption than the UK and implementation of NPM has therefore taken more time (Simonet 2011). The strong professional cultures in countries like France and Italy and also Denmark have slowed down the NPM acceptance in these countries (Jespersen et al. 2002; Simonet 2011). In Germany, the profession is strong as well, but the professional associations make the actions by the German state legitimate and acceptance is thereby enhanced (Simonet 2011). A study by Henriksen et al. (2012) compares NPM in third sector social care within health between Denmark, Germany and the US. They find that although these three countries are very different in context and history, convergence can be found on several levels of NPM implementation. Similarities can be found in their interpretation of NPM and the fact that NPM has led to more regulation within the individual countries. Despite the different starting points for each country they converge on the subject of provider mix. A convergence is not found, however, on the revenue and financing mix. Here, the US is still much different from Germany and Denmark. These observations are relevant in the
discussion of the impact of socio-political issues. It shows how different history and starting points may contribute to variations in the set-up and implementation of NPM in different countries. However, there are many similarities in trends such as the meta discursive trend of democratisation which is evident through the implementation of budgets and performance measures initiated by WHO. It holds the profession accountable and thereby removes old power structures.

A study by Oliveira and Pinto (2005) on “Health care reform in Portugal: an evaluation of NHS experience” describes the development of political health reforms and their effects on Portuguese health care. Again, there are surprising similarities between the Portuguese health care and other European countries as Scandinavia, Germany, Holland and the UK. Reforms have been made to increase equity, efficiency and accountability in Portuguese health care. An article on the French health care system has been published in Health Economics by Bellanger and Mossé (2005). This article describes how France is reluctant to introduce market forces in public health due to a strong traditional top-down public administration. It describes how France has tried to implement economic and cost focused initiatives in health care during the past 40 years, but completely without success. The main focus in France therefore seems to be on reducing the burden of disease and premature deaths and other human issues rather than on economics, which in fact is aligned with other parts of the WHO focus and according to the authors. France has a very efficient system.

Developing and transitional countries

Little research has been done on the developing and transitional countries. But in later years a few studies have emerged. Awasthi et al. (2001) emphasises the cultural differences and the behavioural consequences when adopting performance evaluation systems. It studies US and Chinese nationals in Taiwan. The study is pertinent since it reuses valid questions about national differences and their impact on introducing specific accounting tools. The study shows that it is important to
acknowledge that people of different nationalities may have different work-related cultures. The study focuses on two cultural dimension; individualism/collectivism and power distance. It shows considerable differences in accepting performance evaluation systems depending on these two dimensions. The US has low power distance and high individualism and thus the likelihood of successfully implementing performance evaluation systems is higher than in countries with high power distance and less individualism.

Though not focused on health, but on the police, a study by den Heyer (2011) on NPM reforms in transitioning and developing countries reveals the variations in themes and implementation at a level beyond what has been studied within the industrialised countries. Basic needs and everyday survival strategies constitute the attempt of governments to establish a functional public sector and NPM reforms cannot stand alone but must be implemented in accordance with a comprehensive political framework with clear political goals (den Heyer 2011). Hence in developing countries, the cultural impact seems to play an even larger role than in the industrialised countries where convergence of social systems has existed prior to NPM (Henriksen et al. 2012) and democratic systems are taken for granted. Pillay (2008) studies the cultural influence on NPM states and shows that analyses of NPM fit must take changes in governance systems and level of change in developed countries into account. Moreover, he concludes that both micro and macro level variables are relevant in a complex relationship where congruency between strategy of policy and the public management process is important for success.

Studies of old Soviet Union nations such as Kazakhstan reveal the challenge of implementing NPM reforms in old communist nations where health care has always been comprehensive and free for all citizens. One of the initial aims of introducing NPM in health care in Kazakhstan and Tajikistan has been to reduce the level of corruption (Amagoh 2011). Institutional pressures and differences along with cultural differences play the largest role in the difference of NPM implementation of
developing and transitioning countries (Timoshenko 2010). Though a comparative study of Nepal and Russia by Timoshenko (2010) suggests great variances, he also addresses the same initial ideas and growing institutional pressures from the global community.

The above review of NPM implementation across nations highlights a number of ideological implications. The US differs from the European countries because of its different democratic public setting with larger emphasis on private hospitals. This is linked to fundamental differences in perception between the US and Europe. The Nordic countries differ from the Anglo-American countries as regards performance measurements in the public sector, since the Nordic countries depend on economic flexibility, social innovation and political compromises (Johnsen et al., 2006), but this can also be applied to continental European countries where Neo-Weberian States have a different and more democratic basic culture (Pollitt and Boukaert 2011). Moreover, the nations and cultures are older in central Europe than in the US, Australia and New Zealand for example. These are young multi-ethnic countries where opportunities are grasped and flexibility and acceptance simply exist on a different level. For example, the Danish and the US cultures are similar with regards to the aim of equalisation. However, the basic assumption and definition of equality are different. In the US, everybody is equal measured upon work effort. In Denmark, everybody is equal regardless of the work effort and status. The work ethic is based on duty (Jensen 1998; Nørreklit et al. 2006). It is a contribution to the whole society. In European countries it is possible to have different status and income, though the differences in income are minimal compared to the US (Bergström et al., 2004). When comparing developed and developing countries at a different societal level, other issues are at stake. The developing countries are at some sort of pre-stage to governmentality, but in many countries sovereignty still prevails which makes reflections of governmentality insufficient. The transitional countries come from an extreme form of
governmentality where the state controlled and made decisions on a far more extensive level than known in democratic states. These fundamental differences create some of the system discontinuities and nonlinearities described by Hood and Peters (2004). The WHO documents address developed, developing and transitional countries. Developing countries in particular need the structures of health care systems, but due to the economic and political state of the nations it is difficult as democratic and structured governments are fundamental for the development of NPM. However, the marketisers (Anglo-Americans) develop reforms as ‘hares’ (Hood and Peters 2004) quickly dismissing policies when the anticipated results fail to happen whereas the continental European modernisers develop reforms as snails combined with acceptance on a different level allowing the reforms to develop into a more mature state. These nations, however, run the risk of governing ‘too much’ as Foucault would express it.

The difference of nations is also highlighted in the WHO world health report in 2000 which focuses on health systems and improving performance. It tries to tie all member states together in a report emphasising the continued importance of health systems. It has a different focus on costs than before, stating the importance of protection of patients from excessive health costs; ‘..health systems have a responsibility not just to improve people’s health but to protect them against the financial cost of illness – and to treat them with dignity.’ (World Health Organization 2000, p.8). Thus, three fundamental objectives of health systems are described: 1) improving the health of the population they serve; 2) responding to people’s expectations; and 3) providing financial protection against the cost of ill-health. WHO responds to development of market reforms by marketisers (hares) in the 1990s and spreading of cost and performance measures which resulted in criticism. The report further discusses how to attain results from resources. It maintains the importance of monetary inputs since that is what is used to buy real inputs. However, it is stated that the input – output
relation often gives an obscure and inadequate indication of the health system’s potential (World Health Organization 2000, p. 40). In other words, the WHO report from 2000 digs deeper into the member states’ health performance. It emphasises the importance of money for buying resources and the relevance of optimising the monetary resources. But financial resources should not be the responsibility of the patient and optimising health care should not be an excuse for spending less money on health. In fact, within the member states the more expenditure spent on health care per capita, the better the overall performance of health care (World Health Organization 2000, p.44).

The four health system functions studied in the report are service delivery, input production, financing and stewardship. Stewardship is defined as the ‘function of a government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry’ (World Health Organization 2000, p.119). It is, thereby, addressing the member states’ governments. But many of these states are developing and transitional nations facing corruption which prevents the possibilities of poor people to use the system that they need (World Health Organization 2000, p. 121). WHO further states the importance and increasing trend of health policies that strive to integrate the future by defining a vision and direction. It, moreover, emphasises the responsibility of governments to perform these health policies and governing health care systems in general.

**Post NPM with a focus on quality (2000-present)**

After 2000, health care systems get a new focal point. Though sustaining cost controls, performance measures and budgets, the quality of care becomes more important. The early adopters, for example New Zealand, have switched from the market-based model of NPM towards a broader focus on quality and health targets including the wellness of patients and not economic measures (Library 2009; New Zealand's Minister of Health 2000). Late adopters intensify NPM methods after year
2000 and Denmark is an example of such a country with the Structural Reform introduced in 2003. The Danish structural reform’s objective is to make the health sector more efficient with a higher service level and quality (Danish Ministry of Health 2004; Strandberg-Larsen et al. 2007). The outcome of NPM has provided a need for implementing the quality aspects of health care. Moreover, paradoxes and unintended effects in public sector management have been identified leading to concerns for cultural and social implications (Hood and Peters 2004). This concern is already stated in the WHO report in 2000, but it is applied and integrated in 2006 where WHO publishes a report called ‘Quality of Care – A process for making strategic choices in health systems’. They argue that ‘Even where health systems are well developed and resourced, there is clear evidence that quality remains a serious concern, with expected outcomes not predictably achieved and with wide variations in standards of health-care delivery within and between health-care systems. Where health systems – particularly in developing countries – need to optimize resource use and expand population coverage, the process of improvement and scaling up needs to be based on sound local strategies for quality so that the best possible results are achieved from new investment.’ (World Health Organization 2006, p.3). We are now moving beyond the management accounting focus on resources and costs into quality indicators. They define quality as including six areas within health care systems: (1) effective focusing on improved outcomes for individuals and communities; (2) efficient to maximise resources used and avoid waste; (3) accessible providing timely, geographically reasonable health care in reasonable settings; (4) acceptable/patient-centered giving individual service and understanding cultures and different needs; (5) equitable delivering equal health care disregarding race, income, gender and geographical location; (6) safe which minimises harm and risks to patients (World Health Organization 2006, pp.9-10). Thus, the governments are now urged to optimise resources in health care while increasing individual safety, access and service within health care. A balance between
the six areas of health quality is needed in order to pursue an optimal health care. The management accounting practice such as performance measures are still present and they are now translated into quality measures. Effectiveness and efficiency are also two important factors in the quality definition. However, the management accounting terms have reached a more natural and balanced stage where they are taken for granted but are less dominant than the earlier heavy cost focus. The stated scientific truth concerning measures and indicators has now been normalised, or in other words, it is embedded in wider social practice and is no longer questioned.

4. Key historical points

The historical investigation of the role of management accounting in the development of New Public Management clearly shows the significant role that the World Health Organization (WHO) has played ever since its establishment in 1948, but most markedly since 1978. In addition, the US, UK and New Zealand have significantly influenced the global health care development and the integrated role of management accounting and have later influenced WHO developments. Though the focus on bio-politics such as mortality rate and population stems from the Enlightenment (Foucault 1994; Simons 1995) that gradually led to the establishment of hospitals and medical treatments, it is not until after the Second World War that the population’s health is given systematic attention with NPM as a natural extension to this systematic management. Table 1 summarises the historical development.
Table 1: Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Nation/organisation</th>
<th>Focus</th>
<th>Role of management accounting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1700s</td>
<td>Developed countries</td>
<td>Bio-politics</td>
<td>Quantifications of population and mortality</td>
</tr>
<tr>
<td>The beginning of the 1900s</td>
<td>Developed countries</td>
<td>State centralised health care – increase in hospitals</td>
<td>Structuring health preliminarily</td>
</tr>
<tr>
<td>1948</td>
<td>World Health Organization established (51 states)</td>
<td>Equal access to health</td>
<td>Social measures</td>
</tr>
<tr>
<td>1948</td>
<td>Establishment of NHS in the UK</td>
<td>Universal health system</td>
<td></td>
</tr>
<tr>
<td>1978</td>
<td>WHO – Health for all</td>
<td>Structuring health systems with a focus on costs and efficiency along with outcome measures</td>
<td>Costs, outcome measures, budgets</td>
</tr>
<tr>
<td>1983</td>
<td>US</td>
<td>Medicare for elderly – DRG implementation</td>
<td>DRG</td>
</tr>
<tr>
<td>1983</td>
<td>UK</td>
<td>Griffith Report</td>
<td>Market and cost focus</td>
</tr>
<tr>
<td>1988</td>
<td>WHO</td>
<td>DRG Report</td>
<td>DRG</td>
</tr>
<tr>
<td>1989</td>
<td>UK</td>
<td>White paper – Working for patients</td>
<td>Market focus – Purchaser/Provider split</td>
</tr>
<tr>
<td>1991</td>
<td>New Zealand</td>
<td>Upton – Your Health</td>
<td>Market focus – Purchaser/Provider split</td>
</tr>
<tr>
<td>1997</td>
<td>UK</td>
<td>The New NHS – cooperation</td>
<td>Performance Measures</td>
</tr>
<tr>
<td>1997</td>
<td>New Zealand</td>
<td>Coalition agreement</td>
<td>Accountability and performance</td>
</tr>
<tr>
<td>2000</td>
<td>WHO</td>
<td>Performance of health with a reinforcement of help for poor patients</td>
<td>Performance measures</td>
</tr>
<tr>
<td>2000</td>
<td>New Zealand</td>
<td>NZ Health Strategies – refocus on ethnical minorities and equal access to health</td>
<td>Quality/outcome measures along with prevention measures (targets)</td>
</tr>
<tr>
<td>2006</td>
<td>WHO</td>
<td>Quality for Care</td>
<td>Quality indicators</td>
</tr>
</tbody>
</table>

WHO is currently comprised of 171 member states and had 51 member states at its establishment, and many of the present members are developing countries. The role of Anglo-American countries in the development of NPM models far exceeds the numerical proportion of those countries compared to non-Anglo-American WHO member states and this dominance has not been a matter of language but has been the result of deliberate goals set by those countries. The US especially contributed by inventing the DRG where costs are allocated according to the patient’s diagnosis. Later, the UK and New Zealand have been leaders in market reforms and have taken the WHO
report from 1978 a step further but they also quickly learnt from this and redirected the health care systems towards collaborations and cooperation in 1997. Other countries have followed but have been the snails rather than the hares (Hood and Peters 2004); the direct market reforms have not been established to the same extent in other nations. However, we have recently seen how developing and transitional nations adopt NPM structures and performance measures as stated in the WHO reports of 1978 and 2000. Finally, in recent years quality has again become the focal point, and a rediscovered clinical and professional is integrated with the dominant management accounting focus. NPM does, however, still exist in different versions across nations. The methods and implementations of NPM show discontinuities and nonlinearities with paradoxes and cultural surprises evolving during the 1990s in particular (Hood and Peters 2004). This study shows that the techniques and principles of management accounting such as performance measures and budgets persist despite the problems and the change away from market reforms. The management accounting techniques show a dominating and lasting trend in the managing of health care which makes the discussion of discontinuities irrelevant in this respect although the management accounting techniques add to power struggles and paradoxes, especially through the applied governmentality where blindness of the methods is a central issue. The blindness leads to strong-willed pursuit of one’s own interests in order to ensure one’s own security with disregard for all other considerations, i.e. when society demonstrates an inconsiderate behavior towards anything out of the ordinary (Raffnsøe et al. 2008), which in management accounting terms would be against any deviation which may not be beneficial for the safety of the citizen. A paradox is thereby created. A solution to this paradox is pursued in later years through quality indicators (World Health Organization 2006) and cooperation in health rather than competition (New Zealand's Minister of Health 2000), but the standard costs and performance measures of management accounting are sustained.
5. Conclusions

This study has provided a transversal and holistic analysis and has revealed several significant points, both as regards the development of NPM health reforms and the role of management accounting in this development, but also regarding the suitability of the theories applied. (1) WHO has proven to play an important role in the historical development of NPM reforms. (2) Stemming from WHO, NPM health care reforms exist at different levels depending on the national context, and differences are found between the Western nations and developing and transitional nations. (3) In the discussion of NPM reforms in different national contexts the theories of governmentality and discourse assist in explain the NPM development and contribute to pinpointing vital issues in modern nations, but the theories prove to be of limited use when studying developing and transitional nations. Likewise, the theory of governmentality and the meta discourses of Fairclough (1992) appear to gradually become irrelevant. These observations are relevant in future studies. (4) Finally, management accounting plays a noteworthy role in the development of NPM health care reforms, but in contrast to NPM, management accounting techniques prevail despite the national context, health care reform experience and current national situation.

Through the UN, the WHO plays a significant role in the development of NPM health care reforms. The WHO documents have had a strong influence on both the formation of health systems and also on the later formation of government policies; the so-called NPM reforms. This proves that WHO is a key change agent. The position of WHO in the globalisation provides an international perspective in a more intensive presentation of the role of health care systems. It thus adds to the explanation that is missing in the existing management accounting literature that discusses and criticises narrow aspects of reforms and methods in national health care settings. The WHO reports have shown the crucial importance of structuring health with the main aim of providing equal access to health
world-wide. Unlike the philosophy of NPM, the role of WHO is linear and steady. WHO continuous to play an important role and has recently redirected the health care focus to quality indicators (World Health Organization 2006).

Fairclough’s (1992) meta discourses of commercialisation, democratisation and technology have helped tie the health care development together at the core historical times during the 1980s and 1990s where these issues were reflected in the development of management accounting in health care. Likewise, Foucault’s concept of governmentality (Foucault 1994; Raffnsøe et al. 2008; Simons 1995) has facilitated an understanding of the element of management accounting in the development of NPM in health care. Foucault adds to the knowledge by combining elements between the WHO documents, national documents, academic literature and history. Foucault’s philosophy brings management accounting techniques forward as an applied disciplinary technique to govern the individual, which, through the WHO reports and later through national reforms, becomes an ethical assignment for the state and also reflects a rational power of the state. The care of the individual becomes a duty for the state through the WHO reports and thereby supports those reflections of Miller and O’Leary (1987). As a polar opposite to the public structure of public services we find the neoliberalism which questions the governing and constantly argues that the state governs too much (Foucault 1994, p.74). In the discussion of governing, this historical study shows divergent appearances of NPM. Foucault (Foucault 1972, 1994; Raffnsøe et al. 2008; Simons 1995) and Miller and O’Leary’s (1987) thoughts strongly support the Neo-Weberian State characteristics in central Europe with excessive governmental control and to some extent the marketisation in the Anglo-American nations. We see how governmentality in these nations is powerfully manifested through management accounting techniques such as standard costing, performance measures and later on through quality indicator and thereby shapes the rationality of
governing. Discourse theory reveals how the historical development through ‘fields of statements’ (Fairclough 1992, p.46) creates relationships between various dimensions and constitutes the discourse formation of management accounting terms and techniques. This results in an integration of management accounting in a wider social practice which finally becomes normalised as ‘knowledge’ by the state. Governmentality and discursive formation thus bring out the issues of modern societies regarding hidden power mechanisms through rationalisation of performance measures.

The theories, however, also prove to have their limitations. After 2000 Fairclough’s meta discourses no longer support the health care development. Instead, it is an open question whether a new type of meta discourse is now present in the form of cooperation and quality? There is increasing concern about the quality of care and a redirection towards the social context of health care in later years and these aspects could be interesting to apply to other contexts as well in future studies. The concept of governmentality is of limited use in the world-wide analysis that includes multiple transitional and developing nations. Governmental issues like corruption and poverty take NPM to a different level where the establishment of health care institutions for universal health care is difficult. The thoughts of Foucault and the points made by Miller and O’Leary (1987) are not adequate for the historical study of these nations. In order to understand the transitional and developing nations’ status quo and their interrelation with other nations, for example through WHO, we need to develop a suitable framework for the studies on management accounting techniques used in these nations. WHO’s aim is to establish world-wide universal health care with equal access and quality of treatment for all individuals, and it is therefore essential to study the development of management accounting in all types of nations. The past and present of the developing nations reveal the alternative to a structured health care system which is less desirable. This puts the NPM development into an important
perspective where the initial reasons for NPM may be found. WHO was established right after the Second World War, indicating the ending of war as a specific element of change towards better health and structures in the pursuit of peace. The focus on social measures in the pursuit of equal health care access highlights the positive aspects of NPM which are still relevant when implemented in transitional and developing nations.

The historical focus of this study is built on the ideas of ‘new accounting histories’ (Gomes et al. 2011; Miller et al. 1991; Napier 2006) including the social context of accounting. The study has, however, not departed from accounting to such a degree that it becomes questionable whether the study investigates accounting history which has been noted as a concern by later authors (Gaffikin 2011; Gomes et al. 2011). On the contrary, this study has investigated the role of management accounting in the development of a specific social context, that of health care systems. It has revealed the intertwined roles of nations and the WHO, the management accounting techniques and NPM reforms. It has provided an overview of the origin of NPM and the position taken by management accounting in its development. Management accounting plays a significant role in this development. Management accounting prevails within NPM due to its simplicity, universal language and ability to frame numerous health care activities. This brings out important aspects of management accounting. Although often referred to as significant for the NPM definition, management accounting can be separated from NPM in its core form of techniques. It is those core forms such as budgets, costing and performance measures that succeed despite NPM paradoxes, surprises and redirections. This point provides the foundation for more in-depth and integrated research of management accounting phenomena and their persisting powers along with investigations of the raison d’être of health care systems and the importance of management accounting in this respect.
References


Imhof, A. E. 1977. The Hospital in the 18th Century: For Whom?: The Charite Hospital in Berlin, the Navy Hospital in Copenhagen, the Kongsberg hospital in Norway Journal of Social History 10 (4):448-470.


OECD. 2011. Health: spending continues to outpace economic growth in most OECD countries


Dwight Waldo (1913-2000) was an American Political Scientist. He was a major figure in modern public administration. He has published several books on the issue, the latest being "The novelist on organization and administration; an inquiry into the relationship between the two worlds" Berkeley, Institute of Governmental Studies, University of California, 1968.
Demonstration of economic arguments in the public health care debate - A case from Denmark

Abstract

The role of management accounting in the rise of New Public Management has been widely researched, discussed and studied in various organisational contexts. This study, however, uses discourse theory to investigate the role of management accounting terminology, stemming from neoclassic economics, in the public health care debate after a Structural Reform was introduced in Denmark. The purpose is to examine the importance of management accounting in the NPM discourse and its influence on the initial aim of the reform which was to promote a focus on service quality. 88 newspaper articles and 18 medical profession articles are analysed from 2002 to 2008, using critical discourse analysis. The analysis shows that the management accounting discourse becomes an ideology which is embedded in the social practice of health care. This creates a phantom phenomenon involving the negative consequences of the reform being blamed on the system. The health care profession is also victimised. As a result service quality in the sense of the patients’ well-being does not exist. On the contrary, service quality is identified with quantitative measurements rooted in the management accounting tradition through strong rationalised arguments. This puts the profession in a dilemma where the physicians withdraw from the general public debate, but adopt management accounting terms in their own professional debate over the years. The study therefore demonstrates how management accounting terminology becomes a central aspect of the debate on health service purpose and development in Denmark.

Keywords: New Public Management, management accounting, public health care, performance measurements, discourse analysis, service quality, media debate

Words: 15,237
1. Introduction

This study investigates the role of management accounting in the development of New Public Management (NPM) in Denmark. Critical discourse analysis (CDA) is used to analyse the divergent issues in the health care debate showing the increasing manifestations of rational economic arguments. Management accounting, with roots in neo-classic economics (Ryan et al. 2002), is closely related to these economic arguments where the semiotic use of budgets, costing, savings, efficiency and productivity expresses meanings beyond the traditional practice of accounting techniques (Arnold et al. 1994; Oakes et al. 1994; Samuel et al. 2005). Today management accounting terms, and models used to enhance these focal points, have entered the wider social practice of public services along with the emergence of NPM. This has proven to be complex and problematic on several levels within the public institutions (Llewellyn 1993; Llewellyn and Northcott 2005; Pettersen 2004) and a well-researched tension between policy makers and health care professionals is often apparent (Abernathy 1996; Boden et al. 1998; Broadbent et al. 2001; Broadbent and Laughlin 1998; Glennerster 1994; Lawrence et al. 1994; Mackintosh 1993). Moreover, various different national settings make NPM transition challenging (Hood 1995; Jespersen et al. 2002; Lawrence et al. 1994; Nørreklit et al. 2006; Scarparo 2006) because of different institutional constellations, competition, political and administrative structure and power dimensions (Kirkpatrick 2011).

Unlike prior studies, this study does not examine the internal accounting procedures of relevant institutions. Instead, it uses CDA to investigate the debate in parts of the public media. Newspaper and physician’s journal debates are analysed following an intensification of NPM after the Structural Reform in Denmark. This approach follows up and extends a briefly touched area of
newspaper discourse analysis in costing research which occurred 20 years ago (Arnold et al. 1994; Oakes et al. 1994). It develops and extends this prior study and makes an original contribution to the research literature on the topic. According to Fairclough (1995) discourses found in news media can be seen as an ideological process of considerable social importance which makes this approach highly relevant in the discussion of management accounting in social services. Additionally, the particular language of accounting is seen as complex and includes discursive representations and vocabularies (Miller 1994; Potter 2005). The discursive representation of accounting is manifested through various ‘calculative’ forms (Miller and Napier 1993) in an attempt to seek the ideal of neutrality and objectivity (Miller and O'Leary 1993) which is perceived to represent honest government and true knowledge (Porter 1996). It is through this rationale that accounting techniques are mobilised (Miller 1994). The specific aim of the study is therefore to locate and assess the importance of neoclassic economic rationalisation, manifested through management accounting terms and models, within the broader social practice of health care. This is done by identifying dominant linguistic discourses in the debate surrounding the extensive development of NPM following the Structural Reform of health care in Denmark. To examine the discourses analyses were made of all national newspaper and physician’s journal articles containing material on the issue of the reform and health care between 2002 until 2008.

In addition to the role of management accounting in the public debate, a specific focus concerns the framing and development of the concept of service quality during this NPM intensification. It is within the debate of health care services, its service quality and accounting representation of these social actions, that the above mentioned tensions become apparent. Addressing the concerns of accounting as a social and institutional practice (Kurunmäki et al. 2011; Miller 1994; Miller et al. 1991; Potter 2005), its transfer of ideas and practices into local settings (Kurunmäki et al. 2011) and
building on earlier studies of accounting’s linguistic role in newspapers (Arnold et al. 1994), this paper seeks to provide clarification of the role of management accounting in an unexplored local setting. It will thereby contribute to the overall body of accounting literature on accounting change and the specific continuous relevance of understanding the role of management accounting in social settings like health care.

An explanatory framework for understanding the conflicting issues and for pursuing the study objective is provided in the following section. This section comprises three parts. The first part reviews earlier literature on social conflicts arising in the development of NPM. The second describes the specific Danish situation through illustrations of key aspects in the Structural Reform and the financial contracts made between the government and health care sector. The third refines the discussion further into a conceptual discussion of the common ground between management accounting and the health care profession. The concept of service quality is employed and its meanings and different perceptions are discussed as they play an important role in the debate of NPM and health care. Then the methodology is described with an incorporated illustration of the intertwined issue of ideology and rationalisation in discourse theory. The analysis is presented in a three dimensional framework suggested by Fairclough’s (1992) CDA. The final part of the analysis is a discussion of the findings that are related to the wider social practice on which conclusions are drawn. This discussion highlights the increasing dominant discourse of management accounting in the public debate and the changing role of service quality manifested through rationalization. Additionally, it highlights the pressure that has been put on the doctoral oath by health service reform.
2. The continuously problematic issues of NPM and the relation to the Danish case study

A review of earlier studies has identified continuing tension between the management accounting ideology of NPM and the clinical ethos of the medical profession regarding high service quality. This supports the relevance of this study. For example, the two US studies in 1994 (Arnold et al. 1994; Oakes et al. 1994) on health care cost discourse found that the universal logic of markets and rationalisation is pervasive in the public debate about health care costs, which results in tensions and struggles caused by a contradictive social setting. Additionally, they show an enhanced tendency to use accounting numbers in newspaper reporting rhetorics (Arnold et al. 1994) and in the outputs of health care cost researchers (Oakes et al. 1994). Studies on institutional settings and reform challenges in health care also evidence an incessant contradiction in terms of integrating accounting structures in social practice. It is apparent that the power structure of health care has changed with the evolution of NPM, making management accounting systems more dominant than professional skills in the monitoring and evaluation of clinical performance (Arnold et al. 1994; Brorstrøm and Nilsson 2008; Groot and Budding 2008; Jones 1999b; Oakes et al. 1994; Pettersen 2004; World Health Organization 2000). Moreover, international studies show that the demand for quantitative goals and transparency has reduced some of the original powers and focus of physicians by transferring tasks to administrators and the accounting profession (Brorstrøm and Nilsson 2008; Jones 1999b; Kurunmäki 2008; Mannion et al. 2007; Strandberg-Larsen et al. 2007). This reveals some of the power and reverse-power issues that exist within the public sector where the field of knowledge, in this case medical science, is represented through accounting techniques (techniques of knowledge). But evidently, the techniques of knowledge are applied with a ‘...significance that extends beyond the task to which they are applied, yet without determining the consequences or outcomes of their deployment in any particular setting.’ (Miller 1994, p.3). The rationale behind this power shift can be found in Fairclough’s (1992) meta discourse of
democratisation which illustrates a trend of removing old power structures. But the use of accounting techniques to bring transparency forward and hold the health care profession accountable has not led to the expected improvement in efficiency and transparency which is challenged by the lack of understanding and the de-motivation of employees (Kurunmäki 1999, 2004; Lawrence et al. 1997; Llewellyn 1998; Pettersen 2004; Østergren 2006). Managerial and professional jurisdiction and the problems of standardising work procedures along with ‘drawing professional elites into bureaucratic roles’ (Waring and Currie 2009) have been identified as continuous and very problematic issues. Some of the reasons for these problematic issues may be found in the fact that the health sector generates social outcomes rather than financial outcomes (Brorstrøm and Nilsson 2008; Johnsen et al. 2006; Metawie and Gilman 2005; Talbot 1999) and the origin of accounting techniques stems from organisations with financial outcomes (Broadbent and Guthrie 2008; Froud et al. 1998; Hood 1995; Newberry and Pallot 2004).

The counter problem can be found in the nature of health care systems which is very different from that of the private sector. This provokes two opposing views; i.e. the medical versus the accounting (Brorstrøm and Nilsson 2008; Chang 2006; Jones 1999a; Kurunmäki 1999, 2004; Lee 2008; Linneberg et al. 2009; Llewellyn et al. 2005; Mannion et al. 2007; Metawie and Gilman 2005; Piligrimiené and Buciuiniene 2008; Strandberg-Larsen et al. 2007). However, the NPM issue does not only contribute to two opposing views. It also illustrates how, for example, the role of management accountants changes from bureaucrats to becoming active agents contributing to change (Baldvinsdottir et al. 2009; Kurunmäki 2008; Lawrence et al. 1994). Due to the calculative representation of management accounting techniques, it depicts a rigid form through mechanised objectivism (Porter 1996) which is used to describe facts and thereby does not invite for discussion or change, and accounting therefore easily becomes the cornerstone in social conflicts (Arnold et al. 1994; Lawrence et al. 1994; Oakes et al. 1994).
According to Mackintosh (1993) economic behaviour and its assumptions often obscure the understanding of the true social needs of health care and the definition of the concept of its quality through this rigidity. According to Samuel et al. (2005), this is not merely due to the dominance of accountants and economists over health care professionals, but caused by general changes in the global and economic ideas and trends. This is further supported by Fairclough (1992) who has described a global meta discourse of commoditisation. The globalisation of a commoditisation discourse across different national settings and ideologies contributes to the challenging issues caused by NPM. A study by Nørreklit et al. (2006) on US based contracts in a Danish environment highlights these particular issues as NPM, deriving from the US, represents many management control and performance issues which clash with the Danish working culture. According to Kragh-Jespersen et al. (2002) characteristics of constellations, competition, political-administrative structures and power relations vary across countries. This makes the outcome of NPM differ among professions. But similar global trends in tensions become manifest through internal processes as a result of different ideologies that identify the accounting profession and the health care profession. An understanding of the national setting is thus of particular importance in the NPM debate.

2.1 The Danish structural reform and financial agreements

In the specific case of Denmark, the Structural Reform was introduced in 2004 and it became effective as of January 1st 2007. The concept of service quality is highlighted as one of the core health issues in this Structural Reform. The primary concern is the individual’s well-being, but at the governmental level this concern gets translated into a more precise formula deriving from NPM, where an attempt is made to control service quality through the employment of specified accounting tools such as budgets and performance measures. The Structural Reform was originally motivated by the Danish Government’s “wish to support and promote a strong, public health care service that
offers patients unrestricted, equal and free access to prevention, examination, treatment and care at a high professional level” (Danish Ministry of Health 2004, p.37). The patient is the focus of attention and the text shows an interest in creating a high level of health care and a concern for the patient’s well-being. The rest of the reform is an outline of the initiatives and standards to be set to ensure the achievement of the above statement. The reform is supported by yearly financial agreements between the state and the regions. Five regions are responsible for the Danish secondary health care. In 2000, just before the Structural Reform, the first instances of quality becoming a central concept are seen in initiatives on service measurements in these financial agreements. Following the focus on service quality, minor coordination and standardisation initiatives start throughout the Danish health sector (Salomonson 2004). Two years later, the Danish model of quality is further introduced in the yearly financial health agreement “…. The regions are responsible to meet the specific quality standards. These common standards should be related to structures (physical frames), equipment, patient process, activities and results. The standards should be made public and comparable based on external evaluation.” (Danish Ministry of Finance 2002, p.29). This agreement has a strong focus on quality with the aim of implementing standards in various areas in order to pursue high quality. In addition, this agreement clearly shows that quality is made tangible and quantitative. In 2004, these trends get intensified with the Structural Reform, and in 2005 the demands for public and comparable quality measures are linked directly to efficiency and management accounting of the hospitals “...agreement on that better documentation of the regional assignments and more systematic evaluations of management accounting and efficiency will help ensure that the citizens receive the best service for money” (Danish Ministry of Finance 2005, p.34). We see a change from the original aim stated in 2004 of ensuring high professional quality, treatment and care for the patient to a management accounting view that is not in line with the view of the medical profession. The management accounting view is supported with
the notion of efficiency. According to Miller and Napier (1993) efficiency is not only central to standard costing's ambitions to transform the enterprise, but it is also a technique of socio-political management to measure the individual and support mental hygiene in relation to the norm.

To use NPM in order to ensure high service quality presumes that NPM is an expedient tool to that end. This is, for example, assumed in the Danish financial agreement (2002, p.24) which states “...it is presumed that restructuring and a more efficient work structure, equal to 2% of health costs, are used in areas where the numbers of treatments are growing and to increase quality.” This statement illustrates a clear ideological link between management accounting terms and the wish for better service quality where efficiency again is a focal point, directly connected to costs with a target of 2% improvement p.a. of Danish health care. The background of the Danish contracts further supports the contradictions highlighted in the literature review. High service quality is an aim but it is represented through artefacts and numbers. The numbers are calculative in an economic form, still representing monetary issues as saving 2% or improving activity by 2%. But this improvement in cost is associated with service quality which may lead to conflicting issues in the definition of quality.

The adoption of the Danish Structural Reform is a turnaround in the Danish health care system where major re-structuring of responsibilities has taken place. The state is in charge of the health care coordination, the regions are in charge of secondary health care and the municipals are in charge of primary care (Danish Ministry of Health 2004). Transparency of secondary care gets enforced through accreditation tools and rankings which followed the introduction of the structural reform. The idea is to ensure transparency for the patients, and the free choice of hospitals and general practitioner is further enforced (Downie et al. 2006; Kirkpatrick 2011; Tanggaard Andersen
and Jensen 2010). Prior to the structural reform the Danish health care system was known to have an especially strong medical profession (Dich 1973; Jespersen et al. 2002; Kirkpatrick 2011). They have been strongly challenged during the Structural Reform implementation period (Kirkpatrick 2011; Tanggaard Andersen and Jensen 2010).

2.2 The concept of service quality

The emphasis on service quality in the Danish Structural Reform along with an increased focus on quality in health care in later years (World Health Organization 2006) merits consideration of the various aspects and meanings of service quality. The concept of service quality has suffered within the jurisdiction of both the accounting and the medical professions. Although the starting point for the concept was similar, divergent basic assumptions have contributed to divergent understandings and definitions of service quality (Piligrimiené and Buciuniene 2008). There have been several attempts to define service quality over the years (Piligrimiené and Buciuniene 2008; World Health Organization 2006), but no research has yet been made within the field of management accounting aimed at the specific connotations, emphases and changes in the concept of service quality in relation to NPM. The impact of these definitional variations has also lacked research. In order to ensure high service quality in a complex bureaucratic set-up like the public health care system, the concept is often used as an objective in association with attributes, traits and features linking the definition further to quantifications and costs, which is closely related to the management accounting paradigm. The goal of wishing to provide high service quality, which is stated in the Danish reform, is common across nations and across the public sector. However, the methods used to ensure the promises of higher service quality increasingly draw on management accounting and the NPM philosophy.
The different professional perspectives on service quality will be discussed in the following section. Common ground is identified and a provided explanation of different basic assumptions which result in the contradictive stakeholder views. A link between the common ground and divergent views is necessary in order to comprehend the ambiguity of service quality.

### 2.2.1 The common ground of standards

Management accountants structure, organise and count while doctors register observations in journals and share experiences and experiments with each other in order to develop medical knowledge. There is a common ground of standards. The World Health Organisation (WHO) and the World Medical Associations continuously develop international standards for what is perceived as good health care. One example of this is the document “Quality of care” published by WHO in 2006. “This document provides decision makers and managers at country level with a systematic process which will allow them to design and implement effective interventions to promote quality in health systems.” (p.vii). In order to make sense of knowledge on care and in order to optimise treatment, standardisation is necessary within medicine. According to Miller and O’Leary (1987) these medical standards are closely related to the economic rationale of standard costing. “Clustering around efficiency.... one can witness a diverse group, including engineers, psychologists, accountants, medical practitioners, proponents of eugenics, journalists and politicians propose various projects for improving the life of the person, and thereby of the nation”. They suggest that common forms of standardisation within various fields exist with the main aim of eliminating waste that is identified by deviations from set standards. Miller and O’Leary’s (1987) starting point is rooted in the ideas of Foucault. Foucault believes in a developed societal rationality which emerged during the Enlightenment and is based in the common ground of modernity (Miller and O'Leary 1987; Simons 1995). Foucault, however, views this foundation as a continuous base.
for conflict and power (Flyvbjerg 1998, 2000; Simons 1995). Nevertheless, it is the developed form
of societal rationale that forms the foundation for some sort of common understanding in society.
Accounting is used in this societal rationale to mobilise the calculative practices through a common
meaning and understanding (Miller 1994).
The role of service quality in this common understanding is interesting and relevant, because it is a
concept that exists across professions as standards and rationalisation but still interpreted differently
through different ideologies. In Total Quality Management which has become an integrated part
and outlet of NPM (Pollitt and Bouckaert 1995), the concept of quality is mainly associated with
costs and it becomes physical in the sense of measuring and thus it moves away from its originally
pure and intangible character and becomes quantifiable; Quality becomes a standard! It becomes a
standard that we wish to pursue since it is associated with positive attributes (Weiergang 2004).

2.2.2 The opposing directions
The original incentive for the Danish Structural Reform was a wish to ensure high service quality.
However, in order to pursue high quality, standards must be developed. When introducing and
defining these standards, different basic assumptions seem to emerge.

Quality in health care
Piligrimiené and Buciuniene (2008) argue that defining service quality is complex and has several
dimensions which are difficult to quantify. They find three different perspectives on service quality:
interpersonal relations, tangibles and technical competences. These three perspectives differ
depending on the stakeholder group. The interpersonal relations become problematic in the
quantification and objectification of quality. They (Piligrimiené and Buciuniene 2008, p.104) state
that “Patients tend to evaluate health care quality according to the responsiveness to their specific
needs” and they continue “Most patients define quality as efforts of physicians to do everything
possible for a patient”. When defined in this way, quality is difficult to quantify and it is hard to create a commonly agreed understanding of good quality. This is contrary to what Kincaid (1980, p.1739) says on quality in health care: “quality is what we agree it is. Without agreement we cannot identify quality”. When health care administrators use managerial output measures such as number of patients treated, they seek to obtain the common understanding of - and agreement on - health care quality (Piligrimiené and Buciuniene 2008). The third perspective is that of the professionals and consists of the interaction between the physician and patient along with the technical results of a specific treatment (Piligrimiené and Buciuniene 2008). Consensus is hard to find given these different perspectives. Politt and Boukaert (1995) divide the different perspectives into two major perspectives on quality which they call the provider and the consumer views, respectively. A provider’s point of view makes quality quantifiable by focusing on outputs. The consumer’s view point is a perspective where quality may be defined as a characteristics of the good or bad service as it is perceived by the user and the provider in that specific situation. Note that the terms like consumer and provider used in this definition already suggest a more economics oriented discourse. The physician could have a number of perspectives on quality, but the three described definitions do not take them into account. The different views are important when analysing NPM implications since they may provide some explanations for the existing conflicts.

The medical perspective

The dilemma facing the physicians when defining quality is evident when we look at the Hippocratic Oath. This is the oath that physicians take, swearing to practice medicine ethically. The Hippocratic Oath was updated by the Declaration of Geneva in 1948 where adjustments were made after World War II. One of the points in this declaration is “I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual
orientation, social standing or any other factor to intervene between my duty and my patient” (World Medical Associations 2009, p.18). In a Danish version of the Oath, the physicians promise “always to care with equal conscientiousness for the poor and the rich without discrimination” (Hartling 2007, p.380). The doctoral oath supports the intangible definition of quality and the patient’s perspective, stating that external factors must not influence the situation and the focus on the patient’s well-being. When physicians look at quality, as reflecting superior and outstanding performance in their work, it is based on the patient’s well-being. Thus quality is a property of a specific situation and treatment. Making generalisation is therefore difficult.

The management accounting perspective

When health administrators try to manage health care and ensure quality, they do, however, have to create a common understanding since they need to consider multiple patients, resource allocations and other management practices. Therefore, according to Piligrieme and Buciuniene (2008), the managers’ perspective on health care quality focuses on efficiency and technical competences, a focus that has been further emphasised by NPM introduction. In his paper on definition of quality Kincaid (1980, p.1741) makes a very distinct definition: “... with efforts at cost containment in health care should be seen as the necessity thrust upon us to draw the lines of quality more and more distinctly so that those who pay for that care – all of us – will know better how to make our decisions, both through our social institutions and in our own personal interactions with the health care system”. This perspective seems to be a combination of the patient’s, or at least potential patient’s, and management’s view. A clear link is made between costs and quality. The health care costs are assessed in relation to the quality or features that we receive from this service. In order to handle quality at this broader level it is often organised and controlled (Dahler-Larsen 2008) and in order to make quality valid and legitimate it is repeatedly made tangible. Management accounting
naturally handles service quality in quantitative terms which is a key aspect of NPM where the aim is to create transparency with the introduction of performance measures and contracts. With the standards of care getting translated into numbers focus on efficiency increases with an economic rationale where cost optimisation is vital.

The common starting point gets transformed through different backgrounds and assumptions which results in incompatible parallels between patients’ well-being and money. At this point agreement may never be possible. An example of the incomparable tensions is clearly stated by Samuel et al. (2005, p.249): “.. a resident physician at a New York hospital, reconstructed the ‘slow, costly death of Mrs. K’. By analysing a hospital bill, he tracked the 25 day long descent into oblivion of Mary K.” This example shows the indelicate comparison of human life and costs.

Based on the above literature review, the Danish background and the explanatory framework of the concept of service quality the following research questions will be addressed; (1) what is the role of management accounting presented in the media in the development of NPM through the Danish Structural Reform? (2) and how does the introduction of the Structural Reform influence the perception and use of the terminology of service quality in the media? The use of service quality in the texts is studied within the discourses presented in the media. One must understand the common starting point of the standards described above, but also understand the common wish for better service quality and the transition into divergent ideologies in order to pinpoint the role of accounting and to correct unnecessary developments that have not been beneficial to society in general, which is in fact the core element of critical accounting (Broadbent 2002). It is therefore with a critical perspective that the Danish media concerning NPM is analysed using critical
discourse analysis as a tool to capture historical changes and their effects on the explicit stakeholders’ conception of good health care quality.

3. Methodology

Fairclough’s (Fairclough 1992, 1995, 2001) method of critical discourse (CDA) will be used to analyse the written texts of the media. For the period 2002-2008 the influence on public opinion and the discursive formation will be analysed by means of this method. In relation to the linguistic representation of accounting which constitutes the frame of this analysis, Fairclough’s CDA is relevant since it is a specific method to reveal rhetorical representative discourses.

Fairclough’s (1992) CDA is inspired by Foucault (Fairclough 1992; Kjørup 2003), but it takes a different approach by focusing on linguistics where Foucault’s discursive work is poetic rather than methodological and a precise discourse analysis cannot be found in the works of Foucault (Raffnsøe et al. 2008, pp.181-183). It is a social semiotic tool that focuses on social dimensions of the linguistic meaning in any media of communication and the production, interpretation and implications in social processes as cause or effect of ideology. As Fairclough (Fairclough 1995, p.65) says “The representation of discourse in news media can be seen as an ideological process of considerable social importance, and that the finer detail of discourse representation, which on the face of it is merely a matter of technical properties of the grammar and semantics of texts, may be tuned to social determinants and social effects”. This means that the small linguistic technical details in fact have a larger social effect and moreover reflect the larger social determinants and therefore newspaper articles are highly suitable for analysing public discourses. It is a flexible tool that allows the user to identify variables at different levels. This, however, also involves the risk of subjectivity (Blommaert and Bulcaen 2000; Widdowson 1995). Diversity and flexibility make it
possible to embed the necessary tools. It is then up to the user to manage the study as objectively as possible. Fairclough (1992) applies a very direct analytical tool where he creates a specific framework with the intention of analysing texts within the media. This attribute makes Fairclough’s CDA an appropriate method to employ in this paper. It enables a representation of detailed management accounting techniques in its rhetorical form with the possibility of expanding this to wider social practice which addresses the issue of accounting as social practice. The detailed techniques of Fairclough’s (1992) CDA are explained in the following sections where the concepts of discourse, ideology and power and their interrelation are explained, and the techniques of critical discourse analysis based on these concepts and the data used in discourse analysis are presented.

3.1. Discourse theory; social practice, ideology, hegemony and power

Fairclough’s (1992) theoretical framework of discourse is closely linked with ideology and power. Discourse is a set way of thinking and it operates in social practices, where it forms the way of acting “It is a mode of action, one form in which people may act upon the world and especially upon each other, as well as a mode of representation” (Fairclough 1992, p.63). Discourse both forms and is formed by social practices, and these social practices consist of ideology and hegemony.

**Ideology** is embedded in social practice. It is a system of abstract thoughts with a set of aims and ideas formed within a social group. According to Fairclough (1992, p.90) “It should not be assumed that people are aware of the ideological dimensions of their own practice. Ideologies built into conventions may be more or less naturalized and automatized, and people may find it difficult to comprehend that their normal practices could have specific ideological investments”. In this way an ideology is a basic assumption which may be so subconsciously incorporated in the way of acting that it is impossible for the actors to see alternatives. It becomes a rational argument for
acting and thinking in specific ways. Various ideologies exist, and may be conflicting within the same social group and/or practice, e.g. the medical and the management accounting perspective of a patient’s well-being and the service quality received. Some ideologies, though, are more dominant than others. As part of a discourse, Fairclough uses hegemony to identify the leading discourse. It is the dominating institutionalised way of thinking which is embedded within the text. Hegemony means leadership and domination across societal domains (Fairclough 1992, p.92).

An analysis of the discourse practice of a certain text makes it possible to identify the type of ideology embedded in the text and hence the hegemony. This makes it possible to identify the dominating and changing public discourses. Fairclough further identifies the component of power which is a complex concept. Power is entrenched in discourse and social practice. Therefore in reference to discourse the concept of power is used in discussions and conclusions. Social practice consisting of ideology and hegemony often does not include any direct form of power. A discourse analysis can reveal some of the indirect power mechanisms of management accounting.

An indication of the power of numbers and rationality can be found by reviewing previous studies. Flyvbjerg (1998) discusses power in relation to rationality in a Danish public institution. He describes the differences and interrelations of rationality, rationalisation and power. He observes that “Rationality is content-dependent; the content of rationality is power; and power blurs the dividing line between rationality and rationalisation” (Flyvbjerg 1998, p.97). His study illustrates the different dimensions of power that exist in the public sector. It is particularly relevant to this study, since it illustrates the power relations in a Danish public context and it explains the rational arguments used as a power device. These rational arguments provide a valid foundation for execution as was seen in the Danish financial agreements. The Latin root of validity means power (Porter 1996), and numbers – from a management accounting view – can be used in order to
validate decision-making (Porter 1996). According to the traditional management accounting view, rationality is ‘taken-for-granted’, ‘objective’, ‘absolute’ and ‘orderly’ representing the truth (Gomes et al. 2011). In this view of objectivity and truth, the calculative and linguistic representation of management accounting terms become very powerful.

In the news media, hidden or indirect power is enacted through this type of technical knowledge. It is not a ‘face to face’ or direct power, since there is a clear separation between the producers and interpreters in place as well as in time (Fairclough 2001). The people or organisations used as sources in news reports are not represented equally. Government and front figures are usually represented the most. Therefore, it is not legitimate solely to analyse who is represented in interviews in the news media. On the contrary, it is vital to establish whose perspectives are adopted in the news reports. This is exactly what Fairclough (1992) means when he speaks of hegemony and ideology.

3.2 Discourse method

Fairclough’s critical discourse method is a linguistic tool for discourse analysis in three dimensions (see figure 1). The method makes it possible to (1) recognise the discursive practice by analysing the macro structures such as the stakeholder perspectives; (2) perform an in-depth analysis by identifying keywords and phrasings, thereby establishing the influence of each stakeholder; and (3) establish the overall level of social practice. The identification of social practice will help us understand where the perception of the service quality stems from and how it changes.
The first step in critical discourse analysis is to analyse the discourse practice at the general level, i.e. dimension 2 (Fairclough 1992, pp.232-234), which shows the patterns found in the media sources. In the analysis of the newspaper articles in this study, the following areas have been analysed at the discourse practice level: *interdiscursivity*, which is the identification of discourse types that are drawn upon in the sample; *intertextual chains*, which refer to the identification of the distribution of the discourse sample; and *coherence*, where interpretative implications of the intertextual and interdiscursive properties of the discourse sample are examined.

The second step is the analysis of texts (dimension 1) based on micro aspects (Fairclough 1992, pp.234-237). This is an in-depth analysis of the grammar and words of the text. Throughout this analysis, findings will be related to the discourse practice when possible. The following areas have been included in the text analysis: *interactional control* in order to describe large-scale properties of interactions such as turn-taking rules and exchange structures; *cohesion* in order to establish how sentences are connected and which types of markers are used; reference, ellipsis, conjunction or lexical (Fairclough 1992, pp.174-177); *ethos*, which shows the guiding beliefs with respect to modelling persons (a doctor will, for instance, often be presented as caring, sympathetic or authoritative towards a patient). Ethos combines the diverse features that construct "selves", or social identities, in the sample. It involves not just discourse, but the whole character and...
surrounding sphere (Fairclough 1992, pp.166-167). Grammar: We examine the grammar and look into e.g. transitivity, i.e. which process types are used (type of verbs). Five types of processes exist: material, verbal, event, relational and mental. Further, we analyse theme and modality. Modality is used to establish how the producer of the text, through the language, shows affinity for the proposition and the consequences it has for the dialogue. Do the sentences reveal any doubts or are words used in a way that leaves no doubt? Modality is a major dimension of discourse and power since it is very persuasive (Fairclough 1992, p.64). Moreover, word meaning is analysed. This is central to the analysis. The structure of words and the emphasis put upon key words are identified. We study how they change and vary. Next wording is studied which is also a central theme in the analysis. The types of words, especially management accounting terms like budgets, rationalisation, efficiency, costs and money savings are studied, not only the amount of times the words occur in the text, but also the relations in which they are used. Are they used when explaining health care results of quality for instance?

This brings us to the analysis of the social practice at the macro level (dimension 3) of which the discourse is an element (Fairclough 1992, pp.237-238). It is the overall level where the text connects to social practices of ideology, hegemony and power and can be further related to some of the meta discourses. Here, the systems of knowledge and beliefs, the social relations and social identities are discussed and identified.

The analysis of the material selected in this study has been done according to Fairclough’s (1992) steps. In the analysis section issues within each major area are elaborated and reflected upon.
### Data

Two sets of data were chosen for this research: general newspaper articles and physicians’ journal articles on service quality within the health care sector during the period from 2002 to 2008. The physicians’ journals are the only way to assess this stakeholder’s view in Denmark as the physicians seldom participate in the public debate. Since Denmark is a consensus seeking country, the Structural Reform was debated before it was finalised in 2004. This is the reason for analysing articles from 2002. The debate started when a new right-wing government was elected in 2001 and continued throughout 2007 and 2008.

1. The general newspaper articles consist of 88 articles found by searching all newspaper archives using keywords like service, quality and performance. They were then screened and the articles that did not focus on Danish health care were discarded. The newspaper articles are chosen as data because they show the public’s changing discourse in service quality. Additionally, they identify and illustrate the influence of the dominating discourses within the public sphere. The newspapers are seen as independent voices, which makes them legitimate as data to illustrate who has the power within the media (Fairclough 1992).

2. 18 professional articles, mainly from “Journal of the Danish Medical Association”, were chosen as additional data, since physicians do not participate in the general media. These articles have been chosen using the same screening method as for choosing the general newspaper articles. This reveals that a completely different discourse is represented in these articles on the same issue during the same time frame (2002-2008).

The articles have been chosen because they focus on the Danish health sector in relation to the Structural Reform. Setting the scene with both types of data, the text analysis is conducted using the
general newspaper and professional articles. Finally, through data analysis we identify social practice, and this part of the analysis will be discussed in the results section. It identifies the ideology, hegemony and power that are evident in the debate. Note that a natural overlap exists between the three levels (Fairclough 1992).

4. Discursive practice and linguistic evidence

4.1 Analysis of newspaper articles: time, space and themes (discourse practice, dimension 2)

The series of text types found in the newspaper articles can be classified in two groups: the topics of articles and the newspaper story type. The topics of the articles are most relevant in this analysis and there seems to be a link between the topics, their perspectives and the type of story. When reading the newspaper articles, three different but overlapping phases can be found. The phases are of two years’ length, which is a suitable length of time given the existing sample size, and makes it possible to identify changes and differences. In the total timeframe of both the newspapers and professional articles there is a beginning, middle and an ending.

Phase 1: The first series of articles published from the end of 2002 until the end of 2004 represents the two conflicting views of the health care profession and that of management accounting. Economic facts and issues on cost saving are presented either through interviews with politicians or by referring to the content of the reform. In general, the professionals, who are mainly represented by nurses, react highly critically against the new ideas and the reforms of the new government. They are concerned with the consequences of a focus on savings and efficiency. It marks the beginning of a new phase in the health sector and therefore different obstacles and fears are presented. Some of the main themes are that heart patients will get poorer treatment and how costs have to be cut. Furthermore, there is an article on the opposition of one of Denmark’s largest
hospitals, Aarhus University Hospital Skejby to no-show patient fees. The articles that represent the professional discourse are often presented as debate articles or as letters to the editor. They are either written by people directly involved in the hospitals, such as nurses, or by left-wing politicians.

**Phase 2:** This series starts in 2005 and ends in 2006. The criticism becomes less apparent and the articles are more focused on financial facts. The overall concerns are the amount of money the health sector has to save and how they will do this; how the hospitals are implementing the new reform and what they have to do. For example, one article is about private entities having to take over maternity classes from a hospital because it no longer has the money or resources to offer them. Moreover, the first performance measurements are made public. One article describes a well debated hospital; Vejle Hospital, as the most efficient while for example Skejby hospital is only ranked number 7 in the country although usually perceived to be the best hospital in Denmark. The phase illustrates a dominating management accounting discourse. The articles are descriptive and the health care profession does not take part in the debate.

**Phase 3:** This is the phase from 2007 until 2008. The results, dilemmas and problems of implementing the health reform have started to surface and the articles become critical. The profession is visible - not through debates but through interviews. But the criticism is different from what we saw from the 2002-2003 period. This time “the system” gets blamed. It is unclear how the problems emerge and criticism is not levelled against anyone in particular, but merely against “the system” or some other indefinite object. The system refers to a set of procedures which is complex in this public setting. It is a third party referring to ‘it’ which is not directly identifiable. Since the criticism is not directed towards a specific person, party or politics, it becomes illusionary. In
Foucault terms it would be referred to as a well-practiced governmentality through discipline and technologies of production (Foucault 1994, p.225). In this case the technologies of production are the procedures and systems integrated through reform setting, but manifested in a distant and powerful mode which is difficult to direct towards anyone or anything particular. A feeling of something hidden or inner workings exists and due to insecurity as to where exactly to place the blame, the criticism becomes distant by referring to third party terms like ‘it’ and ‘the system’. This phenomenon will be referred to as a phantom discourse. The criticism also seems to become more implicit especially where the profession and patients assume the roles as victims. Acceptance of implemented changes increases. The profession and the public, despite unhappiness with some results, have accepted the fact that management accounting issues in health care are important and play a major role in decision-making. The focus on money becomes normalised.

The phases show how the themes change over the years. It is worth noting how the last phase shows alignment between government and public discourse. The public starts blaming the system for the changes and savings rather than the government and the politicians. However, several critical articles do not even mention the system. This is evident in the use of the phrase “this is just the way it is”, which clearly supports the phantom syndrome. Equally important are the increased focus on the management accounting theme in the general newspaper articles and the absence of the profession in the public debate. Except for a few interviews made during the last phase, the physicians are non-existent in the public debate. Nurses are represented in the debate for the first couple of years and then disappear in the debate based on direct quotation. When represented in the newspapers in later years, they become more victimised and the type of articles is different. They are based on interviews and not active debate contributions. The analysis of the themes of the
newspaper articles has made it possible to categorise them, which shows how the themes change through the three selected phases. Each phase is further examined below.

4.1.1 Changes over time – the different phases (text analysis, dimension 1)

Phase 1
The analysis of the first phase evidences how an accounting rationale enters health care debates. A management accounting discourse is found in the use of numbers and economic terms as rational arguments and reasoning for “what is”. Examples are, for instance, headlines such as Jyllands-Posten, March 18th, 2003: “Saving demand: more savings cause outrage”, and Jyllands-Posten, March 4th 2004: “Region’s finances: the region has to save 167 million kroner”. These are just two examples of the management accounting discourse represented in the headlines using words like savings, money and numbers and the terminology is also found in the articles themselves. Several arguments use numbers or other economic methods as their background. The management accounting discourse is also supported by the presence of a different stakeholder group, i.e. the economic specialists as shown in example 1 below:

Example 1:

Newspaper: Berlingske Tidende, December 17th, 2002

Title: “Hospital report from an ideological battlefield”

Text: “Apparently, the Danish hospitals are doing well. Operating costs are low, they are relatively efficient and the waiting lists are short when compared to countries around us… Still it seems that radical changes are on their way in the running of the Danish hospitals. Right now an expert group headed by Professor Kjeld Møller Pedersen is completing its conclusions and
recommendations in a report which is to make suggestions on improvements in health care.”

Professor Pedersen is an economist. This example shows how he is used as an advisor on the Danish health care. The expert recommendations are therefore based on economics and numbers. This is also evident in the later phases. In the newspaper articles the specialists use management accounting rationale to argue for changes such as savings and increased efficiency. They comprise 8% of the direct stakeholder perspective in the articles over all three phases. In phase 1, they only control 1% of the stakeholder perspective while in the later stages they control 10-11%ii. The management accounting view and the professionals’ perspective are used, both directly and indirectly, in a large part of the texts. The government refers to these specialists when arguing for the management accounting changes and implementation of management control tools. They are used as a strong rationalising argument representing the ‘truth’.

Critical arguments appear in phase 1 as a reaction to the economic discourse. The criticism is mainly represented in debates or letters to the editors. Nurses and other social workers in hospitals who are concerned with the hospital staff and their working conditions voice their criticism and frustration. Further criticism is made by left-wing politicians. Physicians are not represented in the public debate. Example 2 shows an example of criticism from January 2004. The article is written by a trade union representative for the medical laboratory technicians in the southern part of Denmark.

Example 2:

Newspaper: Vejle Amts Folkeblad, January 21st, 2004

Title: “Should the hospitals in the county of Vejle shut themselves down?”
Text: “We are not convinced that the situation is as simple as Leif Mørck seems to think, which means that Vejle Hospital will be the loser….”

“Surveys have shown that the patients do not mind travelling or having short waiting lists for special treatment, but they also want proximity! So preserve our well-functioning departments with the qualified staff instead of breaking it all up resulting in increased de-motivation, insecurity, inefficiency and economic costs. Leave us alone to work and provide highly qualified care for those who need it instead of using our energy on administration, restructuring and guesswork.”

(Emphasis added)

This article shows a clear and direct criticism of the restructuring and the administration. Furthermore, the criticism is also aimed at a specific person; Leif Mørck, who is a politician. The criticism is thereby direct and unmistakable. The verbs and processes used are demanding and action oriented, for example “So preserve..” and “Leave us alone..”. The article strongly questions the restructuring and justifies the criticism by providing examples of the drawbacks. In the first year, 2003, 42% of all newspaper articles are critical and 25% of all articles question the restructuring. Management accounting phrases like “inefficiency”, “budgets” and “cost” are employed in order to attract the reader’s attention. Here the calculative representation of management accounting techniques is translated into rhetorical terms. They are a major part of the body of linguistics where this language is indissolubly linked to calculations of cost (Miller 1994), manifesting a strong management accounting discourse. Inefficiency and increased economic cost are used as negative modes and a particular concern. However, the article is not objectively informative, but emotionally effective, showing both fear and demands. This shows a tendency of the objective and factual terminology of management accounting expanding into other types of languages and arguments than merely through scientific knowledge and knowledge of truth.
Phase 2

After 2005 we see less criticism and gradually the issues of economic choices and lack of qualified treatments disappear from the public debate. Instead, the focus on management accounting terms becomes more normalised while the focus on the patient’s well-being and type of treatments no longer dominates.

One typical example is an article written about the top 24 Danish hospitals. The hospitals are ranked according to the number of treatments they make for the money received from the Danish government.

Example 3:

_JydskeVestkysten, January 4^{th}, 2005_

Headline: “The region of Vejle the best to get its money’s worth in health”

Text: “There are huge variations in the number of treatments that the tax money can buy in the different hospitals in the country. According to numbers from the Ministry of Health, the hospitals in Vejle and Kolding are the most efficient…..1) Vejle, 2) Kolding, 3) Holstebro, 4) Esbjerg, 5) Roskilde…..”

This article illustrates the focus on economic issues with the introduction of ranking and ‘stars’. In this case the emphasis is on how much treatment is received for the tax money. It does not, however, consider the quality of the treatment received. It also puts emphasis on economic terms such as “efficient”. The economic theme has thus continued in phase 2 with the introduction of ‘productivity’, ‘performance measures’ and ‘activity’, but without the critical reaction found in phase 1. Hence it becomes normalised. There is no longer a clear contrast in opinions or criticism but rather acceptance of economic phrases. The remaining criticism appears as a third theme which we refer to as the phantom syndrome. It is represented by hospital personnel, patients and some
citizens and evolves in the later phases as a consequence of the economic discourse. The economic influence of controlling and focusing on money is viewed negatively. As seen in several texts from 2005, people or politicians are rarely criticised directly; instead the criticism is directed toward the system and the reform per se. The ‘system’ becomes highly impersonal and it is treated as if it is a phantom that is untouchable and everybody’s enemy. This results in powerlessness, and the criticism becomes vague. For example, sentences like “...because the system is more important than treatment and care...” shows how the system is given rationality and power associations; the means of organising the health care becomes an end rather than a means to the end of treatment and care. Management accounting words are often used in connection with the system, e.g. time, money and efficiency in order to support the importance of the system.

**Phase 3**

In phase 3, we see an intensified focus on accounting terms and views and we witness a normalisation of the management accounting discourse. An example of this intensification and focus is provided below.

**Example 4:**

*Newspaper: Weekend Avisen, January 5th, 2007*

Title: “With Blue Lights”

Text: “...that there are large sums of money to be saved if the country’s hospitals lived up to best practice is evident in an analysis made by a special group, consisting of Danish Regions, the Ministry of Finance and the Ministry of Health. In this analysis the productivity of the different hospitals has been measured. This makes it possible to compare how much treatment each hospital delivers for the money.” (Emphasis added)
Example 4 illustrates the direct focus on money and how to obtain the lowest cost per treatment. In this specific paragraph, the economic discourse is referred to five times (the grey highlights). This is supported by relational processes such as is and has. Relational types of verbs are “to be” and “to have” as described in phase 2. Relational verbs are descriptive and inactive (Fairclough 1992, pp.177-185). These types of verbs support quantitative representations. Both relational verbs and calculative representations are factual and thereby become strong in the argument. The large volume of verbs used in the newspaper articles is increasingly relational. When these types of verb are used in a text, the text becomes descriptive rather than dynamic. When the text is descriptive and factual, it is presented as non-negotiable which shows dominance (hegemony) in powerful forms. This is aligned with the high degree of informative text and references to data as well as an authoritative and specialist ethos evident throughout the newspaper articles. The linguistic use of relational verbs supports the objectivity of calculative representations and they are an integrated part of presenting the ‘truth’.

The patients’ well-being and service quality can be found in wordings like “how much treatment…” but it becomes quantified when the sentence continues “…each hospital delivers for the money.” The patients’ well-being is made dependent on and related to service quality, which is a set of descriptive facts that are static and not negotiable. This is further supported by intensifying modals, a method used in 69% of all articles showing an increase in positive intensifying verbs over time and a decrease of negatively intensifying verbs over time. These intensifying modals such as “harder and harder”, “runs really fast”, “demand constant increases”, “as efficient as possible” and “get the most health” support the certainty in the statements described above.
Looking at the key words used in the newspaper articles, one particular theme dominates and that is the use of the words “efficiency” and “productivity”. These words are mentioned 89 times in the articles. In 2002-2004, they are used as positive keywords since everybody would like a more efficient and productive hospital and health system. However, towards the end of the period they become negative in their usage and meaning and are often used in sentences on savings, neglecting patients and stressed employees. Moreover, the meaning of having the best hospital and the highest service standard also changes. In the first phases, the implicit meaning of this is high quality, high service, well-being of patients and happy employees. In contrast, in the last phases, the meaning changes to denote merely the best performance score and the best efficiency such as, for example, how many patients the hospital can treat for ‘as little money as possible’. The idea of the patient’s well-being and the meaning of service quality become matters of economy.

The victim role, manifested through a powerlessness, also continues and an apathetic behaviour surfaces. The blame, if any, is still directed at the phantom of the “system”. An example of the phantom and syndrome of apathy is shown in example 5:

Example 5:

**Newspaper: Århus Stiftstidende, August 29th, 2007**

*Headline:* ”It is not the best solution”

Text: “Bad finances and lack of planning now force the mobile nursing service at Skejby Hospital to close down even though the initial aim was to strengthen this initiative, explains Chief Nurse Vibeke Krøll.

“It seems like a short term quick fix solution?”

“Yes, you are right about that, but at the same time we are looking to see how we can make the district paediatrician become part of the outpatient program that we have in the children’s department”, she says.
“But that is not the reason why you stop here and now – to change it? It is an emergency solution?”

“Yes, it is somehow. But it is a necessary solution, I would say. We have a winter ahead of us and we have to ensure that the other children we receive get the necessary attention and care. (...) But we don’t think it is the best solution we have ever found.”

According to Vibeke Krølll, the management has not asked the Region for more money to fund this initiative. “We know the region’s conditions. We all need money and have to save”, she says.

Again, this article does not question the situation but merely presents it as a fact. In the two texts, hypotactic rather than paratactic use of text is employed. This means that specific people are not mentioned, highlighted or criticised but ‘the system’ is mentioned. Hypotaxis is associated with grammatical complexity, whereas parataxis is associated with lexical density. Grammatical complexity is the complex structures that are evident when one tries to diagram constructions with many relative clauses and other subordinate clauses strung together in grammatical relationship to an independent clause. Lexical density means the number of lexical items ("content words" as opposed to "function words") per clause. The spoken discourse tends to use clauses that are not lexically dense but are strung together in grammatically complex dependency structures (Fairclough 1992). This means that the discussion is indirect. Specific people and situations are not highlighted but remain undefined. This strengthens the hidden power embedded in the text. It also correlates with the use of the authoritative figures, the enemy and the phantom syndrome where ethos is a central concept. The expert and authoritative figures dominate which relates to the phantom illusion. Ethos as an authoritative figure is found in 57% of the articles. Ethos as an expert is found in 45% of the articles. The expert ethos is used to support the authoritative figure. The victim and enemy ethos is found in 60% of the articles. As mentioned in the above article “It is not the best
solution”. The Chief Nurse, Vibeke Krøll, states that we all have to save money and we might as well make the best of it. This shows both authoritative and victim ethos in one article, which enforces the phantom phenomenon and strengthens the increasingly dominant management accounting discourse. The management accounting discourse is normalised.

### 4.2 Analysis of profession articles (discourse practice, level 2)

The absence of physicians in the public debate requires the analysis of the medical professional journals in order to get an insight into their perspective on the issue. This theme of absenteeism is indirect and therefore is a potential latent power.

The articles from the professional journals have been read in order to find patterns, structures and obvious changes. Four themes have been found; the profession, the victim role, the economic theme and the phantom syndrome. Time periods identical to those used for the newspapers have been chosen in order to facilitate comparison. The profession is represented in all periods. Initially, the articles are very hostile and critical and they have an ironic and joking attitude towards the reform. The professional discourse is strong and the level and type of articles are different from those of the newspapers. Professional arguments and language are used. After the first time period the professional discourse starts to reflect a concern about the reform, which indicates an indirect lack of power. The physicians have become victims. By the end of 2005, the economic issues become noticeable in the professional articles. They can no longer be avoided and the physicians integrate economic issues in their debate. From 2006 until 2008, the phantom syndrome appears just like in the newspapers. The economic issues and victim role still exist. Thereby, the strong, clear professional discourse seen initially changes to a more ambiguous discourse that draws on economics, victim roles and blaming the phantom syndrome in the later years.
4.2.1. Phase 1: Absenteeism and profession (text analysis, level 1)

As outlined above, the fourth theme is indirect. However, it is worth noting that no reference to or quote by physicians can be found in any of the newspaper articles. However, the topic of the new health reform is intensively discussed in the physicians’ journals. Fierce opposition is directly stated in terms like “the new reform is a huge fiasco”.

Example 6:

Journal of the Danish Medical Association, 3rd issue, 2004

Headline: "New Public Management – the strategy’s failure in the health sector"

Text: “…(..) England and New Zealand have previously implemented the liberalistic market mechanisms in the health sector. In both countries it must be concluded that the NPM model has proved to be a failure…(..) with international experiences of these management models, but the government is still pursuing them. The reason is the increasingly populist behaviour which the government displays in the health area as election time draws close. It is obviously more important for the government to increase the number of medical supermarkets in Denmark in addition to capital benefits than to increase the Danes’ average life expectancy and health condition…(..)

(Emphasis added)

The focus on the Danes’ average life expectancy and health condition shows a concern with the patient’s well-being, the very foundation of the Doctoral Oath. It opposes the view of good service quality being quantitative and short-term oriented. Though the Danes’ average life is a quantitative indicator, the approach to health conditions is different from the efficiency aspect shown in the previous examples. Example 6 further reveals a critical position on the new reform and the restructuring of the health sector. It shows the profession’s strong disagreement with the
commercial management accounting theme when using word-based metaphors like “supermarkets”. The article also shows a high level of expertise. The profession is able to state what is actually important; e.g. average life expectancy. Moreover, they are fully aware of international experience with the model of NPM upon which the new reform is built.

In general, the professional texts show that physicians and their unions are critical of the reform and it soon becomes apparent that an opposition to the reform exists. The physicians are well educated and knowledgeable and their unions are financially strong and they represent thousands of people. They can therefore easily affect the way in which other stakeholders write on the issue. This raises the question of whether a latent conflict exits since these thoughts and opinions are not represented in the general newspapers. There may be several explanations. One of the reasons could be related to democratisation. Democratisation is a need to remove inequalities and asymmetries in society (Fairclough 1992). It represents the idea of the new Danish health reform and the implementation of standards that try to systemise and somehow equalise hospital performance through balancing measurements. The hospital doctors are a highly skilled service profession and they have been very authoritative in the past but there has been very little transparency in their activities. People have great confidence in physicians and have given them power (Brorstrøm and Nilsson 2008; Dich 1973; Jones 1999b). Now this power is disappearing, the usual work routines work are challenged and changing, which naturally creates tension among personnel (Brorstrøm and Nilsson 2008; Jones 1999b; Kurunmäki 1999, 2004; Mannion et al. 2007; Strandberg-Larsen et al. 2007). The information-based power that hospitals and doctors used to have is being further challenged because of another meta discourse of technology (Fairclough 1992), which provides access to information, often through the internet, and thereby more transparency. However, a controversial factor appears in the ranking of the hospitals by performance because this creates inequality but in a different way.
A hospital may not be so powerful in relation to all other hospitals when looking at the performance measurements if it has a low national ranking. Nevertheless, it is impossible for the performance measures to capture the whole picture of quality in service and the risk of not giving a true picture of the individual service quality experience is high.

**Phase 2**

Phase 2 indicates some initial despair within the profession. However, it is different to the despair found in the general newspaper articles. The profession asks questions on how the various tasks should be solved with the new allocation of resources. Doubts about success are apparent.

**Example 7:**

*Journal of the Danish Medical Association, January 3rd, 2005*

**Headline: “If the reform is to succeed”**

Text: “…(..) There are several assumptions which must be made if the reform is to succeed. It will be most necessary to have a large increase in the resources of the Ministry of Health if it is to carry out the many various assignments that it has in mind.”

There is an obvious concern about the different tasks in the health sector that are to be controlled at a state level. The medical profession is anxious about this huge responsibility and about the consequences. The uneasiness may arise from a dilemma for the profession. They have to be more economically responsible which potentially conflicts with the essence of the Doctoral Oath where
the patients’ well-being is of absolute primary concern. The possibility of scarcity of resources may put the Oath at stake.

The critical view shown in phase 1 is still present in phase 2. An example is the article called “Health reform implies cash registration” by the magazine Resonansiii, issued by a union formed for physicians. The economic discourse becomes evident in the professional articles during 2006. Questions are still raised, but compared to the public newspaper debate, the victim discourse is less apparent. However, as shown in example 7, the general feeling is one of despair as the new reform challenges the physicians’ basic assumptions and their entire professional training.

Phase 3
In phase 3 the professional articles become more aligned with the management accounting discourse. The profession uses accounting terms as a tool to communicate and make their views understood. However, the paradox between the management accounting view adopted by policy makers and the professional views is still apparent and the power battle still exists as shown in example 8:

Example 8:


Title: "Who is in charge of the Danish Health Sector?"

Text: “I am in favour of a clear separation between the medical profession and the politicians. We, the politicians, should not interfere with medical discussions. We are interested in getting the highest number of treatments for our money. Since there is a gap between what we wish to do and the resources we have, the expertise we can get is crucial. Our priorities must not be based on self-interests,” says Bent Hansen, President of the Danish Regions.
“It is a political priority that the money follows the patient. I don’t like the moral qualms about physicians making money. We should be happy that some physicians want to work more. If we get a situation like in the US, we will have a tremendous problem because patients with the most urgent needs should be treated first”, says Jens Winther Jensen, Chair of the Danish Medical Association.” (Emphasis added)

This example shows a tension between the politicians and physicians. The politicians use the management accounting discourse like “the physicians make money” as an argument and a way of avoiding a conflict. The physicians use the professional discourse like in “thinking of the patients in need” and “average life and health condition” (example 9). The ideology and hegemony are different. The profession tries to focus on service quality, centring on the patient, but they have learnt to integrate some of the accounting terms in their arguments. The terminology used in the professional articles is related to the profession. However, as seen above, economic terms like money are also used. This shows how policy makers, through management accounting terms, have succeeded in convincing the profession that accounting terms are part of the profession’s sphere of interest as well and money has also become one of the profession’s objectives. This may be another reason for the absence of the physicians in the public debate. Along with the Danish Structural Reform came a higher degree of freedom for private hospitals which resulted in an increase in private hospitals in Denmark. Many physicians work both in a public hospital and part-time in a private hospital. This could be a reason for the lack of participation in the debate. This is also supported by one of the newspaper articles; “..several physicians, who normally keep a low profile when faced by public criticism, describe the depressing situation in the health sector where the best physicians are enticed by better wages and better working conditions in the private hospitals while the public are left with a desperate need of physicians” (Newspaper: Information, May 22nd 2007).
The physicians may simply not want to enter the public debate fearing that it may lead to sanctions towards their private hospitals. The silent physician is an example of conflict prevention where the possibility of privatisation may have been a tool to avoid conflicts.

5. Discussion – the winning arguments in social practice

The management accounting and the medical profession discourses represent opposing views which support earlier studies on the tension caused by accounting in health care (Bourn and Ezzamel 1986; Coombs 1987; Glennerster 1994; Jespersen et al. 2002; Kurunmäki 1999, 2004, 2008; Kurunmäki et al. 2003; Llewellyn 1993, 1997). Despite worldwide tension between the medical and accounting professions in the pursuit of NPM reform implementation, the type and level of resistance differ across nations. The study of Kurunmäki (2004) discusses how management accounting was integrated into the Finnish medical profession during the 1990s without large battles and discussions of abstract knowledge. This study of the Danish Structural Reform shows similar results. Though resistance is present in the beginning, it transforms into an acceptance of the management accounting vocabulary and becomes a part of the medical profession’s own vocabulary. This acceptance, as Kurunmäki (2004) states, is different from the Anglo-American countries where major opposition has been present. In Denmark, the medical profession has always played an important part in the representation of state knowledge. They have been an intertwined part of the scientific ruling class of Denmark, determining socio-economic conditions in the political era (Dich 1973). Based on the medical knowledge which served many of the European governments during large parts of the 20th century (Foucault 1994; Simons 1995), the power of this knowledge became strong as seen in Denmark. This makes the entrance and transformation of the management accounting terminology even more peculiar. But the medical knowledge has had to be
represented through technologies such as accounting terms which have always existed in biopolitics (Simons 1995). Therefore the technology itself may not be so unfamiliar to the profession. It is the accountability that becomes reversed and a counter power is produced, and this is the point of interest in this discussion. In this analysis the counter power is manifested through the economic scientists who constitute what Potter (2005) calls an epistemic community. The technical experts in this case, the economists and accountants, (who are referred to as DJØF’er in Denmark) constitute this community using the same type of scientific language as their counterpart, the medical profession. The reason why the medical profession in Denmark adopted this technical language of management accounting is not obvious, but multiple explanations can be given. First, it is an attempt to remain powerful through adoption of the same rhetorical language for arguing for the medical profession’s needs. Second, the management accounting argumentation is manifested so powerfully through descriptive and factual linguistics representing an objective view which represents the ‘truth’. The ‘truth’ is a strong argument which is difficult to alter, and in its representative form, it does not leave room for discussion. Pettersen (2004) also found that accounting terminology became part of the profession’s vocabulary in the Nordic hospital sector. She finds that the reason for this adoption is the calculative representation in reports and statistics at the clinical level. The present study on Danish health care supports these earlier findings, showing that the medical profession responds by using more accounting rhetoric, thus supporting the power shift from health care professionals to the accounting and administrative professions.

The analysis shows how the management accounting discourse evolves over time. It starts by indicating the importance of results and costs within health care. It then intensifies by constantly insinuating that costs within health care are the core concern. The costs and other quantitative measures form the basis for all important decision-making within health care displayed in the
Finally, the management accounting discourse becomes normalised and spreads from being the policy makers’ and specialists’ voice to becoming an accepted perception of good health care in the media as well as within the profession. The obvious management accounting domination leads to some of the other more ambiguous, but central issues found in the texts, e.g. the absence of the medical profession in the public debate, the slow and seemingly helpless acceptance and the constitution of a phantom syndrome. Moreover, the vital issue of service quality per se largely vanishes in the arguments. However, it is frequently referred to in combination with management accounting terms. The phantom syndrome is an interesting phenomenon. Applying Foucault’s thoughts cannot fully explain this syndrome; we need to incorporate his views on discipline and governmentality as well. Technologies of production (Foucault, 1994, p.225) can be related to management accounting techniques, which then transform into technologies of power (Foucault 1994, p.225), thus creating the domination that is referred to as governmentality by Foucault. This domination can be described through Fairclough’s terminology of hegemony, the discourse practice applied which is a ‘normalisation’ of accounting vocabulary and the developed ideology of accounting which is a counter reaction against the previous power of the medical profession described as democratisation by Fairclough (1992). However, the response from the originally powerful profession in the creation of a phantom, the system, is not fully explained by these concepts. The phantom syndrome, however, describes some of the elements that transform calculative accounting into a powerful device. Management accounting calculations and vocabulary supported by the linguistic use of rational processes create a distance by describing objects as ‘is’ and ‘facts’. Thereby, these factual objects eliminate the need for direct responsibility. The counter reaction refers to these indefinable, in a personal sense, factual objects, which then become a phantom since they do not represent opinions, circumstances, real situations or persons. Management accounting terms thereby constitute a rationality which becomes so strongly
embedded in society that it is hard to argue against it. It is considered a rational and “real” way of thinking. The rational accounting terms become a power device for rationalisation (Flyvbjerg 1998; Kurunmäki 1999; Miller 1994; Porter 1996) and we see that it is difficult for the medical profession and the public to argue against such rational arguments. This leads to troublesome issues where the patients’ well-being becomes synonymous with the concept of service quality which is increasingly perceived and evaluated as standards in quantitative terms.

Rationality and management accounting

The issues of performance and rationalisation make it possible to influence the public and the physicians who adopt the management accounting discourse using rationalisation as a rational power device. The public is interested in high service quality. Supporting the Structural Reform and financial agreements is an attempt to achieve this because the efficiency of hospitals is labelled as high quality and free choice.

The rationalisation of the management accounting discourse is evident when accounting arguments are used as a rationale to denote ‘the right thing to do’. Flyvbjerg’s (1998) views on rationality enable us to show how the political system has tried to prevent demands by using a specific and highly persuasive rationale which is so highly embedded in the ideology that policy makers themselves may be unaware of it. As Flyvbjerg (1998) discovered in Aalborg, rationality becomes a discourse of power at a completely different level than the one which is normally acceptable and consequently contracts become a dominant tool. This study confirms these trends. In the specific case of the Danish health sector, the obvious exercise of power is that of deciding on the financial agreements and the Structural Reform. The key issues are free choice and efficiency. Political participation is revealed in the policy preferences for economic results in the hospitals. In line with
one of Flyvbjerg’s (1998) observations, the use of these management accounting arguments results
in rationalisation and, in the end, it can be questioned whether this rationalisation remains rational,
since there is an inherent duality. Rationalisation means making something more productive and
efficient. Rationality, on the other hand, refers to the common sense and sanity of humans’ actions,
meanings and plans (Flyvbjerg 1998). Discharging a patient from the hospital prematurely may
contribute to rationalisation, but it is not a rational action. It conflicts with the patient’s well-being.
This double dimension and view on rationalisation is supported by a study by Townley et al. (2003)
who argue that performance measures represent twin dimensions of rationalisation which is the
pursuit of reason in human affairs and rationalisation as the increasing dominance of a means-end
instrument.

Another reason for the existence of the phantom syndrome can be found in between the two terms
of rationalisation and rationality since it becomes difficult for the hospitals and the public to dispute
the use of numbers as rational arguments. Thus they create “the system” as a scapegoat and “it”
becomes the focus for their criticism rather than the government, politicians and scientists. The
hospitals and the public become engaged in this discourse and they do not question it in the last
phases of the period studied. This is similar to Foucault’s (Fairclough 1992; Simons 1995) work on
discourse where his main interest is to question the discursive obviousness (Simons 1995). In this
respect, the highlighted and powerful focus on quantifications rather than the patient’s well-being
could be questioned. This is not done, however, since numbers and performance measures are
increasingly persuasive in argumentation (Porter 1996; Townley et al. 2003). This is confirmed by
earlier findings regarding the New Zealand turnaround during the early 1990s where Lawrence
(1994) emphasises the construction of accounting technologies and practices which become so
embedded in social practices that accounting becomes the ultimate argument which is difficult to
criticise. The ideal of finding the truth and doing the ‘right thing’ enables this implementation where accounting expertise represents the ideals of neutrality and objectivity and where facts become a set of laws like generalisations (Miller and O’Leary 1993). The management accounting discourse is intensified through NPM reforms such as the Danish Structural Reform which assists in the management accounting terms becoming embedded in expressions and the vocabulary used. The strong and dominating accounting ideology has specific consequences for the perception of service quality and the state of the patients’ well-being which changes during the period of this analysis.

*Service quality and the Doctoral Oath*

The social practice of the management accounting discourse can be further related to Fairclough’s meta discourse of commodity (Fairclough 1992). The public’s interests are globally moving towards concepts such as free choice, transparency and “best value for money”. Patients become consumers and physicians become providers. The challenge is the definition of “value” and in this case service quality. The reason for this development can be seen as a step-wise development. First, several issues are at stake when the common understanding of service quality and standards is neglected due to increasing financial arguments which slowly take over the ideological assumptions in practicing health. The Doctoral Oath proves, from this view, to be at stake. The profession’s goal of treating all patients equally and focusing on the well-being of the patients is challenged by the NPM tendency of adopting management accounting terms and methods. The normalisation of economic resources becoming equally or more important creates a critical dilemma that relates to the human rights that provide the foundation for medical ethics (World Medical Associations 2009). It is exactly at this point where the use of accounting represents certain interests at the expense of others (Broadbent 2002). The transformation of the patients’ well-being into quality measurement
represents the first instance of turning the medical discourse towards the economic rationale. The economically rationalised medical decision making, where the profession is ‘bought’ by having the opportunity of opening private hospitals, seems to be the next step which finally silences the professional voice. The medical professional discourse is successfully overtaken by the management accounting discourse. The medical profession is now acting in a way that conflict with their original ideology which is stated in their oath. This creates anger displayed through the constitution of a phantom focus, but yet it is accepted and the expressions and techniques are adopted. The medical profession’s services have become standardised for economic reasons. The standardisation creates inequality and a lack of ability to optimise the individual patient’s well-being. A treatment is not easy to plan in advance or standardise since patients are different and the outcome of the service depends on the interaction between the physician and the patient. Each patient is unique. Therefore, the complexity of planning and structuring service treatments is far higher than the complexity of planning tangible products (Pollitt and Bouckaert 1995). But the health care professionals are not merely the victims of this trend. In Flyvbjerg’s (1998) study on the Aalborg project, he finds that in open confrontation, rationality yields power: ‘In an open confrontation, actions are dictated by what works most effectively to defeat the adversary in the specific situation. In such confrontations, use of naked power tends to be more effective than any appeal to objectivity, facts, knowledge, or rationality, even though feigned versions of the latter, that is, rationalizations, may be used to legitimate naked power.’ (1998, p.232). These findings suggest that the medical discourse could have prevailed, or at least sustained at the same level as the management accounting discourse if the medical profession had been more active in the public debate. This is not evident in this analysis which further supports an angle of the medical profession adopting management accounting vocabulary to argue its own cases. This, however, does not assist the patient in the service quality definition of his or her individual treatment.
Another viewpoint is when policy makers integrate service quality in the debate of health care, which they have done in later years maybe in an attempt to address the physicians and a way of inviting them to the crucial debate. When a few physicians did make comments in 2008, the issue was indeed quality. The physicians thereby get a chance to stand up for their values and create a stronger character in the debate. However, this does not happen in the Danish case.

So, to sum up, global trends and research suggest that we do not necessarily witness a dominance of economists over the medical profession, but a trend towards commodisation and rationalisation which is a common condition for many professions and involves engineers, technicians, economists, researchers, politicians and medical professionals (Fairclough 1992; Flyvbjerg 1998; Samuel et al. 2005). Miller and O’Leary (1987)(1993) discuss the rationalisation of economics intertwined with the political wish to construct through rational structures, not only economic issues, but societal and health issues.

In 1993, Mackintosh points out the problematic issues of economic behaviour and contracting outcome in relation to the UK NHS reforms. She highlights how important it is that policy makers incorporate co-operative and ethical values, essential for the service provider, into contracting. This study further supports the importance that policy makers recognize this in the public debate and invite stakeholders to discuss rather than state ultimate conditions through the use of accounting terms.

5. Conclusion

The aim of this paper was to investigate the role of management accounting in the development of NPM using Denmark as a case study. A further aim was to understand the outcome and relation to
the initial aim of better service quality in the Structural Reform. The study has shown that the role of management accounting has intensified rhetorically through the public debate that followed the Structural Reform. The outcomes of this intensification change during the time period with direct criticism only found in the first years. Later, it gets transformed into acceptance of a management accounting terminology with unease, however, which is manifested through indirect criticism represented as accusing a phantom. The phantom is a third party that is rhetorically presented as ‘it’ and ‘the system’. The medical profession also adopts the management accounting terminology and in later years uses it in its own argumentation. The initial aim of better service quality to the patient vanishes in the management accounting intensification and becomes translated into quantitative categories with monetary aims. This transformation of service quality challenges the Doctoral Oath of equal treatment to patients and a focus on patients’ well-being. The management accounting calculative representation becomes a power device through rationalisation.

The critical discourse analysis has assisted both as a tool for analysis and as a theoretical framework, helping up to identify some of the social practice changes that are evident in aspects of societal media (newspaper articles and professional journals). This has made it possible to establish how major changes occurred in small detailed patterns which according to Fairclough (Fairclough 1992, 1995, 2001) have an effect on ideologies and social practice. The analysis shows an intensification of a management accounting discourse and reveals how the professional discourse becomes much weaker in the debate. The paper adds to the conclusions drawn by Piligrimiene and Buciuniene (2008) on the different understandings and definitions of service quality and supports the earlier conclusions of increased rationalisation in the argumentation (Townley et al. 2003) with a specific focus on costs (Arnold et al. 1994; Oakes et al. 1994). As described by Arnold et al. (1994) the strong dominance of accounting and costing vocabulary in the newspapers, which was present in the US media in the late 1980s and early 1990s has also shown to be prominent in the newspaper debate in Denmark in the 2000s.

The work of Foucault (Fairclough 1992; Foucault 1972, 1994; Raffnsøe et al. 2008; Simons 1995) has assisted in the formulation of the role of management accounting during this period of change and management accountings final manifestation through his concepts of knowledge, truth, discourse practice and governmentality. However, these concepts were limited in the pursuit of an expression and understanding of the medical profession’s ‘phantom syndrome’ which is a dissociate phenomenon where the responsibility of the established management accounting techniques cannot be identified. This phenomenon and the calculative apparatus of management accounting representation in a third person would be of high relevance and interest in future studies in the
understanding of the role of management accounting. Additionally, Flyvbjerg (1998) offers a specific local presentation of the role of rationality in Danish public institutions. Rationalisation readily becomes a strong argument which is implemented through a dominating ideology reflecting and using a management accounting perspective (Flyvbjerg 1998; Townley et al. 2003). The results change the degree of focus on and perception of service quality. Rational arguments, using accounting terminology, control the discussion in the media. There is, indeed, a paradox between the wish for better quality in health care and the use of management accounting concepts to achieve it. However, Flyvbjerg (1998) also questions the adequacy of using Foucault’ thoughts in relation to the power shifts in the debate as the assumed objective and factual knowledge seems to provide totally unexpected outcomes. Though the present study found little open debate allowing the traditional management accounting domination in rhetorical and technical use, future research on open debates and the application of accounting power is relevant to enhance our understanding of the accounting domination.

Service quality is an essential theme in the debate of a desirable health care system. As shown in the Structural Reform and in the State financial yearly reports, service quality plays a significant role. However, the study shows that service quality is not apparent in the media debate. When the strong arguments and rationale of service quality are presented through management accounting terms the patients become powerless. Piligrimiené and Buciuniene (2008) suggest a service quality definition which they argue is different depending on stakeholder. According to their definition, the administrators’ definition implying measures and outputs wins in the Danish public debate where good quality is identified by good rankings and ‘most value for the money’.
Studies on open debates, phantom syndrome and public debate seem particularly relevant for our future understanding of the changing role management accounting in different local settings. These understandings have implications, not only for accountants, but also for policy makers and the medical profession in their pursuit of valid and sustainable solutions with a focus on the quality of patients’ well-being. Future studies in these areas will facilitate our understanding of the dynamic processes of national reform making and its contextual influences. Where this study has contributed to the understanding of these elements in a Danish context, it has also added to the global learning process of the roles of accounting and its counter reactions. Implementing the issues of service quality and patient’s well-being will assist in a focus on the initial end which should be distinguished from the mean and techniques of management accounting.
References


Pollitt, C., and G. Bouckaert. 1995. *Quality improvement in European Public Services - concepts, cases and commentary*: Sage Publications Ltd.


## Appendix 1:

<table>
<thead>
<tr>
<th>Phase 1: 2003/04</th>
<th>General Newspapers</th>
<th>Professional Magazines</th>
</tr>
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<tbody>
<tr>
<td><strong>Discourse practice</strong></td>
<td><strong>Trends:</strong> Opposition to the new reform from the profession – mainly nurses and others – no doctors in the debate.</td>
<td><strong>Trends:</strong> Derisive and intelligently formulated articles. International knowledge.</td>
</tr>
<tr>
<td><strong>Issues:</strong> Concern about consequences of savings and the focus on efficiency</td>
<td><strong>Issues:</strong> The failures of New Public Management</td>
<td><strong>Issues:</strong>: Profession versus management accounting on a global basis</td>
</tr>
<tr>
<td><strong>Emergent discourses:</strong> Profession and management accounting – absenteeism of the physician</td>
<td><strong>Emergent discourses:</strong> Profession and management accounting are dominant, expressing and demanding ‘run’, ‘say’, ‘give’ and ‘maintain’ which are action oriented verbs.</td>
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<tr>
<td><strong>Text analysis</strong></td>
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<tr>
<td><strong>Interactional control:</strong> In 2003 focus is on hospitals and hospital staff. In 2004 this changes to an increased focus on budgets and the overall societal economy gets related to the discussion of the changing health care sector.</td>
<td><strong>Interactional control:</strong> In 2003 patients have the highest interactive control (35%) whereas in 2004 the experts top the list in the form of international researchers proving the negative aspects of NPM.</td>
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<td><strong>Affective involvement and formulation:</strong> In 2003 the affective involvement is concerned with fear, but is also somewhat demanding whereas in 2004 it becomes more informative. ‘The best’ goal is implemented in 37% of the articles.</td>
<td><strong>Affective involvement and formulation:</strong> A feeling of neglect is the dominant affective formulation and is present in 80% of the articles. The formulations are a mixture of explanation, criticism and derisiveness.</td>
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<td><strong>Politeness and ethos:</strong> There is a positive politeness tone in the articles. Ethos is manifested through an authoritative figure in more than 50% of the articles.</td>
<td><strong>Politeness and ethos:</strong> Ethos is expert and helpless dominating people and the politeness is both positive and negative.</td>
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<tr>
<td><strong>Verb expressions and manifestations:</strong> Material processes are dominant, expressing and demanding ‘run’, ‘say’, ‘give’ and ‘maintain’ which are action oriented verbs. Intensifying adjuncts are used in most cases to underline the importance of what is being said.</td>
<td><strong>Verb expressions and manifestations:</strong> The main use of verb processes is material showing an active formulation rather than passive. Paratactic voice pointing at specific events and persons is present.</td>
<td><strong>Wordings:</strong>: The highest word counts are ‘quality’ and ‘patient’ but also the use of the word ‘economy’ is dominant.</td>
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<tr>
<td><strong>Social practice</strong></td>
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<td><strong>Social practice</strong></td>
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<tr>
<td>- Introduction of management accounting phrases and words by politicians and experts.</td>
<td>- The physicians show a well-documented and researched knowledge of the issue of restructuring the health care system through a reform like the Structural Reform and it is directly referred to as New Public Management.</td>
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<tr>
<td>- Management accounting terms are used as arguments in favour of changing the health care sector and introducing a new reform.</td>
<td>- Due to this knowledge a basic concern is related to the outcome of the reform and the consequences of it on quality and patients.</td>
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<tr>
<td>- Focus on budgets and health care costs is introduced in 2004 to underline this, which is closely related to a recent global trend of New Public Management focus where the health care sector is marketised.</td>
<td>- However, there seems to be a tone of not completely taking the issue seriously by being derisive in most articles.</td>
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<td><strong>Phase 2: 2005/06</strong></td>
<td><strong>Discourse practice</strong></td>
<td><strong>Discourse practice</strong></td>
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<tr>
<td><strong>Trends:</strong> Opposition fades out. Information giving period where the agreement of the structural reform has been finalised. Introduction of ‘experts’ in the debate. Still absence of doctors.</td>
<td><strong>Trends:</strong> Integration of economic issues in the debate, e.g. how to optimise the health care sector economically. But also a minor withdrawal from the issue with practical focus on issues like EPJ.</td>
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<tr>
<td><strong>Issues:</strong> Practical concerns, restructuring issues and listings of hospitals.</td>
<td><strong>Issues:</strong> Quality and electronic patient journals (EPJ), patient rights and the ‘stars’ alias rating the hospitals are the main issues.</td>
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<tr>
<td><strong>Emergent discourses:</strong> Management accounting discourse is enforced. The professional discourse is fading out. Absenteeism of the profession.</td>
<td><strong>Emergent discourses:</strong> Management accounting and adjustment. The phantom syndrome.</td>
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<tr>
<td><strong>Text analysis</strong></td>
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<td><strong>Text analysis</strong></td>
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<tr>
<td><strong>Interactional control:</strong> In 2006, the national right wing politicians (the government) have 41% of the interactional control in the articles. In 2005, the ‘experts’ are highly involved in more than 25% of the articles.</td>
<td><strong>Interactional control:</strong> In 2005, physicians have the major interactive control with over 40% whereas in 2006, the government has control with up to 50% in the articles.</td>
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<tr>
<td><strong>Affective involvement and formulation:</strong> It becomes even more information giving representing 91% of the articles. By the end of 2006 some neglecting emotion starts appearing.</td>
<td><strong>Affective involvement and formulation:</strong> It is still informative and with some focus on neglecting. Fear evolves as well like ‘what is going to happen with…’. The criticising element becomes more explanatory.</td>
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<tr>
<td><strong>Politeness and ethos:</strong> In 2006, a negative politeness appears</td>
<td><strong>Politeness and ethos:</strong>: Ethos is dominated by a mixture of enemy and expert knowledge.</td>
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and the authoritative ethos is further strengthened. Moreover, the expert ethos supports this in 64% of the articles.

**Verb expressions and manifestations:** Relational processes become stronger and more dominant with verbs like ‘is’ and ‘have’ which are describing a fact and not discussable. With some verbal processes as well which means that situations are made factual by ‘what is’ and often in verbal stakeholder statements.

**Wordings:** Words like productivity, performance measures and activity are introduced in several articles. Budgets and costs are not as dominant as in 2004, but are replaced by words like economy and money. Increased use of ‘quality’ whereas ‘treatment’ is no longer in focus. ‘Patients’ are replaced by ‘users’ in 10 articles, which has not been seen before.

**Social practice**

- Development of the management accounting terminology.
- Introduction of quality which is seen as an important element in legitimisation of economising the health care sector.
- Quality is associated with productivity, performance measures and activity and is seen as a positive treat for the public and the patients.
- Rationality which creates the hegemony and power which is difficult to argue against.

<table>
<thead>
<tr>
<th>Phase 3 2007/08</th>
<th>Discourse practice</th>
<th>Discourse practice</th>
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<tbody>
<tr>
<td><strong>Trends:</strong> Opposition appears again but in a different form. Distance making and lack of taking responsibility characterise the critics. Doctors are increasingly referred to but only appear directly in a couple of the articles.</td>
<td><strong>Trends:</strong> Consensus seeking with economists and management accountants as regard the structuring of the health care sector, but also questioning responsibilities and describing paradoxes in the system.</td>
<td><strong>Trends:</strong> Consensus seeking with economists and management accountants as regard the structuring of the health care sector, but also questioning responsibilities and describing paradoxes in the system.</td>
</tr>
<tr>
<td><strong>Issues:</strong> The system neglects patients. Worse treatments due to bureaucracy and centralisation.</td>
<td><strong>Issues:</strong> Patients’ rights, quality, acute health structure, internationalisation, disregarding populism.</td>
<td><strong>Issues:</strong> Patients’ rights, quality, acute health structure, internationalisation, disregarding populism.</td>
</tr>
<tr>
<td><strong>Emergent discourses:</strong> Phantom symptom and victimisation</td>
<td><strong>Emergent discourses:</strong> Consensus making, adapting management accounting terms and argumentation</td>
<td><strong>Emergent discourses:</strong> Consensus making, adapting management accounting terms and argumentation</td>
</tr>
</tbody>
</table>

**Text analysis**

**Interactional control:** Hospital staff has the majority of interactional control in 2007 (21%) whereas the society and economy have 38% of the control and focus in 2008.

**Affective involvement and formulation:** Neglecting and anger exist in 56% of the articles. The use of negative intensifying modals is increasing.

**Politeness and ethos:** The negative politeness and some derisive language appear in most the articles. The helpless and dominated ethos is predominant along with victim and enemy ethos.

**Verb expressions and manifestations:** Large use of normalisations, management accounting terms and expressions used to criticise the system as well.

**Wordings:** Costs and budgets appear widely again along with economy, savings and money. To a minor degree we find a usage of productivity, efficiency and activity. ‘Quality’ is still an important word and other medical terms like ‘equal’ and ‘treatment’ are increasing as well.

**Social practice**

- Critical debate on various health care outcomes and situations but now with an implemented management accounting terminology that has been adapted by the profession as well.
- The physicians enter the scene to a small degree but they are maintain their distance to the issues and do not take responsibility.
- An alignment seems to happen between the management accounting discourse and the public discourse.

**Verb expressions and manifestations:** The relational processes become dominant like in the general newspapers where things become facts and informative rather than discussable.

**Wordings:** Savings and patients are still central words but also ratings and activity become evident. Structure, specialisation and profession are central words used throughout the articles.

**Social practice**

- The ‘know it all better’ attitude among the physicians has disappeared and a more subservient role has emerged.
- A practical attitude towards how to make things work is implemented in the debate.
- The management accounting terminology slowly becomes a part of this discussion. It becomes dominant and powerful through rational arguments.

**Text analysis**

**Interactional control:** Expert as in gaining medical knowledge has 75% of the interactive control whereas the government has 25%.

**Affective involvement and formulation:** Neglecting and sympathy manifest the affective involvement along with critical formulations in the texts in this period.

**Politeness and ethos:** Negative politeness along with a dominant expert and authoritative figure ethos is present.

**Verb expressions and manifestations:** Negative infinity and large usage of normalisation with an emphasis on permission modality.

**Wordings:** The use of ‘money’ increases significantly along with ‘savings’ and ‘costs’ which are words that have not been much used prior to 2007. ‘Patients’ and ‘treatment’ are still dominant words though.

**Social practice**

- Debating various outcomes and asking ‘who is in charge of the health system?’. A similar distance taking as in the general newspapers is present where the physicians are not responsible but some phantom is.
- The management accounting terms have gradually become incorporated in the physicians’ own arguments which could be an intelligent way of reaching desired goals or it could be a subconscious adoption of the management accounting discourse.
### Appendix 2:

<table>
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<tr>
<th>Date</th>
<th>Berlingske tidende</th>
<th>Arbejderen</th>
<th>Politiken</th>
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#### Stakeholder perspective control:

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Appendix 3: Data

Newspaper articles:
December 17th, 2008; "Sygehus Rengøring og Ansvar” by Niels Tinglev in Berlingske Tidende. English translation of headline: 'Hospital cleaning and responsibility’ – 858 words

December 12th, 2008; "Kurs mod privatisering af sundhedssektoren” by Kai Vangskjær in Arbejderen. English translation of headline: 'Steering towards privatisation of the health care sector’ – 2133 words

November 27th, 2008; “Politisk analyse: Hvilke hospitaler skal væk?” by Peter Mogensen in Politiken. English translation of headline: 'Political analysis: Which hospitals need to close down’. – 980 words

November 19th, 2008; “Læger skal belønnes for at opdage rygerlunger” by Martin Kaae in Politiken. English translation of headline: 'Doctors should be rewarded for detecting emphysema’. – 397 words


July 9th, 2008; “VENTELISTER: Tilbage til plankommunismen” by Ellen Holm in Information. English translation of headline: 'WAITINGLISTS: Back to planning communism’. – 552 words

June 15th, 2008; ”Enighed om flere penge til sygehusene” by ritzau in Jyllandsposten. English translation of headline: 'Agreement on more money to the hospitals’. – 371 words

April 6th, 2008; “Livsvigtig medicin på samvittigheden” by Anders Langballe in Jyllandsposten.
English translation of headline: ’Critical medicine on the conscience.’ – 1946 words


January 17th, 2008; “Lad pengene følge patienten” By Peter Norsk in Berlingske Tidende. English translation of headline: ’Let the money follow the patients.’ – 1287 words

September 26th, 2007; “Hovsa er ofte løsningen når sygehuse mangler penge” by Michael Dalsager in Århus Stiftstidende. English translation of headline: ’Whoops! Is often the solution when hospitals need money.’ 408 words

September 26th, 2007; “Det er ikke den bedste løsning” by Michael Dalsager in Århus Stiftstidende. English translation of headline: ’It is not the best solution.’ – 370 words

August 30th, 2007; “Ingen sygeplejersker og læger skal fyres på hospitaller” by Lars Igum Rasmussen in Nyhedsavisen. English translation of headline ’Nurses and doctors in hospitals are not getting layed off’ – 380 words

August 29th, 2007; “Skejby sygehus skal også spare” by anonymous in Politiken. English translation of headline: ’Skejby hospital also has to save money.’ - 503 words


June 3rd, 2007; “S vil stoppe sygehuslukninger” by Bjarne Steensbeck and Philip Egea Flores in Berlingske Tidende. English translation of headline: ‘S (the Social democrats) will stop the shutdowns of hospitals.’ - 324 words

May 22nd, 2007; ”Hjerneflugt fra hospitaler” by Torben Ørntoft in Information. English translation of headline: ’Brain escape from hospitals.’ – 776 words


March 16th, 2007; “Danske sygehuse på operationsbordet” by Jakob Martini in Ingeniøren. English translation of headline: ’Danish hospitals on the operating table.’ – 698 words

February 25th, 2007; “Små sygehuse har de mest tilfredse patienter” by ritzau in Berlingske Tidende. English translation of headline: ’Small hospitals have the most satisfied patients.’ – 561 words


January 2nd, 2007; “Danmark er flyttet” by Lars Løkke Rasmussen (Minister of Home Secretary) in Jyllandsposten. English translation of headline: ‘Denmark has moved.’ – 445 words

December 1st, 2006; “Danmark som Kvalitetsstat” by Karsten Bjarnø in Randers Amtsavis. English translation of headline: 'Denmark as Quality State.' – 348 words


November 30th, 2006; “Regeringen møder med fem minister I Århus” by Jørgen Bollerup Hansen in Århus Stiftstidende. English translation of headline: 'The government shows up with five ministers in Århus.' – 218 words

November 29th, 2006; “Regeringen lukker møder om kvalitetsreform for pressen” by ritzau. English translation of headline: 'The government closes the meeting on the Quality reform.' – 139 words

November 16th, 2006; “Offentlig service: Sådan vil VK gøre os mere tilfredse” by Line Aarsland in Politiken. English translation of headline: 'Public service: this is how the VK (the rightwing government) will make us more satisfied.' – 976 words

November 8th, 2006; “Foghs seje træk” by Thomas Larsen in Berlingske Tidende. English translation of headline: ‘Fogh’s (the prime minister)tough move.’ – 560 words


May 29th, 2006; “Sundhed: 35 danske skadestuer I fare for lukning” by anonymous in information. English translation of headline: 'Health: 35 danish emergency rooms may close down.' – 531 words

March 13th, 2006; “Skejby sygehus og de regionale sygehuse” by anonymous in Lemvig Folkeblad. English translation of headline: 'Skejby hospital and the regional hospitals.' – 1000 words

March 15th, 2006; “Behov for masterplan 2” by Ulla Fasting in Randers Amtsavis. English translation of headline: ‘In need of a second masterplan.’ – 748 words
January 30th, 2006; “Sundhedsvæsen: at få endevendt sit liv på en banegård” by Lone Dybdal in JP Århus. English translation of headline: 'Health care: to have ones life turne upside down at a railway station.' – 1344 words

October 20th, 2005; “Sundhedsforbrug: mest forebyggelse til de rigeste” by Niels Thimmer and Mille Marie Christensen in Jyllandsposten. English translation of headline: 'health spending: most prevention to the rich people.' – 1042 words


August 28th, 2005; “Sundhed – offentlig gode eller privatsag?” by Lars Løkke Rasmussen (Minister) and Bent Hansen in Politiken. English translation of headline: ‘Health care – public service or a private case?’ – 1318 words


May 25th, 2005; “Umuligt at stoppe sygehusudgifter” by Anne Steenberger in Mandat. English translation of headline: 'Impossible to stop hospital costs.' – 850 words

April 30th, 2005; ”Vision af et samfund af raske” by Tove Eriksen and Annie Søberg in Information. English translation of headline ‘A vision of a society of healthy people.’ – 1401 words

April 14th, 2005; “Patienterne er ligeglade med strukturer” by Birthe Skaarup in Mandat. English translation of headline: 'The patients don’t care about structures.' – 274 words

March 2nd, 2005; “Så lyt dog til økonomerne!” by Jesper Poulsen in Mandat. English translation of headline: 'Please, listen to the Economists!' – 896 words

February 18th, 2005; “Et sundhedssystem med focus på tid og penge” by Per Andersen in Information. English translation of headline: 'A health care system focusing on time and money.' – 675 words

January 4th, 2005; ‘Vejle Amt for mest for sine sundhedspenge” by Claus Baggersgaard in Jydske Vestkysten. English translation of headline: 'The region of Vejle is the best to get it’s money worth in health.' – 425 words
December 18th, 2004; “Sygehuset blandt de mest effektive” by Mette Graugaard in Horsens Folkeblad. English translation of headline: 'The hospital among the most efficient.' – 356 words


October 28th, 2004; “Ombygning gavner mange kraftpatienter” by Birte Frøslund in DeBergske. English translation of headline: 'Reconstruction benefits several cancer patients.' – 452 words

October 20th, 2004; “Efter syv magre år beder vi nu om nogle fede år” by Søren Lauerberg in Jyllandsposten. English translation of headline: 'After seven poor years, we now ask for some rich years.' – 670 words

September 7th, 2004; “Århus Amts budgetter med fortsat realvækst” by Jens Kurt Jørgensen in Jyllandsposten. English translation of headline: 'Århus Regional budgets with continuing real value.' – 350 words

May 16th, 2004; “Sundhed: Reform kan svække sundhedsvesenet” by Lisbeth Bjerre and Dorte Kuula in Jyllandsposten. English translation of headline: 'Health: Reform may weaken the health system.' 1457 words.

May 12th, 2004; ”Kæftoperationer koster amtet seks mio. kr.” by Henning Just in DeBergske. English translation of headline: 'Cancer operations cost the region six mill. DKR.' – 295 words


April 5th, 2004; “Amter skyder genvej til elektroniske journaler” by Thomas Breinstrup in Berlingske Tidende. English translation of headline: 'Regions cut corners to integrate electronic journals.' – 412 words

April 2nd, 2004; “Indsigt i patientjournaler” by ritzau in Politiken. English translation of headline: 'Access to patient journals.' – 125 words

March 25th, 2004; ”Sygehuse i rationelt nybyggeri” by Benny Jensen in Jyllandsposten. English translation of headline: 'Hospitals in rationel new construction.' – 395 words

March 5th, 2004; “Statspenge skal rede amtets økonomi” by Jens Kurt Jørgensen in Jyllandsposten. English translation of headline: 'Statemoney shall rescue the Regions economy.' – 563 words


January 28th, 2004; “Staten må tage ansvaret for vores sygehuse” by Frans Clemmensen in Politiken. English translation of headline: ‘The state must take responsibility for our hospitals.’ – 2026 words


August 17th, 2003; “Vi ventende” by anonymous in JP Århus. English translation of headline: ‘Us, the waiting people.’ – 392 words


January 1st, 2003; “Kulturrevolution på sygehusene” by Lars Løkke (Minister) in Information. English translation of headline: ‘Culture revolution in the hospitals.’ – 433 words


November 26th, 2003; “Fra syg til dødssyg ” by Søren Christensen in Horsens Folkeblad. English translation of headline: ‘from ill to fatally ill.’ – 278 words

Professional articles:


April 16th, 2007; “Når ret skal være ret” by Bente Bundgaard in Ugeskrift for Læger. English translation of headline: ‘When right is right’ – 1007 words


August 28th, 2006; “Nu kommer Stjernene” by Christian Andersen, Michael Reiter and Dorte Jungersen in Ugeskrift for Læger. English translation of headline: 'The stars are coming now.' – 1471 words
May 8th, 2006; “Strukturreform, specialisering og sammenhæng” by Bente Bundgaard in Ugeskrift for Læger. English translation of headline: 'The Structural Reform, specialisation and connection.' – 967 words

January 16th, 2006; “Regionerne: Tøvende tilgang til ny sygehusstruktur” by Helle Ib in Ugeskrift for Læger. English translation of headline: 'The Regions: hesitating attitude towards the new hospital structure.' – 1946 words

January 1st, 2006; “Tid til at træde i karakter” by Jens Winther Jensen in Ugeskrift for Læger. English translation of headline: 'It is time to assert one self.' – 492 words


January 3rd, 2005; ”Hvis reformen skal lykkes” by Jesper Poulsen in Ugeskrift for Læger. English translation of headline: 'If the Reform is to succeed.' – 464 words

May 21st, 2004; “Eksperter frygter enkeltsagpolitik og ansvarsforflygtelse” by Mette Ebdrup and Ole Felsby in Dagens Medicin. English translation of headline: 'Experts fear single issue politics and responsibility escape.' – 1670 words

May 8th, 2004; “Lægen som visitator – nu til flere tilbud” by Lars Løkke Rasmussen (Health Minister) in Dagens Medicin. English translation of headline: 'The doctor as a medical officer – now for more offers.' – 757 words


August 28th, 2003; “Hjertepatienter vil få en dårligere behandling” by Bent Østergaard Kristensen in Dagens Medicin. English translation of headline: 'Heart patients will receive worse treatment.' – 569 words

January 1st, 2003; “Det ender med en Kjeld Møller Pedersen – model” by Christian Andersen in Ugeskrift for Læger. English translation of headline: 'It is going to end with a Kjeld Møller Pedersen (Health Economy Professor) model.' – 1251 words
Quality stems from the Latin ‘qualitas’ meaning “of what sort”. It is further described as a philosophical word introduced by Marcus Tullius Cicero (106 B.C. – 43 B.C.) as a direct translation of the Greek work “poiotes” used by Plato (424 B.C. – 348 B.C.). Plato created the word in order to describe the difference between a white object and whiteness as an attribute or feature. Thereby, quality originally describes an intangible trait and feature of something else. It does not suggest whether this feature is positive or negative. However, in the 17th century quality becomes a concept used to identify good or bad quality and it becomes a term that refers to a positive attribute. During the last century quality has become a widely used concept with positive attribute associations and a property in itself that everybody demands. It has moreover developed into different management philosophies such as Total Quality Management (TQM) which has become an integrated part and outlet of NPM.

The text in the analysed article has been divided into stakeholder groups according to the focus and attention given in the text. The words are then calculated and measured against the total wording of an article. See appendix 2 for an example of this calculation.

Resonans is a magazine published by one of the main organisations for public and private employees.
Chapter 5

The interplay of management accounting research and NPM health initiatives

Abstract

This paper investigates the development of management accounting research in the context of New Public Management (NPM) initiatives in health care. Drawing on concepts from diffusion theory and earlier literature reviews, the paper examines the interplay between management accounting research and health care reforms in relation to country of origin, development, theoretical approach, research method and topic. The study thus establishes a different focus; namely the interrelationship between the development of management accounting research and practical socio-political NPM innovations. 190 management accounting papers are analysed, over a period of 30 years, and related to 23 health initiatives in an established diffusion analytical framework. The study shows that management accounting techniques are increasingly adopted in governmental health reforms and diffused across nations, themes and initiatives through time with the result that wider social practices become more and more integrated in management accounting research themes. Additionally, The role of management accounting research and the impact of increased NPM health care legislations show how research is driven by governmental issues. Thus management accounting research takes upon a reactive role.

Keywords: health care sector, New Public Management, diffusion theory, literature review, management accounting

Words: 8.741
1. Introduction

During the past 30 to 40 years public health care has undergone large managerial changes. One important aspect of these changes has been the introduction of various management accounting tools like budgets, costing methods and performance measures (Christensen 2007; Glennerster 1994; Kurunmäki 2008; Lapsley and Pallot 2000; Lapsley and Wright 2004; Llewellyn 1993). These management accounting based developments, implemented through the philosophy of New Public Management (NPM), have influenced the health care sectors worldwide (Ashton 1996; Glennerster 1994; Groot and Budding 2008; Gruening 2001; Hood 1995; Pettersen 2004; World Health Organization 2000). NPM is not a new phenomenon and has been widely discussed in management accounting literature (Broadbent and Guthrie 2008; van Helden 2005) and its philosophy is well represented in practice (Jackson and Lapsley 2003; World Health Organization 2000). However, little attention has been given to the interrelated link of NPM literature research and practice at the socio-political level through reforms and health legislations. Using diffusion theory to illustrate such developments, this paper reviews the management accounting literature on NPM and investigates the integration of management accounting techniques in public health care initiatives.

Previous literature reviews done by Broadbent and Guthrie (Broadbent and Guthrie 1992, 2008) show that much research effort has recently been devoted to the area of NPM in health care. The 1992 study by Broadbent and Guthrie focuses on a trend within accounting research which they call ‘alternative’ accounting research. They argue that accounting impacts social and organisational practices, and this initiates these ‘alternative’ studies. Based on an extensive literature review conducted in 2007, Broadbent and Guthrie concluded that management accounting is the most researched area within public services. Likewise they find that health care is the most studied field
within the public sector. This justifies a specific management accounting literature review on public health care. van Helden (2005) conducted such a study with a focus on the role of management accounting, but within the entire public sector. This study focuses on health care and the literature review integrates the research made on the health reforms with a specific focus on the represented countries, their health care legislations and reforms, and the adjoining management accounting research.

Diffusion theory is an appropriate theoretical framework for combining research on literature, practical political initiatives and their interrelated development over time. It supports the possibilities of catching multiple developments and integrations of management accounting in various directions. It thereby allows a dual focus on how management accounting has spread through NPM initiatives and makes it possible to assess the counter-influence of national NPM initiatives on management accounting research. Diffusion theory further enables an investigation of management accounting spread and development across nations’ health legislations and vice versa; i.e. how NPM in health care influences the topics of management accounting studies along with the type of research approaches. The research design draws on three management accounting papers on diffusion; “Diffusion and accounting: the case of ABC in Norway” (Bjørnenak 1997), “The development of activity-based costing journal literature, 1987-2000” (Bjørnenak and Mitchell 2002) and “The diffusion of management accounting innovations in the public sector: a research agenda” (Lapsley and Wright 2004). The first two papers assist in the actual conceptual framework of the research design whereas the last paper facilitates our understanding of management accounting diffusion within the public sector. According to Lapsley and Wright (2004) management accounting often spreads within the public sector because of governmental and statutory requirements, especially within the national health sector, and consequently no natural selection
process exists at the organisational level. The selection takes place at the governmental level and consequently a study of NPM development at this level is fully justified. Despite its focus on the management accounting theme, this study differs from the three diffusion studies mentioned above as it investigates a dual diffusion of management accounting in health care reforms and legislations on NPM and NPM’s influence on management accounting research. The following research questions will be addressed: (1) How is management accounting constituted through NPM health initiatives? And (2) how are these NPM initiatives represented in the management accounting literature? A historical and universal approach is taken to explore this objective.

The paper is structured as follows. (1) The conceptual and theoretical framework of diffusion theory applied to literature review and the health reform interaction will be discussed; (2) the research design will then be described followed by (3) the presentation of results. Finally, (4) the results are discussed and concluding remarks and future research suggestions provided.

2. Theoretical and conceptual framework

Several elements are combined in the research framework of this study; diffusion theory, literature review and health care initiatives. The departure point of diffusion theory is grounded in innovations. In this paper it is the innovation of management accounting through NPM that is studied. According to Bjørnenak (1997) “An innovation is the successful introduction of ideas, perceived as new, into a given social system. It is essential that as long as it is recognized as new in a given area or social group, it may be viewed as an innovation”. Bjørnenak (1997) studies the spread of ABC in the private sector across Norway. The present study uses the 1980s as its starting point as this marked the introduction of NPM. Bjørnenak further distinguishes between the leaders
as being the initial innovators who created the idea and the adopters who adopt the innovations in later stages. In this study leaders and adopters are twofold; the public health care entity of a country and the management accountant researchers over time. Combined with this integrated time aspect of the diffusion stages is Hägerstrand’s (1967) model of diffusion over time which Bjørnenak integrates in his model. This model is especially relevant in this study as it illustrates the diffusion process over time and may reveal the time of different stages along with the differences between the management accounting research and health care initiatives.

Figure 1: Adopted by Bjørnenak (1997)

As can be seen in Figure 1, a diffusion process has an S shape where it remains constant at the saturation stage. Bjørnenak (1997) uses the Bandwagon concept to explain this process of acceptance where adopters adopt the innovation because of a specific convincing trend. This concept will be integrated in the presentation of the results. Bjørnenak (1997) applies two other concepts to this model; the information field and barriers. Information field in this study is the research papers that are investigated and the reform or acts that are constituted by government and accessible to the public. Barriers refer to obstacles in the information field such as physical
distance, cultural barriers and language. This will be further discussed in relation to the results. However, as noted above, most of the NPM innovations and adoption are forced upon health care institutions leaving no room for abandoning the projects (Lapsley and Wright 2004). On the other hand, resistance may occur at this level through health care profession oppositions. This, however, will not be directly addressed in this study, but in the later provided discussions.

The study by Bjørnenak and Mitchell (2002) builds on Bjørnenak’s prior diffusion study. It is, however, an ABC literature review reviewing and comparing both academic literature and practical literature. Bjørnenak and Mitchell’s (2002) five main objectives with additional perspectives and in particular the dimensions; volume, focus, research method, author and content/role, will create the basis for this study’s research design although with additions and modifications. Bjørnenak and Mitchell’s (2002) first three dimensions are described as being descriptive whereas the last two dimensions have communication and diffusion perspectives. The present study differs as the diffusion and descriptive perspectives overlap as they play an integrated role in the formation of management accounting literature and health initiatives.

This study also differs from both of Bjørnenak’s studies in the characteristics of innovations which in this study is the public sector. Moreover, the characteristics of innovators are societal entities like the health care sector and not manufacturing companies as in the first study of Bjørnenak (1997). Therefore, the study of Lapsley and Wright (2004) on diffusion in the public sector is added to the foundation of this paper. Their study contributes to the understanding of management accounting diffusion in the public sector. They state that “Within the public sector, the issue of diffusion of accounting practices has assumed a new importance, given the range of reforms of institutions and modifications to existing practices” (Lapsley and Wright 2004). Additionally, they state that innovations in the public sector originate in the private sector which justifies the combined use of diffusion theory in management accounting private sector studies. However, they conclude that
even though the private sector diffusion studies may clarify some diffusion processes in the public sector, they are unable to completely explain the results. This particular point will be further addressed in the discussion.

Lapsley and Wright (2004) also state that further research is called for to address the supplier side of diffusion, i.e. the central role of governments, who promote and integrate accounting innovations. This particular issue is addressed in this study by integrating the governmental health initiatives where the management accounting themes of the initiatives are highlighted and studied in relation to the management accounting literature.

The definition of NPM in this study draws on the specific accounting component of its philosophy. This is a set of accounting methods adopted from the private sector and transferred to the public sector (Froud et al. 1998; Hood 1995; Lapsley and Llewellyn 1992; Marriott and Mellett 1995; Mayston 1999; Newberry and Pallot 2004; Shaoul 1998). In particular management accounting methods like budgets, performance measures and costing methods are the focal point of management accounting through NPM which is also the central themes of Lapsley and Wright’s (2004) study. Therefore, when studying health care initiatives, special attention is drawn to the adoption of these methods. Health care initiatives, also referred to as health care reforms, can be understood through the written texts, contributed by the government, describing the aims and conditions of change within public health care. The 1978 declaration “Health for All” (WHO, 1978, Østergren, 2006) is very central to the NPM health care reform movement as it sets up specific targets to improve transparency with public sector health care.

The structure of the literature review itself draws on combinations of van Helden’s (van Helden 2005) classifications according to settings, topics, theories, research methods and results combined
with the literature characteristics described above by Bjørnenak and Mitchell (2002). Goddard’s (2010) groupings of theories and methodological approaches are adopted under this category; that is functionalist, interpretive and radical. These classifications along with the specific research design will be described in the following section.

3. Research design

The research design is lateral in the sense that each dimension is added onto the previous investigated dimensions. Thus, the complexity of the study and the studied interrelations increase as the presented results.

The first dimension is descriptive but still diffusion illustrative in the sense that it depicts the increasing volume over time. It lays the important foundation of the structure of management accounting literature over time. The context dimension focuses on health care initiatives. This dimension adds a communication and diffusion perspective when combined with management accounting literature on a time scale. The theoretical dimension, research method dimension and
focus/content provide the extra and more qualitative dimensions to the diffusion of health care initiatives combined with research perspectives and content. In the analysis of these three dimensions, the focus is academic research papers, but with integrated reflection of the governmental health care initiatives. In the following section each of these dimensions and how they will add to the previous dimensions will be described.

In the volume dimension, the selection of management accounting research data will be described and justified. Time is a very relevant cross-sectional theme in this study as it lays the empirical foundation together with the management accounting academic papers. It is important to emphasise the significance of exact time since it gives a focus on the longitudinal aspects of this study which is central to the diffusion process and the interrelation between the different dimensions described below. The time dimension moreover adds dynamics to the diffusion study and is thereby a very central element. The study covers a natural time dimension based on the logic that the phenomenon of management accounting literature studying NPM in health care starts sporadically and then after some time intensifies and then shows a trend. Therefore, the researched management accounting journals are investigated in their entire time of existence with present electronic access.

**Volume dimension**

This dimension is directly adopted by Bjørnenak and Mitchell (2002). They describe it as a valuable dimension since it provides the quantitative basis for measuring publishing activity. It is simple in a sense, but it is also the most crucial since it is this activity that defines the importance of NPM in the management accounting literature and enables us to see whether a diffusion process is present. In this dimension the quantitative amount of management accounting research is divided into management accounting journals but also countries. Unlike Bjørnenak and Mitchell’s study, country of origin is added to the quantitative production of research. In the global transformation of
health care and the spread of NPM this is seen as an essential element. It contributes to the identification of leaders and later adopters of the NPM innovations in management accounting research settings. It furthermore gives the basis for pursuing national health initiatives. The volume dimension includes the classification of country of origin and creates a basis for identifying trends and changes in the following dimensions.

The data collection consists of articles from 12 different accounting journals with management accounting issues. Journals are ranked on different lists and it is a challenge to find the most correct list or ranking. However, most rankings agree on the top five journals within the accounting field (Bonner et al. 2005, p.663; Chan et al. 2009, p.884): The Accounting Review (TAR) 1971-2011, Journal of Accounting Research (JAR) 1977-2011, Contemporary Accounting Research (CAR) 1991-2011, Journal of Accounting and Economics (JAE) 1979-2011, and Accounting, Organizations and Society (AOS) 1976-2011. These five journals are also found on the Financial Times Top Academic Journals in the Business, 2007\(^7\) and on the Danish bibliometric list\(^{\text{ii}}\). In order to represent management accounting more narrowly, four other journals are included in the sample: Accounting, Auditing and Accountability Journal (AAAJ) 1988-2011, Journal of Accounting and Organizational Change (JAOC) 2005-2011, Journal of Management Accounting Research (JMAR) 1992-2011 and Management Accounting Research (MAR) 1990-2011. JAOC is a new cross-disciplinary journal and has had several public sector reform issues which makes it eligible for this sample. Moreover, Journal of Accounting Literature (JAL) 2002-2011 is relevant since this journal includes literature reviews but it does not feature any articles on health care. Critical Perspectives on Accounting (CPA) 1990-2011 is chosen as it is able to diversify the sample and include more critical articles in order to challenge the biased construction of health care. Finally, Financial Accountability and Management (FAM) 1985-2011 and Journal of Accounting and Public Policy (JAPP) 1984-2011 are chosen due to their focus on governmental and non-profit organisations and
services and the journals include several health care articles. 190 articles were found on management accounting themes within health care.

**Context dimension**

This dimension is similar to the authorship dimension in Bjørnenak and Mitchell’s study. However, it adds one additional sector, i.e. governmental health care reforms and acts. This is referred to as the context dimension as it states the exact national socio-political context in which a given management accounting research study operates when reflecting and analysing NPM in health care. The country of origin is important in order to pursue the right national contexts. The sources of these health care initiatives are primarily found in the very extensive World Health Organisation’s (WHO) descriptions of national health care systems in transition. Each of these reports is written by health care academics and they constitute extensive information at a high level. Historic reform information is displayed in different ways as some authors describe each change within the public health care in detail while others only point out major highlights of health care changes. Therefore, the national health ministries’ webpages are used to find the reform and health act documents. In this study, only health care reform changes that include New Public Management aspects will be implemented in the time line. Adding this dimension to the academic literature and the time line will give a depiction of the interplay of research and reform making. It is this dimension that adds an interesting and novel aspect of diffusion in this study. The most crucial interrelation of this dimension is the focus or discussion of specific national health care initiatives. This is crucial since this is exactly how we determine whether an interplay of management accounting research and practical initiatives does exist; in other words it shows whether a diffusion process exists.
Theoretical dimension

The theoretical dimension and the following two dimensions are restricted to research papers. They do not include the previous described health care reforms since they do not employ theory and research methods. The theoretical dimension is adopted from Goddard (2010). Goddard mentions that it is a very interesting aspect to investigate but also the most difficult to categorise. His categorisation is adopted since it proves to be valid in his public sector accounting literature review. He uses a framework based on Burrell and Morgan’s (1979) categorisation which is also employed in the accounting research book of Ryan et al. (2002). The categories are functionalist research, interpretive research and radical/alternative research and they are closely related to Ryan et al.’s (2002) categorisation of mainstream, interpretive and critical accounting research. Functionalist research is objective and external to the subject. It uses quantitative methods of data collection which may provide a basis for generalisations. Goddard (2010) further categorises the included economic theories into agency theory, contingency theory, organisation and accounting. In this study, however, organisation is categorised under interpretive research. Interpretive research is characterised by subjectivity. It is descriptive and explanatory as is the case for organisationally focused studies. It further includes grounded theory and sociological studies. However, it proved necessary to add another group of research to interpretive studies; this group is called reform discourse. It is a specific research approach describing and investigating the governmental reforms. Radical/alternative research is concerned with radical change and this specific category is the focal point in Broadbent and Guthrie’s (1992) literature review and may be of specific interest in this study. They define alternative accounting as “.. being concerned with technologies in context; and that concerned with accounting’s impacts on organizations as whole entities.” (ibid, p.5). Goddard’s categorisation includes institutional theory, labour process theory, Foucauldian, Latourian and Habermasian approaches. Providing the research approach classification with types
of theory and methodology makes the categorisation more clear and justified. The categorisation is relevant to this study since it gives an indication of the type of interaction between NPM reforms and management accounting research; i.e. whether objective models are suggested or modified, specific contexts and case settings are described or whether critical analysis of NPM in health care is provided.

**Research method dimension**

This dimension is also adopted from Bjørnenak and Mitchell’s (2002) and adds a natural element to the literature review following the theoretical dimension. The categories are **literature, historical and document reviews; technical theory development; analytical modelling; econometric analysis; surveys; laboratory experiments and case and field studies.** Laboratory experiments, however, are not a used or suitable research method in the study of health care management. Instead, a comparative research approach is implemented and used to illustrate different national settings and outcomes. Like the theoretical dimension, this dimension sheds light on the development of research methods over time concurrently with other diffusional developments. It is relevant because it demonstrates the type of interaction and interplay between practical NPM adopters and creators and academic research.

**Topic and content dimension**

This dimension is explorative in the sense that it is developed through the literature review. Drawing on Lapsley and Wright’s (2004) findings on important topics in the innovations of accounting techniques, the topics are divided into performance measures, budgeting and costing. These are three broad topics and other topics are implemented as they evolve over time. Additionally, the level of the topic study seems relevant in this dimension; these levels are adopted
by van Helden (2005) who draw on Pollitt’s (2002) study of NPM adoption. The levels are are discourse, decisions, practices and impacts. Discourse means discussing the conceptual agenda of NPM. Decision is the instrumental innovations of NPM through reforms such as budget or costing developments. Practice is concerned with how NPM innovations are used by public sector organisations and impacts focus on savings, efficiency gains, improvement of quality and other types of impact. The framework of Morill et al. (1988), adopted by Bjørnenak and Mitchell that uses the contrasting definitions of propagators versus moderators with propagators being in favour of the NPM innovations and moderators being more critical towards the initiatives. However, these two categories are not sufficient to fully explain the researchers’ attitude in this study. Therefore, the concept of Bandwagon described above is added. Bandwagon illustrates an accepted and/or assuming attitude of research discussion, not proclaiming a pro or con attitude, but a fully accepting incorporation of the NPM trend.

4. Results

Volume dimension

With 68 articles on health care issues, Financial Accounting and Management (FAM) is the dominant journal with a considerable amount of papers on NPM in health care. Moreover, Accounting, Auditing and Accountability Journal (AAAJ), Management Accounting Review (MAR) and Accounting, Organization and Society (AOS) have published 24, 22 and 22 articles, respectively, on health care during the past 20-30 years. Accounting Review (AR) proved less useful as most search results turned out to be either books or book reviews. Journal of Accounting and Economics (JAE), Journal of Accounting Research (JAR) and Journal of Management Accounting Research (JMAR) have surprisingly only had five articles on the issue of
health care. Critical Perspectives on Accounting (CPA), Journal on Accounting and Organizational Change (JAOC) and Contemporary Accounting Review (CAR) have only published five to seven articles on NPM issues in health care each. No articles were found in the Journal of Accounting Literature (JAL).

Table 1

<table>
<thead>
<tr>
<th>Journal</th>
<th>Number of papers</th>
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<tbody>
<tr>
<td>MAR</td>
<td>22</td>
</tr>
<tr>
<td>AOS</td>
<td>22</td>
</tr>
<tr>
<td>AR</td>
<td>11</td>
</tr>
<tr>
<td>CAR</td>
<td>6</td>
</tr>
<tr>
<td>CPA</td>
<td>5</td>
</tr>
<tr>
<td>FAM</td>
<td>68</td>
</tr>
<tr>
<td>JAE</td>
<td>3</td>
</tr>
<tr>
<td>JAOC</td>
<td>6</td>
</tr>
<tr>
<td>JAPP</td>
<td>12</td>
</tr>
<tr>
<td>JAR</td>
<td>6</td>
</tr>
<tr>
<td>JMAR</td>
<td>5</td>
</tr>
<tr>
<td>AAAJ</td>
<td>24</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>190</strong></td>
</tr>
</tbody>
</table>

The cross-sectional variable; years of publication, shows that the majority of the articles were published in the 1990s. Two articles were published in the 1930s in AR. Then there were no articles until the end of the 1970s when three articles were published in JAR. In the 1980s, AOS started publishing articles on health care and they have continued until today with an average of one article per year. FAM also started in the mid-1980s and has published up to 15 articles per year on health care. In the 1990s, AAAJ and MAR started publishing several issues on health care. In 1994, AAAJ had a special issue on health care as had MAR in 1998. After 2000, articles are evenly spread among the various journals; however, AAAJ has only published one article on health care since 2003.
Historically, the first articles were published in the 1930s, a time when standard costing was emerging as a widely recognised practice. NPM evolved by gradually starting in the 1970s, continuing through the 1980s and peaking in the 1990s. This is shown in figure 3. The figure illustrates the amount of articles published per year on NPM in health care. With the exception of 2002 when only one paper is published altogether, the curve shows a similar S shape as illustrated in the Hägerstrand’s (1967) diffusion model in Figure 1 with a diffusion period in the beginning of the 1990s. A condensing period is noticeable during the 1990s and a saturation period occurs in the 2000s. Compared to Hägerstrand’s (1967) diffusion model, however, the saturation period flattens the curve as regards the amount of research papers on NPM in health care instead of bringing about a slight increase in the diffusion.

Figure 3: Volume of papers over years

Integrating country of study in the analysis shows a similar trend of research interest spreading to other countries. Despite one article on Sweden in 1987 (Coombs 1987), all articles up until the 1990s originate in the US or the UK. In 1990 one study is published on Australia (Abernethy and
Stoelwinder 1990) in AAAJ, but not until 1996, due to a special issue in FAM on NPM in health care, are non-English-speaking nations represented. After 1996 this tendency becomes more common though the English-speaking nations are still the dominating countries of study. This trend of diffusion through the countries of study is illustrated in figure 4.

Figure 4: Number of countries represented in research studies per year

![Number of countries represented](image)

Figure 4 shows a similar diffusion trend with a visible S curve. It is, however, delayed compared to the amount of research papers on health care. When it comes to the number of countries represented the diffusion period is the middle of the 1990s and the condensation period takes place around 2000. The delay may be natural through the rationale of the journals having Anglo-Saxon origins and English as the publishing language. Nevertheless, the trend is illuminating and supports the theory of a theme diffusing in several directions including increases in the amount of studies and amount of countries being studied. The exact countries represented and the amount of studies per year is shown in appendix 1. It is evident that the US and the UK are leaders whereas New Zealand, Australia, Sweden, Norway and Finland are later adopters. Additionally, Canada, Taiwan, Belgium,
the Netherlands and Germany are represented but only with one or two studies. Germany, for example, is included in a comparative study.

**Context dimension**

This dimension is the most extensive dimension since it includes an additional written source which is the health care initiatives. The majority of the research articles refer to a specific health care reform enacted in the national setting of the researched paper. Especially *FAM* papers focus on specific health care initiatives and mainly UK initiatives. This is supported by the fact that more public health care initiatives take place. Table 2 reveals that there are eight different UK health care initiatives which research papers refer to. Also in the health care initiative context, the UK is clearly a leader in the diffusion process. The most debated initiatives have been the Griffith report 1983 and the white paper ‘Working for patients’ in 1989. The Griffith report is a letter to the Secretary of State with the purpose of improving the NHS control system (Bourn and Ezzamel 1986; Boyle 2011; Griffiths 1983). The report suggests in details how a rearrangement of management and decision-making may take place within the NHS. Bourn and Ezzamel (1986) study the Griffith report and the subsequent criticism of the letter specifically. They conclude that the main management accounting role in this report is holding managers and clinicians accountable by allocating budget and monitoring responsibilities (Griffiths 1983). The white paper ‘Working for patients’ in 1989 takes management accounting tools even further. An internal market is developed through a purchaser-provider split and cost contracts per activity are introduced. The rationale behind this initiative is that the health care sector will become more efficient (Boyle 2011; Rivett 2007). No less than 21 research papers address this health care initiative in the following 12 years. This type of health care reorganisation generally meets with major concerns as it is argued to be unnatural in a health care context (Laughlin et al. 1994; Mackintosh 1993), and to have resulted in
various challenges in the NHS (Fischbacher and Francis 1998; Glennerster 1994; Rea 1994). The GP performance contract 1990 and the Private Finance Initiatives 1992 are both offshoots of the ‘Working for patients’ document (Boyle 2011). In 1997, the market and competition line of thought is replaced by collaboration with the white paper ‘The new NHS: modern, dependable’. This paper still focuses on performance indicators, but in a far less ‘free market’ manner. It is debatable whether academic research influences this reorganisation due to the criticism of the internal market in NHS. Clearly, the internal market was criticised both academically and publicly (Ellwood 1996; Llewellyn 1993; Mackintosh 1993; Mullen Penelope 1990). This criticism may reflect the refocus on collaboration. However, the diffusion link between health care reforms and academic debates is more obvious since health care reforms are directly stated and referred to in academic research whereas health care reforms seldom directly refer to academic research. An illustration of the links between the UK health reforms and academic research is provided in appendix 2. It reveals that academic research responds heavily to the health reforms though there are some reforms and legislation which are not directly considered (these are the light blue boxes). Likewise, the health initiatives have clear management accounting tools such as budgets, costing and accountability closely tied to them, illustrating the interplay of management accounting methods and NPM (Boyle 2011; French 2001; Glenngård et al. 2005; Halligan 2007; Vuorenkoski 2008; World Health Organization 2000).
Table 2:

<table>
<thead>
<tr>
<th>Year</th>
<th>US</th>
<th>UK</th>
<th>New Zealand</th>
<th>Australia</th>
<th>Finland</th>
<th>Sweden</th>
<th>Norway</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970s</td>
<td>'The way forward' (1 article refers to this)</td>
<td></td>
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<tr>
<td>1980s</td>
<td>Medicare 1983 (13 articles refer to this)</td>
<td>Griffith report 1983 (6 articles refer to this)</td>
<td>Choices for health care 1986 (1 article refers to this)</td>
<td>Australian medicare 1986 (1 article refers to this)</td>
<td>The DAGMAR reform (1 article refers to this)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DRG 1985 (4 articles refer to this)</td>
<td>‘Working for patients’ 1989 (21 articles refer to this)</td>
<td>Unschackling the hospitals 1988 (1 article refers to this)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1990s</td>
<td>GP performance contract 1990 (2 articles refer to this)</td>
<td>Your health and the public health 1991 (5 articles refer to this)</td>
<td>The market model 1993 (4 articles refer to this)</td>
<td>Coalition agreement 1997 (1 article refers to this)</td>
<td>1993 State subsidiary reform (2 articles refer to this)</td>
<td>The Stockholm Model early 1990s/Purchaser-provider split local governments (7 articles refer to this)</td>
<td>Health Law Reforms of 1999/Patient right act/Hospital act (3 articles refer to this)</td>
</tr>
<tr>
<td></td>
<td>Private Finance Initiative 1992 (4 articles refer to this)</td>
<td>The new NHS 1997 (3 articles refer to this)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2000s</td>
<td>National Performance Review (1 article refers to this)</td>
<td>Payment by results 2002 (2 articles refer to this)</td>
<td>The New Zealand Health Strategy 2000 (1 article refers to this)</td>
<td></td>
<td>Stop law</td>
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<tr>
<td></td>
<td>Update and next steps 2005 (1 article refers to this)</td>
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New Zealand’s health care initiatives show similarities to those of the UK. New Zealand is also undergoing several changes during the 1990s. ‘Your health and the public health’ 1991 and ‘The market model’ in 1993 show similar internal market introductions as in the UK in 1989. The two internal market initiatives are also health care reforms that are referred to the most in management accounting academic research. After heavy criticism of what has been denoted ‘the great experience’ (Lawrence et al. 1994), New Zealand introduces the coalition agreement in 1997 and
turns away from internal markets at the same time as the UK introduces the collaboration reform. This is taken further in ‘The New Zealand Health Strategy 2000’, which directly states that the earlier internal market attempts have been unhealthy for the health care system (New Zealand’s Minister of Health 2000). Australian academic research responds little to their health initiatives but more to the UK initiatives, though one article refers to the Australian Medicare in 1986.

The US management accounting papers refer primarily to the Medicare introduced in 1983 and the following DRG implementation. The US Medicare is an agreement on reimbursement for patients older than 65 years and younger people with disabilities. The US Medicare has existed since the 1960s, but the reimbursement practice was changed in 1983 from actual cost to a fixed amount per inpatient. This has given rise to some debate and 13 research articles refer to this debate. Otherwise there is only one other US health care initiative regarding National Performance Review after 2000. The reason for these minor health care initiatives in the US can be found in their legislations of not having a universal health care system (Thomson et al. 2011) and the fact that most initiatives are state-based. These two aspects make the US health care context different from that of the other OECD countries though the US still produce the majority of research on health care within management accounting with 55 research papers out of 190. These papers normally analyse and discuss the profit angle as well as costs.

The Scandinavian countries; Finland, Sweden and Norway, are also discussed in the management accounting literature. Sweden introduces a so-called ‘Stockholm model’ in the early 1990s. The Swedish health care is decentralised and the local authorities have implemented a purchaser-provider split with a focus on payment by activity. These local reforms have been referred to as the Stockholm model (Glenngård et al. 2005). In Finland and Norway there is no directly stated purchaser-provider split in the health transition reports. However, Finland is still strongly influenced by the international trends of accountingisation of the health care sector (Kurunmäki et
This is further supported by the WHO report, Health Systems in Transition – Finland (Vuorenkoski 2008); “The WHO Health for All programme contributed significantly to Finnish Health policy. In the 1990s, developments in health care were influenced by ‘external’ circumstances: severe economic recession, the 1993 state subsidy reform and Finland’s membership of the EU” (p.123). This illustrates the cross-national diffusion process and the bandwagon concept. In Norway the only reforms referred to in the literature is the Health Law Reforms of 1999. This focuses particularly on the two aspects of patient rights and hospital act. These acts show the later tendency of re-involving and focusing on patients and quality although still through established budgets and performance measures.

The overall picture of the health reforms and their interaction with academic research reinforces elements of diffusion of management accounting. As seen specifically in the UK and New Zealand much accounting emphasis is put into the health care sector in the late 1980s and early 1990s. This extreme change of health care levelled out throughout the 1990s and after 2000 but still included the management accounting elements of stricter performance measures, budgets and accountability. It becomes normalised and a renewed focus can be put on patients, collaboration and quality. This is similar to the condensation and saturation stages of the diffusion S curve, Figure 1.

**Theoretical dimension**

This analysis includes different types of journals and research papers. A remarkably large proportion of the researched papers has either no theory or belongs to the category of ‘other’. According to their research method many of the ‘no theory’ papers would belong in either the functionalist or interpretive category, whereas most of the ‘other’ would belong to radical or interpretive. Among ‘other’ theories are Weick’s sense-making (Kurunmäki et al. 2003), Gidden’s structuration theory (Lapsley 2001), hermeneutics (Oakes et al. 1994) and Hybrid theory (Llewellyn
Other theories are in the group of ‘others’ due to multiple difference in theory and the seldom use of a particular theory. 43 research papers (23%) belong to the functionalist group, 49 (26%) to the interpretive category and 42 (22%) to the alternative category and finally 56 (29%) to ‘other’. Thus there seems to be a fairly even distribution between the different theoretical categories. The large reform discourse group consists of research papers directly discussing and analysing health care reforms. These are mainly published in FAM. They have a specific reform-technical approach which often diverts from the traditional management accounting issues.

Table 3: Theoretical category of research papers

<table>
<thead>
<tr>
<th>Theoretical Category</th>
<th>Number</th>
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<tbody>
<tr>
<td><strong>Functionalist</strong></td>
<td></td>
</tr>
<tr>
<td>Accounting</td>
<td>4</td>
</tr>
<tr>
<td>Agency theory</td>
<td>13</td>
</tr>
<tr>
<td>Contingency theory</td>
<td>4</td>
</tr>
<tr>
<td>Economic theory</td>
<td>22</td>
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<tr>
<td><strong>Interpretive</strong></td>
<td></td>
</tr>
<tr>
<td>Sociological</td>
<td>15</td>
</tr>
<tr>
<td>Grounded theory</td>
<td>2</td>
</tr>
<tr>
<td>Organisational</td>
<td>11</td>
</tr>
<tr>
<td>Reform discourse</td>
<td>21</td>
</tr>
<tr>
<td><strong>Radical/alternative</strong></td>
<td></td>
</tr>
<tr>
<td>Bourdieu</td>
<td>1</td>
</tr>
<tr>
<td>Foucault</td>
<td>3</td>
</tr>
<tr>
<td>Habermass</td>
<td>3</td>
</tr>
<tr>
<td>Latour</td>
<td>7</td>
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<tr>
<td>Saussure</td>
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<tr>
<td>Institutional theory</td>
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<tr>
<td></td>
<td>27</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
</tr>
<tr>
<td>No theory</td>
<td>30</td>
</tr>
<tr>
<td>Other</td>
<td>26</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>190</td>
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</table>
If the categories are distributed over time as shown in Figure 5, functionalist studies are somewhat evenly distributed over time despite a peak in 2005 of 4 papers. Interpretive papers peak in the mid-1990s which coincides with the large amount and development of NPM health care reforms. Radical studies grow over time except for 1999, 2003-2005 where they are completely absent. As such the data does not reveal any significant relations between time and development of specific categories. Though it does reveal additional papers distributed throughout the three combining categories of interpretive, radical and other types. This fact is compatible with the role of management accounting diffusing into new areas such as the health care sector where more emphasis is given to social context and individual experience. This requires additional and different research studies than merely the traditional studies, resulting in this natural development which can basically be identified as part of the diffusion process.

The data shows the traditional majority of functionalist papers being produced on the US. However, 20% of the US papers can be categorised as radical, which is a large proportion compared to the UK with only 14% of the research papers in the radical category. This can be partly explained by the
‘other’ category which consists of 42% of the UK research papers compared to just 18% of the US research papers. New Zealand has the largest proportion of papers in interpretive and radical; 95% in these two categories. New Zealand has no ‘other’ types of research papers.

Research method dimension

Mitchell and Bjørnenak’s (2002) research methods have been applied to the research papers with only minor modifications. There are three methods that are significantly represented; Case-Field study, Econometric analysis and Reform analysis. Table 4 shows that case-field study is especially embodied in Australasian and Scandinavian research whereas both case-field study and reform analysis are significant in the UK. Not surprisingly econometric analysis and analytical modelling are most significant in the US. These findings support earlier findings of research methods in academic ABC research according to Mitchell and Bjørnenak (2002). The penetrating method of reform analysis in the UK draws parallels to the intense reform transformations of the UK health care during the 1980s and 1990s and to the theoretical dimension findings. The UK reform researchers thoroughly discuss implications of reforms with a moderator legislating perspective not always directly involving management accounting. The scope of the discussion and the reform discussed are therefore easily detectable in the UK studies. Appendix 3 indicates how the adopted research methods have been used over time. Turning to this cross-sectional dimension, it is evident that econometric studies are steady during the 1970s, 1980s, 1990s and 2000s whereas case-field studies emerge in the 1980s and intensify strongly during the 1990s where they level out at a higher level in the 2000, exactly as the diffusion S shape. Reform analysis is intense during the 1990s, which correlates with the amount of reforms during this time frame. In this table the reform analysis is separated from historical papers. Comparative analysis emerges around 2000 where the NPM in
health care phenomenon is well known and different transnational processes and results are recognised.

Table 4:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Australasia</th>
<th>Continental Europe</th>
<th>International</th>
<th>Other</th>
<th>Scandinavia</th>
<th>UK</th>
<th>US</th>
<th>Total n</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Analytical modelling</td>
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<td>1</td>
<td>1</td>
<td></td>
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<tr>
<td>Comparative study</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td></td>
<td>3</td>
<td></td>
<td>12</td>
<td>6%</td>
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<tr>
<td>Econometric analysis</td>
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<td></td>
<td>9</td>
<td>32</td>
<td></td>
<td>46</td>
<td>24%</td>
</tr>
<tr>
<td>Historical</td>
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<td></td>
<td></td>
<td></td>
<td>5</td>
<td>4</td>
<td></td>
<td>9</td>
<td>5%</td>
</tr>
<tr>
<td>Literature review</td>
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<td></td>
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<td>2</td>
<td>3</td>
<td></td>
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<td>3%</td>
</tr>
<tr>
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<td>1</td>
<td></td>
<td></td>
<td>4</td>
<td>2</td>
<td></td>
<td>10</td>
<td>5%</td>
</tr>
<tr>
<td>Reform analysis</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>17</td>
<td>2</td>
<td>2</td>
<td></td>
<td>29</td>
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<tr>
<td>Survey</td>
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<td>1</td>
<td>1</td>
<td></td>
<td>4</td>
<td>1</td>
<td></td>
<td>9</td>
<td>5%</td>
</tr>
<tr>
<td>Case - Field study</td>
<td>12</td>
<td>1</td>
<td>1</td>
<td>16</td>
<td>23</td>
<td>6</td>
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<td>59</td>
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</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>9</td>
<td>6</td>
<td>5</td>
<td>25</td>
<td>68</td>
<td>55</td>
<td>190</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Topic and content dimension**

One of the most prominent accounting themes in the research papers is costing, closely followed by performance measures and management control. Costing is a broad theme which includes specific costing issues, funding, resource allocation, DRG, pricing, standardisation, equity and capital charging. *CAR* shows US research papers which build on costing theory and the health care data seems secondary since the conclusions are drawn on the model and not the data as such. Costing is similar to the econometric analysis constant throughout the entire time period, whereas performance measures and management control intensify throughout the period. Standardisation is also a theme within performance measures and management control along with specific performance tools like the balanced scorecard. The balanced scorecard is especially popular in the Swedish research studies and on Swedish health care sites.
Table 5:

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
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</thead>
<tbody>
<tr>
<td>Accounting information systems</td>
<td>3</td>
</tr>
<tr>
<td>Budgeting</td>
<td>22</td>
</tr>
<tr>
<td>Compensation/ incentives</td>
<td>3</td>
</tr>
<tr>
<td>Costing</td>
<td>62</td>
</tr>
<tr>
<td>Efficiency</td>
<td>5</td>
</tr>
<tr>
<td>Management control</td>
<td>32</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
<tr>
<td>Performance measures</td>
<td>36</td>
</tr>
<tr>
<td>Social context</td>
<td>22</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>190</strong></td>
</tr>
</tbody>
</table>

Budgeting is a central issue too, but like costing it is a constant theme. Social context, on the other hand, is strongly represented towards the end of the time period. The social context category consists of papers with a specific focus on this issue through profession, behaviour, power groupings and patients. It is, however, not isolated to these 22 papers with a specific focus but also a cross-sectional issue focusing on research papers on performance measures, budgeting and management control and a cross-sectional theme of accountants’ roles and accounting changes. Especially in *AOS* and *AAAJ*, the role and impact of accounting along with its influence on health care contextual change are major themes. *AOS* and *AAAJ* likewise focus on professional rivalries, accounting manifested through hybrids and power issues.

The level of study is evenly distributed through the four different levels. However, when including the time dimension, it becomes evident that the practice level is dominant in the last period of the time frame and discourse and impact are more prominent towards the end of the period. This does not support the findings of van Helden (2005) who mainly finds a focus on discourse and decision
level. The reason could be the fact that health care studies are more impact and practice focused than public sector studies in general. It could also be a question of definition of the different levels. Is a survey, for example, a research of opinions which would take place at the discourse level or practice and impact because some of the questions address how the local practice functions and what impact specific initiatives may have had in the local hospital? In this study, if questions or data analysis is focused on post reform results, it has been levelled as practice or impact.

Throughout the analysis it has become clear that merely categorising research papers into a “moderator” and a “propagator” group is too simplistic. In the last decade, many research papers have taken some kind of accountingisation of the health care system for granted and are no longer moderators or propagators at the same level as used to be the case. For example, a paper may signal moderation in specific NPM and management accounting angles but not in the overall implementation of management accounting tools. Therefore the bandwagon category was added to these diffusion attitudes, capturing acceptance and assuming that NPM is accepted at a different level and assumed incorporated into health care practices. This category is mainly manifested after 2004. In spite of the new category, research papers are primarily moderating. This may be a natural result illustrating researchers’ careful analytical approach to themes in general. However, it is completely contrary to the findings of Mitchell and Bjørnenak (2002) who find a large proportion of propagators among ABC researchers. This could be explained by the issue in focus. ABC is a specific costing tool and the research of Mitchell and Bjørnenak (2002) is heavily focused on the private sector, as is the implementation and use of ABC. NPM in health care on the other hand includes multiple issues, and a specific and continuous tension is management accounting themes in the social context of health care which creates a different type of research focus.
5. Discussions and conclusions

This review of literature on management accounting and its interaction with NPM reforms in healthcare has revealed the spreading of NPM reforms and management accounting terminology and techniques over the past 30 years. Originating in the US and UK, placing these two countries as leaders, both academic management accounting research on health care and NPM legislation have grown through the 1990s where it spread into several following adopting countries with consistent expansion during the 2000s. The language and cultural barriers that caused a delay in the adoption in other nations have, however, been partly overcome. The combined health care reform and academic literature analysis confirms a diffusion of management accounting terminology and methods through the governmental health care legislative context and also confirms the implementation of the social health care context and topics into academic management accounting research where the focus of research studies has spread to various social and political issues such as health care profession, behavioural factors, power issues and health care treatments rather than the traditional subjects of management accounting methods. Thus management accounting has become accepted at a different level and has become naturally integrated in health care reforms. Likewise, a tendency of integrating and accepting the social context of health care in management accounting research creates a different starting point for some research papers than was seen earlier where integrating the social context had to be justified in accounting studies. This is, for example, seen in the analysis of moderators and propagators.

The academic interest in a given country is related to the emergence of national health care initiatives. Thus, the role of management accounting research is significantly influenced by governmental changes. Diffusion theory brings forward the role of management accounting research as integrated with governmental NPM legislation where management accounting research
mostly plays a reactive role. Management accounting techniques such as budgets, performance measures and costing methods have been implemented in many health care initiatives since the 1980s. Academic management accounting research responds to this leading to an increase in research in NPM and health care research. The increased number of countries that implement NPM health care reforms forces academic research to include issues such as social context, apply case studies and broadens the themes to encompass accounting changes, the role of management accounting, power issues, behavioural issues and impacts. Simultaneously, health care initiatives advance from having an internal market focus to a collaboration focus but with accepted and integrated performance measures and a focus on costs and budgets.

The impact of the progressed state of management accounting acceptance is taken to an even more advanced level where accountability becomes a cross-sectional theme signalling responsibility. This results in aspects where the use of diffusion theory in this study is limited, which was also concluded by Lapsley and Wright (2004). Building on the analysis of stages and time lags, this study could be extended with hybrid theory which may explain the practical results of the management accounting diffusion. This form of hybrid theory has already being applied to accounting in health care and discussed by Llewellyn (1997), Kurunmäki (2004) and Miller et al. (2008). Kurunmäki (2004), for example, defines hybridisation as making medical professionals financially accountable through management accounting tools such as budgets. The study of hybridisation is highly relevant to the process of investigating the impact of management accounting tools. Clearly, the transformation of management accounting cannot be identified by diffusion theory but rather by hybrid theory. This study has, however, shown the dynamic processes of adoption of the highly needed management control tools in the complicated and growing health care sector.

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The role of management accounting research and the impact of increased NPM health care legislations show how research is driven by governmental issues. This can, for example, be seen in the integration of quality into management accounting practices. As stated above, the WHO report of 1978 laid the foundation for the first NPM reforms. In 2006, WHO made a report on implementing quality into health care (World Health Organization 2006). This report combines quality with management accounting techniques with the goal of improving health care quality through management accounting techniques such as indicators and performance measures. This is an obvious example of hybridisation of management accounting into health care. If we look at the historical trend of WHO setting the scene and health reforms evolving across nations resulting in academic research discussions, it will be interesting to see if this trend continues and if the future issue in both health reforms and academic research will be the further integration of quality. The tension of combining costs with quality has been discussed by Llewellyn (1993) at a time when integration of internal market reforms was at its peak. Later, integration of quality in health care reforms can be seen in e.g. Denmark (Kjellberg 2007) and the impact of implementing quality indicators is becoming a theme in management accounting academic papers such as Østergren (2006).

From the perspective of management accounting research, this study supports earlier studies on the development of ‘alternative’ research (Broadbent and Guthrie 1992, 2008) which we call radical. This study explains part of this trend by illustrating the diffusion of the role of management accounting into areas to which it was previously unapplied. Examples are public sector professions with different setups, aims and social contexts than the private commodity sector on which management accounting used to focus. Lapsley and Wright (2004) study the diffusion of
management accounting innovations in the public sector, but their study focuses on the practice of the UK public sector, investigated through surveys. The present study is similar in that it uses diffusion theory, but at a different level where the discursive origins of health care reforms are compared to the development of the academic research. In addition, the present study adopts an international perspective in order to establish how management accounting techniques in NPM health care legislation and management accounting research on health care issues diffuse across nations. The international findings of management accounting research reflecting governmental initiatives support Lapsley and Wright’s (2004) findings regarding the large governmental influence on accounting innovations, not in practice but in academic research. They seek a time lag explanation for the adoption of management accounting processes in order to capture different attitudes and acceptance in the UK. The present study has covered a different time lag combined with an investigation of the development of governmental health care initiatives across nations, but the diffusion process in practice would be a natural extension of this study and would thereby support Lapsley and Wright’s (2004) proposition of this as a future research area.

The refocus on quality in health reforms and management accounting research, the growth in case studies and radical/alternative researches are all well connected and not only show the diffusion of management accounting processes, but reflect a learning process where the social context plays an increasing role in the application of management accounting techniques. These settings may also be of significance due to the forced selection process (Lapsley and Wright 2004) where the implementation of management accounting techniques does not diffuse naturally into the social context and practice. The ensuing tensions and conflicts make it necessary to restructure the implementation of management accounting techniques. We therefore suggest that future research be directed towards the hybrid accounting process in health care described above, with a focus on
explaining how the management accounting methods are actually applied and practiced and on
determining whether new constructive research is necessary to study alternative accounting
techniques depending on the social setting. This study has shown a directly reactive pattern of
researchers reacting on health care initiatives, but whether management accounting researchers
influence health care initiatives is not clear. In the sample of journals examined in this study we did
not find any articles that proposed specific management accounting methods to be used for
improving health care management. This is supported by Granlund and Lukka (2002) who find that
consulting research in accounting is virtually non-existent. Their research, however, is on practical
application of ABC.
References


## Appendix 1:

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- Bourn and Ezazami, 1986; Bevan and Bovaird, 1987
- Bevan, 1987
- Muller, 1990; Bryan and Bech, 1992; Laughlin et al., 1992
- Preston et al., 1992
- Llewellyn, 1993
- Bates and Brignall, 1993; Willmott, 1993; Mackintosh, 1993; King et al., 1994; Glanster, 1994; Lapsley 1994; Laughlin et al., 1994; Rea, 1994; Levaggi, 1995; Marron and Mellett, 1995; Llewellyn and Grant, 1996; Elwood, 1995
- Jones and Dewing, 1997; Francis, 1998; Hodges and Mellett, 1998; Mayston, 1999
- Jones, 1999; Jones, 2002
- Gill et al., 2003; Shoaib and Williams, 2003; Shoaib, 2005
- Llewellyn and Northcott, 2005
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- Toms et al., 2011
- Conrad and Usiu, 2010; Conrad and Usiu, 2011
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(Blanchard et al. 1986; Kim 1988; Krishnan 2005; Eldenburg 1994; Eldenburg and Soderstrom 1996; Rorem 1930; Mensah et al. 1994a; Rorem 1936; Sherman 1986; Eldenburg et al. 2011; Pizzini 2010)

**Accounting, Auditing and Accountability Journal – 26 articles**

**Accounting, Organizations and Society – 22 articles**

**Contemporary Accounting Research – 6 articles**
(Abernethy and Chua 1996; Balakrishnan et al. 1996; Balakrishnan and Gruca 2008; Eldenburg and Krishnan 2008; Petersen 2007; Hsu 2011)

**Critical Perspective on Accounting – 7 articles**
(Hill et al. 2001; Shaoul 2005; Shapero 2002; Watkins and Arrington 2007; Acerete et al. 2011; Holmgren Caicedo and Märtensson 2010; Toms et al. 2011)

**Financial Accountability and Management – 69 articles**
Journal of Accounting and Economics – 3 articles
(Eldenburg Leslie and Kallapur 1997; Ittner Christopher et al. 2007; Noreen and Soderstrom 1994)

Journal of Accounting and Organizational Change – 6 articles
(Funck 2007; Llewellyn et al. 2005; Nyland et al. 2009; Robson 2008; Agrizzi 2008; Petterson and Nyland 2011)

Journal of Accounting and Public Policy – 12 articles

Journal of Accounting Research – 6 articles
(David 1977; Elnicki 1977; Michael and Marais 1998; Neumann 1979; Krishnan and Yetman 2011; Balakrishnan et al. 2010)

Journal of Management Accounting Research – 5 articles
(Balakrishnan et al. 2007; Banker et al. 1998; Hwang 1994; MacArthur and Stranahan 1998; Evans et al. 2010)

Management Accounting Research – 23 articles


Notes:

i www.journal-ranking.com
ii The Danish bibliometric list is a list of journals acknowledged and acclaimed in Danish research.
iii Lack of electronic uploading could, however, explain the time gap.
Chapter 6

Riding the waves of NPM – from New Zealand to Denmark

Abstract

This paper compares New Public Management (NPM) implementation in New Zealand and Denmark. New Zealand implemented NPM a decade or more before it was introduced in Denmark. The purpose is to illustrate how different national set-ups, history and assumptions of health care along with timing have an effect on the impact of NPM and role of management accounting. Drawing on a developed contingency model, similarities and differences within initiatives, contexts, processes and contents are identified. The model is applied in a flexible way by adding a time dimension in order to compare NPM implementations in New Zealand and Denmark despite their time lags. Health initiatives are studied from a historical perspective and interviews are made in both countries on the managerial level in order to capture specific current mechanisms. A reason for the time difference in NPM adaption can be found in the history of the institutions and the cultures of the two countries. New Zealand’s rapid reform changes display flexibility and willingness to adapt whereas Denmark’s history with a strong medical profession results in a slower decision making process. Additionally, the modes of implementation differ greatly; New Zealand, during its NPM transition, focused on competitive elements along with performance measures whereas Denmark focused primarily on work productivity and funding sanctions and rewards. This study contributes to the understanding of differences in NPM outcomes across nations and illustrates the importance of bearing a health care’s set-up, background and assumptions in mind when implementing a management control system at a practical level. Finally, a flexible contingency model is developed by adding a time dimension which has not been done in earlier studies.

Key words: Health care, New Public Management, performance measures, New Zealand health care, Danish health care, contingency theory

Words: 12.263
1. Introduction

New Zealand and Denmark are relatively small countries with mixed economies and predominantly publicly funded health systems. Along with numerous other nations, they have been through a process of major restructuring of the public health sector over the past decades as a result of the emerging New Public Management. The various worldwide attempts of NPM implementations to enhance the effectiveness of health care (World Health Organization 1978, 2000) have added to the complexity of management control systems in health care with an increasingly heavy focus on performance measures and funding allocations (Aidemark 2001; Ballentine et al. 1998; Bevan and Brazier 1985; Chang 2006; Glennerster 1994; Kirkpatrick 2011; Kurunmaki and Miller 2006; Lapsley 1996; Lawrence et al. 1994; Llewellyn 1993; Modell 2001; World Health Organization 2000). In many cases, the initial aim of providing better and more efficient service in order to increase the patients’ well-being and give the citizens better value for money (Danish Ministry of Health 2004; Upton 1991) has added to the difficulty of controlling a complex set-up of public health care where politicians, hospital managers, economists and physicians struggle to articulate goals, belief systems and ideologies in the midst of budget restraints and performance indicators (Bates and Brignall 1993; Covaleski and Dirsmith 1986; Jacobs and Barnett 1996; Lawrence et al. 1994; Lawrence et al. 1997; Llewellyn 1993). In spite of a common understanding of NPM as an efficiency and accountability model with the main aim of increasing health care performance, its employment differs when it comes to nationality, set-up, background, assumptions and most importantly, the time of implementation (Gruening 2001; Kragh Jespersen et al. 2002; Whitcombe 2008). These factors are central when comparing New Zealand and Denmark where history, set-up and the time lag of implementing NPM create large differences.

There are different perspectives as to the origin of New Public Management and NPM implementation in nations. While some researchers claim that NPM stems from the US at the end of
the 60s (Gruening 2001; Stivers 2008), some believe that New Zealand is the initial example of NPM and that they invented the concept (Lawrence et al. 1994; Whitcombe 2008). Others believe that NPM evolved in the UK during the Thatcher regime in the 80s (Boden et al. 1998) and finally some believe in the simultaneous development of NPM across nations (Kirkpatrick 2011) with origin in the World Health Organization (Vrangbæk 2006). It is unclear to what extent the NPM evolution is linked and interrelated across nations. In any case, local politics play a large role in the implementation of NPM in public health care. Reforms and contracts are usually the tools used to enforce NPM in public health care (Blakely 2010; Christensen 2007; Ezzamel and Willmott 1993; Halligan 2007; Kirkpatrick 2011; Library 2009; Pettersen 2004). Boyle and Lemaire (1999) describe three waves of evaluation starting in the US in the 1960s with clear connotations to the NPM waves. The first wave was an attempt to institutionalise evaluation in order to monitor and improve government programmes. Dwight Waldo (1968) saw a need to enhance the public sector by holding public sector entities accountable for their performance in order to avoid discrimination and injustice (Gruening 2001; Waldo 1968). This constitutes the beginning of implementing private sector tools in the public sector and is derived from the American culture of privatisation and competitiveness where the private sector is a natural element within health care. Boyle and Lemaire (1999) speak of the second wave of evaluation that started at the end of the 70s and lasted throughout the 1980s. Now the evaluation is seen as a tool to hold the public sector accountable through budgetary processes. In this wave government bodies are much more actively involved and in order to control entities, standards and objectives are set to ensure high performance. During the last part of 1980s and throughout the 1990s a third wave develops and consists of nations that implement NPM drawing on first and second wave knowledge and inspiration. NPM gradually becomes globally accepted as a future norm (World Health Organization 2000). After 2000 a fourth wave appears. The fourth wave of NPM becomes increasingly complex as it consists of countries that have slightly touched the idea of NPM but have never been able to go through with the idea,
often due to national and cultural reasons. The fourth wave is characterised by the slow acceptance and the complex way of implementing NPM, also called the post-NPM reforms (Christensen 2007). It builds on early waves’ experiences but also seems to create a new centre of attention on quality with heavy performance measure focus, however.

New Zealand has been seen as the epitome of New Public Management as it was the first country to completely turn around the public sector during the 1980s and the beginning of the 1990s (Ashton 1993; Blakely 2010; Cook 2004; Jacobs and Barnett 1996; Lawrence et al. 1994; Whitcombe 2008). All stakeholders played an integrated part in the turn-around with decentralised economic responsibilities (Ashton 1993, 1996; Halligan 2007) and an abundant number of performance indicators. Though belonging to the second and third waves, New Zealand has been seen as a pioneer due to the extent of its transition. Before the concept of NPM emerged, New Zealand decided to implement accounting standards and tools from the private sector in order to hold public sector institutions accountable (Ashton 1996; Hood 1995; Library 2009; Newberry and Pallot 2004; Whitcombe 2008). The turnaround in New Zealand created worldwide debate in the 1990s. The commercialisation of health care seemed difficult in some areas and as the starting point was an already economically healthy health care sector (Ashton 2001; Whitcombe 2008), the gains from implementing NPM were not as straightforward to identify as originally assumed (Ashton 2001; Chua and Preston 1994; Lawrence et al. 1997). Consequently, the New Zealand government released a new strategy in 2000 with the specific aim of handling inequalities and safety in health care rather than maintaining a focus on commercialisation (New Zealand's Minister of Health 2000).

Although it had made the small changes by creating budgets and focusing on management during the 1980s and 1990s, Denmark did not seriously adopt any of the NPM management philosophies until the beginning of the 2000s (Jensen 1998; Kragh Jespersen et al. 2002). The emergence of
private hospitals and physicians became one of the corner stones in a new reform in 2004. With a focus on activity-based funding and with a view to reducing waiting lists, private clinics were allowed as a supplement to the public sector in an attempt to create a more coherent and client-oriented health care system (Borum 2006; Danish Ministry of Health 2004). Hospital managements were given more liberty in controlling their own hospitals (Bech 2006), but they also had to meet specific targets. The need to meet specific targets created a primary focus on economic measurements and made financial performance the main duty instead of health care quality (Strandberg-Larsen et al. 2007).

Several studies on NPM in health care show different challenges, complexities, consequences as well as similarities in the implementation of NPM tools. However, little research has been done on the time differences of implementing NPM reforms and on the consequences of these time differences. This paper investigates aspects of the introduction of NPM reforms in New Zealand and Denmark with a specific focus on the time interval between NPM implementations. As suggested in the different waves and assumptions, the core goals and elements in restructuring the public health care are the same irrespective of time lag.

It remains an open question whether the time lag and difference in experience have led to different outcomes and differences in the present state of health care in the two countries. Do the two countries use similar NPM tools? Do they use them in the same way? Do they have the same social impact and understanding? Using archival data such as previous studies, contracts and papers along with interviews of key employees within health care, this paper seeks to explore the similarities and differences between the Danish and New Zealand health care sectors with the focus on NPM implementation. The following research questions will be addressed; does NPM implementation differ in initiative and contextual outcome in Denmark compared to New Zealand? What role
does the time difference play in this respect? How do these differences affect the process and outcome in each of the countries?

Contingency theory is used as a structural basis for analysing the intricacy of the health care sector. Contextual and behavioural variables are identified in order to explain the reform processes in the two countries. The focus is on the political and managerial levels. The political level consists of contracts and demands made at the national and regional level with hospitals. The managerial level refers to hospital finance and management and focuses on the way they implement these contracts. The technical focus of the study is primarily on performance measures and funding allocation.

2. Setting the scene

In order to understand the New Zealand and Danish health care systems a review of historic and demographic issues is necessary. Each country and its health care system development will be described below. A focus is placed on health care reform changes over the past three decades. From this review important differences are highlighted.

2.1 New Zealand

New Zealand comprises two main islands and several small islands and the country is isolated from other countries by the Tasman Sea and the Pacific Ocean. In 1999 New Zealand had a population of 3.8 million (French 2001) but that figure has now risen to 4.4 million people (Statistics New Zealandi). The population density of New Zealand is low at 16.32 capitaii per square kilometer. This is much less than European countries. To some extent this fact has an impact on the set-up of health care since the population is too spread out to allow closing of smaller hospitalsiii. Unlike Denmark centralisation has therefore been limited.
The New Zealand health care system consists of the Ministry of Health which is responsible for policy making and regulations and a National Health Board which makes service agreements with the private sector and negotiates accountability with the district health boards. There are 20 district health boards in New Zealand. The district health boards are responsible for hospital services, some community services, public health services and assessment along with treatment and rehabilitation services within their area. They also make service agreements with private and non-government organisation (NGO) providers (The Ministry of Health 2011). Most services in the New Zealand health care are free of charge. However, a fee must be paid when consulting a general practitioner (Gauld 2008).

The medical history of New Zealand is not as long as that of most European countries. Up until 1900 the state played a minor role in health care. Health care was organised along laissez-faire lines (Authority and Consulting 1999/2000) and often doctors, who worked independently, were too expensive for patients to afford. Public hospitals, however, were established during the 19th century to treat the patients who could not afford a doctor (Authority and Consulting 1999/2000; French 2001). In 1938, the public health system was introduced through the Social Security Act (Ashton 2011; Gauld 2008). From the 1950s hospitals were able to provide sufficient treatment (French 2001). Government funding increased while patient’s fees decreased, and the health sector was centrally controlled up until the early 1980s.

The Labour party won the general election in New Zealand in 1984. Due to a currency crisis, the party removed financial controls and floated the NZ dollar from 1985 (French 2001). With the State Owned Enterprises Act in 1986, several state-owned entities such as electricity, Air New Zealand and the postal services became state-owned enterprises. These were sold off between 1987 and 1988. During this time the New Zealand health care system was decentralised and health boards were established. The government made national guidelines and closely monitored the districts’
activities (French 2001; Halligan 2007). In 1988, a State Sector Act led to major changes in the public sector senior management by introduction of new procedures for appointing executives and deciding on chief executives’ pay through performance contracts and annual performance agreements (French 2001). Together with The Public Finance Act in 1989 this reform revealed that the hospital balance sheets were unsound. Assets were valued at historical cost, excessive debt at high interest rates was revealed and large variations between different health boards complicated the funding (Easton 2002; Newberry and Pallot 2004). Moreover, the public had increasing demands for public health care. This marked the beginning of what was later referred to as ‘The Great Experiment’ and which made New Zealand known around the world as the NPM trendsetter (Christensen 2007; Cook 2004; Jacobs and Barnett 1996; Lawrence et al. 1994; Lowe 1997; Newberry and Pallot 2004; Whitcombe 2008). The Great Experiment stems from a document supplied by the Minister of Health, Simon Upton, called “Your health and the Public Health” (1991). The document became effective through the 1993 Health Services Act with the main aim of running the hospitals efficiently like successful businesses (Ashton 1993; French 2001; Halligan 2007; Lawrence et al. 1994; Upton 1991). It was based on the rationale that the market model would provide better allocation of resources (Halligan 2007; Lawrence et al. 1994). Furthermore, the purchase and provider roles were separated in order to make the system more fair, transparent and efficient, to reduce waiting lists and increase consumer choice (Ashton 1993, 1996; French 2001; Jacobs and Barnett 1996; Lawrence et al. 1994; Upton 1991; Whitcombe 2008). Four regional purchasing agencies were established. They were to negotiate funding with the government and purchase services through contracts with the public hospitals which were now referred to as Crown Health Enterprises (Ashton 1993; Ashton 2011). They spent the two years from 1991-1993 to completely rearrange the health sector where hospitals, as Crown Health Enterprises, became strictly monitored on the basis of multiple outcome measures. Setting up a health care system based on commercial principles led to numerous performance measures. Today, they total approximately
460 (Auckland District Health Board, 2011). The reforms, however, turned out to be expensive and the costs amounted to between 2% and 10% of the total annual health vote (Easton 2002). The initial aim of reducing costs had not been met (Ashton 1996). This resulted in a new reform in 1996 that converted 23 Crown Health Enterprises into Hospital and Health Services (HHS) that were relieved from the requirement of making a profit. The government shifted the focus away from quasi-market models, acknowledging that strict competition was not a valid option in the health sector (Ashton 1996; Ashton 2011; French 2001; Whitcombe 2008). However, most of the restructuring established in 1993 continued throughout the 1990s.

In late 1999, the Labour party won the general election again. Their aim now was to make the hospitals non-commercial and more community-oriented. This resulted in the 2000 New Zealand Health Strategy based on seven principles that focused on communities, ethnical groups, consumers and a high-performing health system (New Zealand's Minister of Health 2000). This document was based on more than 450 written submissions from members of the public, health professionals and organisations. After the health care commercialisation during the 1980s and 1990s it was time to cooperate rather than compete and an adjustment of the strategy was needed to put people at the centre of health care (Ashton 2011; Blakely 2010; French 2001; New Zealand's Minister of Health 2000). The Health Strategy (2000) states that “The Government believes, however, that this hard work has been hampered by the commercial focus of health care in recent years. It is clear that, despite improvements in health status, New Zealand is slipping behind other developed countries. This is particular evident in Maori and Pacific peoples’ communities” (p.3). The ‘Health Strategy’ is a response and realisation that the commercialisation did not yield the results as intended and that a special focus on ethnical groups was needed as well. In 2001, 21 District Health Boards were formed and a Primary Health Organization was developed in 2002 with the aim of managing primary care including general practitioners (Gauld 2008; Library 2009). The 2000 reform has
resulted in a decade of semi-stability in the New Zealand health system (Blakely 2010). There has been a focus on ensuring and improving quality and safety which has improved the patient experience, safety and quality in a sustainable way (Health Quality Commission interview, 2011). With a new government in 2008, a new 2009/10 reform was made and it centered on bringing office planning activities back together and on improving information technology. New Zealand has learned from the 1993 Health Act and commercialisation. There has been a genuine acknowledgement and understanding that the health care sector is not a business-like entity (Ashton 2001). However, performance measures are still plentiful but used separately from funding.

2.2 Denmark

Denmark is one of the Scandinavian countries with a population of 5.4 million and a population density of 125.2 capita per square kilometer (Strandberg-Larsen et al. 2007), i.e. eight times the density in New Zealand. Danish health care is primarily decentralised. The Danish health care system consists of three different responsibility centers; the ministry, the regions and the municipalities. The ministry is in charge of the administrative functions and financing. There are five regions in Denmark which own and run hospitals and provide finance to private practitioners. The municipalities are responsible for preventive medicine, health promotion and rehabilitation outside hospitals (Danish Ministry of Health 2004; Strandberg-Larsen et al. 2007). The Danish health care sector has always been free of charge and fully public administered. Since 2004, the patients have had a free choice of hospital and care taker.

The first Danish public hospital was established in 1757 (Krasnik and Vallgårda 1997). More than a decade later, the Danish Medical Society was established in 1772 in Copenhagen. Shortly after that, it could call itself the Royal Society of Medicine and that organisation had to give authorisation to medical practitioners and surgeons. In 1857 a trade union for doctors was established. In the second half of the 19th century the Danish health system gradually developed and expanded with small and
large hospitals in provincial towns throughout Denmark and with several general practitioners. In 1892 a mutual benefit health system was enacted where the state funded health care for people with low incomes (Krasnik and Vallgårda 1997). At the beginning of the 20th century, the profession specialised into various fields, each of which founded its own scientific society. Thus on June 4th 1919, the Danish Medical Society, as it is called today, was founded and unified all medical societies (Harvald 1991). During the 20th century the government slowly increased the organisation and structuring of the different health services. In 1932, the National Board of Health was founded, which makes it the oldest national health board in the world (Downie et al. 2006). As the government and communities grew strong during the 1960s, they completely took over health care administration and by 1973 the health insurance schemes were taken over by the counties (Krasnik and Vallgårda 1997) as they were at that time.

Similar to New Zealand, Denmark experienced a decrease in productivity and an increase in health care costs in the early 1980s (Pallesen 1997). In 1980, annual budget negotiations between the state and counties and the state and municipalities were introduced (Strandberg-Larsen et al. 2007). These discussions constitute the first attempt to control the health care finances. In 1982, a conservative government entered the political scene in Denmark. They were very keen on the NPM idea of accountability and privatisation; however, they were met with strong opposition and were only able to implement a change in hospital management giving the hospitals financial responsibility which had not been the case before (Downie et al. 2006; Jensen 1998; Kirkpatrick 2011; Kragh Jespersen et al. 2002). In 1985, hospital plans no longer needed approval by the National Board of Health. This was one of the attempts to make health care personnel more financially responsible. The physicians played an active part in this transformation and they positioned themselves in most of the administrative jobs at the different hospitals. Moreover, the nurses saw an opportunity to advance and become more equal in status with the physicians and they
struggled to get the same administrative positions claiming that they had better economic and administrative skills than the physicians because these subjects were part of their education (Kirkpatrick 2011; Kragh Jespersen et al. 2002). This led to a so-called Trojan model where the leading hospital management team consists of one external manager, a physician and a nurse. However, the model has only been put into practice at a few hospitals (Kirkpatrick 2011).

Throughout the 1990s, Denmark had a social democratic government. They were more successful in privatising part of the public body such as the Danish telephone company, Teledanmark, and some life insurance and transportation companies. According to Jensen (1998) the population seemed to need time to get used to the idea of privatisation and it was easier for the social democrats to initiate small aspects of NPM since they did not meet with opposition. In addition the Danish working traditions are very strong and changing the culture is therefore a difficult task. These traditions are based on high job security, centralised pay negotiations between unions and public authorities, use of technocratic rather than ideological debate and well organized staff. Contracts are negotiated and they are a sign of agreement rather than a legal instrument (Jensen 1998) and trustworthiness, duty and equalisation are central to the Danish working environment (Knudsen 1996; Nørreklit et al. 2006).

During the 1990s budget agreements increasingly included specific objectives and demands. However, the financial yearly contracts between the state and the regions did not even remotely increase as much as in New Zealand. Specific objectives regarding control and feedback were introduced for the first time in 1995 (Salomonson 2004). Before the mid-1990s the control of health care was based on a loose frame control. Not until the mid-1990s did this control become tied to economics. From 2001 the control started to include economic incentives. Before 2001, the national political level of health care was characterised by consensus seeking reforms and agreements. After 2000 the contractual agreements expanded from a mere one page per year to up to 6-7 pages. In
1993, a reform ensured that patients could freely choose any hospital for treatment (Downie et al. 2006; Kragh Jespersen et al. 2002; Krasnik and Vallgårda 1997; Strandberg-Larsen et al. 2007). However, free choice of general practitioner only came with the extensive Structural Reform in 2004. In 2002 a new conservative government took power and initiated a large crusade to completely change the public sector. This resulted in the Structural Reform in 2004 (Borum 2006; Strandberg-Larsen et al. 2007; Tanggaard Andersen and Jensen 2010). The patients in effect got more rights such as the right to choose a preferred hospital or caretaker and reimbursement of hospitals fees changed into activity-based payment using Diagnostic Related Group (DRG) taxation as a benchmark in most cases. The responsibilities changed and today the municipalities have more responsibility than earlier regarding homecare (Tanggaard Andersen and Jensen 2010). This turnaround has changed the main focus to performance indicators such as waiting lists, hospital admittance, length of hospital stay, number of treated patients and so on (Borum 2006; Tanggaard Andersen and Jensen 2010). Moreover, hospitals are ranked on a national web page, mainly based on economic and quantitative performance indicators. Denmark did not fully integrate NPM aspects before the Structural Reform, which indicates that Denmark was a late adopter. Earlier attempts do not seem to legitimise the claim of using NPM (Pallæsen 1997). With the Structural Reform traduceded in 2004, a plan for an extensive relocation of regions and municipalities along with health care responsibility areas was made. Private hospitals emerged and in order to reduce waiting lists the patients may choose a private hospital and have the bill paid by the state if a state hospital cannot provide treatment within 30 days. After the Structural Reform in 2004 focus is on economic and quantitative measures, e.g. “Systematic and publicly available productivity analyses at regional, hospital, department or any other relevant level should clarify the ability to provide value for money. The productivity analyses will become an important management tool ensuring that the best methods become known quickly” (Agreement on Structural reform, 2004, pp.41-42). The reform is centered around productivity and responsibilities but it fails to provide a definition of
health care and therefore fails to relate the measures to that context (Borum 2006; Tanggaard Andersen and Jensen 2010). The responsibilities are completely divided between the state, which is responsible for administration, the regions which are responsible for health care services, including hospitals, general practitioners and specialties, and the municipalities that are responsible for home care (Danish Ministry of Health 2004). The Danish structural reform is different from the New Zealand health strategies since it focuses on the entire public sector with health care being just a part of that. Quality has been a concern since the 1990s though it is often connected to economic or quantitative measures. In 2010, the focus on quality was increased and quality indicators were introduced. However, these are still highly quantitative.

2.3 Key Differences

Similarities exist in the development of the New Zealand and Danish health care systems, but there are also some fundamental differences which can be identified in the historical review. These differences include the history of the two nations, recent time differences in reform development, health care responsibilities and different public structures which result in different current stages of the health care systems.

The history of the nations plays a major role in the founding of the first health care systems, where Denmark establishes hospitals even before the Europeans have settled in New Zealand. This may constitute an important factor in the current establishments of the health care systems where Denmark has a stronger and more rooted working culture than New Zealand which has led to a strong and dominating Danish health care profession (Jensen 1998; Kirkpatrick 2011; Tanggaard Andersen and Jensen 2010). This is reflected in the reluctant acceptance of economic focus in the Danish health care system compared to New Zealand as described above, resulting in a difference in NPM reform implementation in later years.
Another major difference is found in the division of health care responsibilities where New Zealand has established 21 district health boards who are fully in charge of the health care services, administration and home care within a particular district. In Denmark, no entity is fully in charge of health care services within a particular geographic location. On the other hand, the regions have been established to take care of health care services. However, the regions are also responsible for infrastructure, nature and environment, trade and industry, tourism, employment, education and culture (Danish Ministry of Health 2004). This broad area of responsibilities leaves health care services with only partial focus from the regions. Additionally, the municipalities are responsible for home care which creates a grey zone between health care services and home care which obscures the responsibilities and may lead to conflicts (Tanggaard Andersen and Jensen 2010).

The key differences are essential when studying and comparing New Zealand and Denmark since these differences will interact with and affect reform differences and outcomes and therefore influence the choice of method applied.

3. Methodology

As differences in politics, reforms, outcomes, times and places interact and affect NPM implementation and because of the substantial amount of research material on this issue, the present comparison becomes extremely complex. A specific framework is therefore necessary in order to understand and convey the essential findings. Pettersen’s (2004) contingency study on reforms in the Nordic countries is used as a foundation for the specific contingency model developed in this study. The model, however, is modified to include the reciprocal contingency framework developed by Luft and Shields (2003). This gives a theoretical support for understanding and locating different contingency variables and their links.
Other comparative studies draw on Weick’s sense-making (1976) and have a looser conceptual framework. Examples are Kurunmaki, Lapsley and Melia (2003), who compare the use of accounting information in intensive care in Finland and the United Kingdom, and Jacobs, Marcon, and Witt (2004), who compare cost and performance information for doctors in Germany, Italy and the United Kingdom. However, these studies are done at the organisational and individual levels and this type of analysis is appropriate for them. This analysis differs by studying the political and organisational levels and links. A comparative study at the same levels made by Pettersen (2004) on the reforms in the Nordic hospital sector successfully uses contingency theory. This supports its suitability at this level of study and adds further understanding to the political contingency.

Contingency theory can be applied in alternative ways (Luft and Shields 2003; Pettersen 2004; Shapiro and Bedi 2007). As stated above, reforms and contracts are central elements of NPM within health care. These reforms and contracts are contingently related in different ways (Pettersen 2004; Shapiro 2002; Shapiro and Bedi 2007). In the book ‘Political Contingency’, edited by Shapiro and Bedi (2007), a number of authors look into contingency’s role within politics and in the way that reforms and situations evolve. They state “By calling something contingent as a minimum we are saying that it did not have to be as it is” (Shapiro and Bedi 2007, p.1). Different political decisions set the scene for the public health care. These political decisions may have been forced, to have happened by choice or by coincidence (Luft and Shields 2003; Shapiro and Bedi 2007). Using the contingency method, ‘political contingency’ (2007) seems appropriate in order to understand the different evolving links and the reason why NPM develops differently in different nations. In natural science contingency theory is often used as a tool or model to control different variables and thereby to monitor the outcome (Shapiro and Bedi 2007). This social study, however, will use contingency theory as an exploratory tool in order to find and understand the links that exist in abundant numbers within the dynamics of politics. ‘Political Contingency’ (2007) is a valuable link
between the method and a theoretical framework and will be used to support the analysis and discussion.

Thus, prior to the analysis, a suitable contingency framework must be made. Luft and Shields (2003) claim that three fundamental questions must be asked in order to do a valid contingency study. First, it is crucial to understand what is being researched; that is which variables. A contingency map is shown below, listing the general variables used as dimensions in this study. The variables draw on the dimensions in Pettersen’s (2004) model; source, level, context, process and content. Pettersen’s (2004) model is suitable in this study since it examines the complexity of the public sector and explains reform processes by focusing on contextual and behavioural variables.

![Contingency Map](image)

Figure 1

Adapted from Pettersen (2004)

This study focuses on reforms in New Zealand and Denmark with a specific focus on context and content. However, one more variable, time has been added. Place is also integrated in the model but not explicitly. Pettersen (2004) compares the three Nordic countries but not over time. Comparing countries over time makes the model more dynamic and makes it possible to study several interrelated issues. This makes duality possible. In other words it becomes possible to analyse two ‘places’ or countries simultaneously and/or with integrated elements. Pettersen’s (2004) five dimensions remain unchanged in order to maintain coherence where the two dimensions; initiative
of reform and responsibility of implementation. The added variable of time gives the possibility of having the other five dimensions existing at two different places either at the same time or at different times.

The second requirement stated by Luft and Shield (2003) is to identify the causal-model forms used in the model. Adding the time variable, the model becomes a cyclically recursive model where there is an identifiable time interval between the “content” in one “place” and the “context” in another “place” and/or the “content” in one “place” and the “context” in the same “place”.

Figure II

![Diagram](image)

Adapted from Luft and Shields (2003)

Here, the dimensions are seen as dynamic and interactive, especially since the four vertical dimensions exist dually at the different places. Because of the extra time dimension and the duality, the model becomes more complex. However, the extra dimension is necessary in this study in order to explain the significance of the time lag and in order to understand the interaction between the dimensions. The six contingent variables are explained in more detail below.

Pettersen (2004) describes (1) source and place as the origin of reform initiative and considers whether the initiative is centrally or locally driven. This means whether the state has the central power of decision-making or whether the reform changes are rooted locally. This study extends this
by including the nationality of the reform. (2) Level in this analysis refers to sub-organisational representation, the political and managerial arena comprising the regions, health boards as well as the hospital management level with a specific focus on reform developments and contents. Luft and Shields (2003) point to level as the thirds variable that is crucial to identify. In the present analysis the hospital management level explores how the organisations implement NPM. According to Pettersen (2004), the level of implementation is also important when studying the type of reform in the form of e.g. explicit standards of performance, contracts and private-sector management models. These elements tend to develop a more dominant accounting information environment than earlier traditional bureaucratic organisational structures that depended on rules and routines (Pettersen, 2004).

(3) Contextual variables at the national (sub-organisational) level include motives and opportunities for reforms (Pettersen, 2004; Lüder, 1992) which are situational as opposed to structural factors such as social, environmental, political and administrative characteristics. Identification of the legitimate reasons for developing a new reform is a major part of the context. Arguments concerning the financial situation and the lack of resources in hospitals are often used to legitimise NPM reforms (Pettersen, 2004). The dimension of (4) process takes this further and refers to the way in which the variables are implemented and to the internal changes that have been initiated. The process variable looks at who is in charge of the implementation and how it is processed. This dimension is more abstract and refers to several layers and levels of an institution and it also evolves over time. It is a vital part of reform implementation that guides several behavioural factors.

(5) Content refers to the outcome of the context and process of reforms and contracts. The typical NPM reforms focus on paying hospitals by performance, usually based on activity (Pettersen, 2004). As discussed in the introduction, however, the content of reforms may still differ across nations as some nations focus far more on quality than others. Additionally, the perception of
quality differs and that tends to have a substantial impact on the understanding of reform contents. The last, but in this study the most important dimension is the influence of (6) time on the context, process and content. As described in the introduction, there have been different waves of NPM implementation that span a period of 30-40 years. This time lag evidently makes a difference in the context and outcome of the reforms because of global trends but also because of the knowledge and experience gained concerning NPM implementation. Reforms and contracts can be problematic because of the uncertainty of the future. Studies that span a period of time make it possible to see contingent links between initiatives and outcomes (Huber 2007). Political events along with reform-making can change or contribute to ideology in different ways (Shapiro and Bedi 2007). Using the framework described above, these political events and changes of ideology in New Zealand and Denmark will be reflected upon in the analysis along with possible inter-related events or learning curves.

3.1 Data

The analysis in this paper is primarily based on the central national reforms and governmental documents. In addition, seven interviews have been conducted in Denmark with financial managers at hospital management level. Two of the interviewees had recently been employed by the regions. In New Zealand six interviews have been made at different institutional levels such as departmental, hospital management and health district levels. Moreover, a health performance symposium in Dunedin, New Zealand, was attended. The Associate Minister of Health, Dr. Jonathan Coleman was a guest speaker. Finally, complete access to the Auckland District Health Board and Greenlane Hospital was obtained which opened the door for attending hospital conferences and district and regional meetings.
4. Comparison of New Zealand and Danish health sectors: roots, contingencies and outcomes

In this section the differences, similarities and outcomes are considered for each dimension. The outcome focus, described in the sub-sections ‘Process’ and ‘Content’, is specifically on performance measures and funding allocations in the current health care systems in the two countries.

Source of initiative and level

In New Zealand as well as in Denmark the reform implementation has primarily taken place at the political level during the past 30 years. One difference, however, is the form of the initiatives which influences the level and place of initiatives. In Denmark, politics did not play a part in the Danish health care system until the early 1980s (Kragh Jespersen et al. 2002). The Danish health care was dominated by the medical profession. This domination led to a very strong profession with great power (Dich 1973; Kirkpatrick 2011; Kragh Jespersen et al. 2002). The reason was the strong position of the medical society in Denmark and the result was that rather than making decisions the politicians only made suggestions on the health care system during the 1980s and 1990s. This situation did not exist in New Zealand. Until 2000 the Danish power structure led to local initiatives (Jensen 1998; Tanggaard Andersen and Jensen 2010). One example is the Trojan model of management consisting of one nurse, one doctor and one administrator, which was inspired and partly initiated by nurses who argued for their positions and abilities as administrators (Jensen 1998). Therefore the model started as a local initiative but eventually became a centrally accepted model. The roots of the Danish health system and the power of the profession reflect the level of continuous decentralisation and the role of the counties (pre-regions), starting from the 1970s, which gave local authorities and the medical profession a strong sense of autonomy (Civitas 2002).

In 1982, the Conservative Party took over in government after more than a decade of social
democratic government. But it was at that time, not possible for the government to make radical changes in the public sector. The government unsuccessfully tried several arguments for transforming the public sector but was met with strong local resistance (Civitas 2002; Jensen 1998).

In contrast, in New Zealand politics played a much larger role during the 1980s and 1990s. Due to the shorter history of New Zealand health care, the government is met with less opposition from the medical profession and the local authority. This has given the politicians greater power and New Zealand is renowned for facilitating majority vote and fast laws (Gauld 2008). In contrast Denmark has a history of consensus law making (Kirkpatrick 2011). The Danish culture is therefore less maneuverable than the New Zealand culture.

In Denmark, however, the local authority and medical professional power changed with the introduction of the Structural Reform in 2004. ‘Venstre’, which is a right-wing Danish party, and the Conservative Party formed a new government in 2001 and laid the solid ground for initiating and implementing the Structural Reform which was agreed upon in 2004 and which has been the foundation for the national funding of the public sector since that time. Though new to Denmark, New Zealand is used to having a strong trend of governmental changes influencing initiatives of health reforms New Zealand got a new government in 1984; the Labour Party. Then the National Party gained power in 1990 and in 1993 a mixed member proportional (MMP) government was established because of the national minority election. During the 1990s right-wing Prime Minister Jim Bolger led the large public sector turn-around. In 1999, the Labour party formed government again with Helen Clark as Prime Minister. This government of Labour-Alliance Coalition initiated the 2000 Health Strategies with the focus on change. The latest shift in government was in 2008 where the National Party won the majority of votes. During each of these governmental switches a health care reform change has been established in New Zealand, except from the last switch in 2008. This illustrates their dominantly political policy-making culture.
In both countries, the health care reforms have primarily focused on management relations, performance and increased emphasis on output control and contracts and, lately, a focus on various quality indicators. Nevertheless, due to demographic challenges of an ageing population and tight budgets, the idea has been to establish the best and most efficient health care system. In both countries, the health care providers along with different specific health sector bodies are responsible for implementing the reforms which means that the implementation takes place on the institutional level (Pettersen, 2004).

**Context**

According to Pettersen (2004), the contextual variable is double-sided; the structural dimension which refers to the historical, cultural, traditional and economic elements of a nation. These elements were described in “Setting the scene” as a foundation for the study. The other dimension is situational and refers to ideological and rhetorical trends that represent motives and opportunities for the reforms. Pettersen mentions that a financial crisis or other lack of resources is often the primary motive for implementing NPM reforms in the Nordic countries. This is also the case in New Zealand. Due to a currency crisis in the early 1980s (French 2001) that left New Zealand close to bankruptcy, the NPM ideas and methods were seen as the only possible way to survive this financial crisis. The health sector, however, was the last public sector area to be influenced by the NPM trend and a complete NPM implementation in the New Zealand health sector was not established until July 1993 through a comprehensive market reform (Ashton 1993, 1996; Lawrence et al. 1994). This reform was based on the Upton Document from 1991 which described a total restructuring of the health care system in detail. It based this restructuring on some of the current key points which were “People wait too long for public hospital treatment. .....Despite the best intentions, the health care system does not treat all users fairly. ... Users of the system, health professionals and tax payers all loose out under the present structure.” (Upton 1991, p.7). The
contextual and situational reason for rearranging the health care system was to provide better health care to the ‘user’. Though not stating the current state, the same structural futuristic aim is seen in the Danish Structural Reform in 2004 which set clear aims, time schedules and allocated responsibilities. The main reason for the restructuring attributed to the patient, “..wish to promote strong, public health care service that offers patients unrestricted, equal and free access to prevention, examination, treatment and care...”. The main difference between these two reforms is the rhetorical use of ‘people’ and ‘users’ in New Zealand versus ‘patients’ in Denmark, which indicates a stronger market orientation in New Zealand in the beginning of the 1990s. In spite of a time difference in the implementation of these two types of market-oriented reforms, similar trends could be observed in the two countries at the same time. During the 1980s, both Denmark and New Zealand experienced a move towards local entities assuming more responsibility in their struggle to become cost and productive-oriented. During the 1990s, this tendency was strongly enforced in New Zealand with a centralisation of health funding and much emphasis on output and performance. This trend is not seen in Denmark until the Structural Reform, published in 2004 and finally implemented in 2007.

A new tendency started in New Zealand at the end of the 1990s and manifested itself through the Health Strategies in 2000 where the focus shifted from the economic motives to the patient’s well-being, to ethnical groups and to quality. This has not fully happened in Denmark yet. Though some focus is now put on quality in Denmark as seen in a document from the Danish Regions in 2011 (Regions 2011), the primary focus remains on economy. In New Zealand a reaction to the strong commercialisation evolved to reverse this tendency and to put emphasis on health quality rather than accounting tools and information. In both cases, ideological trends of commercialisation combined with a productive and efficient health care system do exist but manifested differently and at different times. The reaction also had characteristics similar to a refocus on quality. The motives,
however, were different. Where New Zealand had a financial crisis, Denmark did not experience the same financial pressure prior the Structural Reform.

**Process**

Both countries have experienced the duality of decentralisation and centralisation. Along with NPM implementation there has been a tendency of centralizing decision making on the creation of administrative goals and performance indicators. However, the very core of NPM is to make entities responsible for their work through decentralization. Both countries did decentralise. Hospitals, regions, health board areas and communities took whatever initiative was needed and they were free to implement different management and accounting tools as long as they delivered what was required in terms of performance and as long as they registered the required data.

In Denmark large differences in the types of accounting and information tools implementation were seen. Standardisation efforts have recently been made by means of electronic patient journals. However, full integration across hospitals has not been achieved yet, which creates difficulties of implementation of reform processes. Some hospitals have electronic patient journals with the specifically required data which makes it easy to provide the required numbers. Other hospitals are still implementing these technical aspects and the process is therefore more difficult for them. A hospital manager said, “*We have had electronic patient journals since 1992. But there are some hospitals that still do it manually*”. This shows some inconsistency in the Danish health information system. Furthermore, since the Structural Reform, the managements have been under pressure caused by the growing private sector and implemented competition factors such as activity-based costing focus. One hospital manager expresses the situation like this; “*We are under pressure from the private sector. We try to break the curve by sustaining our patients. It is problematic because we are paid by DRG taxation which includes research and acute patients. These costs do not exist in the private sector and they can therefore skim the cream.*” This indicates problematic funding
issues. Each region is paid by the state on a DRG basis according to the number of treated patients. The regions then pay each hospital according to the same DRG levels and number of patients. The high focus on activity and the link to funding have put heavy pressure on some hospital entities whereas other hospitals are doing really well. Another hospital manager mentioned the seemingly never-ending struggle against deficits: “In 2009 we produced a lot of activity but not related to the DRG groups which meant that we ended up with a deficit of 65 million DKK. We have to pay back that amount. So first we need to cut 65 million out of our activities and then we have to reduce the budget even further in order to pay back the 65 million. Everything is about budgets! Nothing else matters. We are not sophisticated at all. We don’t use balanced scorecards or any other management tool. It is just a matter of budgets.” This indicates a strict budget and DRG-driven funding resulting in no room for strategy or management development once the deficit spiral starts. Hospitals that do not struggle with previous deficits have far more surplus and energy to integrate patient focus, efficient management and future strategies. “In our daily work we don’t focus on DRG. We only focus on the patient. We don’t focus that much on finances.” This statement comes from a hospital manager in one of the most successful hospitals. In contrast the previous statement was from a hospital with demographic issues, earlier budget difficulties and lack of clarity during the earlier restructuring of health care. This results in a downward spiral, a race to the bottom, with no elements in place to support or change this situation. The reason is the government’s sanction and reward policy that states that if you spend above DRG level you have to pay a penalty of 50% of that group’s DRG. Conversely, if you are doing better than the DRG level you receive a bonus of 50% (Bilde 2010).

In New Zealand, the data is collected centrally in a National Master (Patient) Data Set (NM(P)DS) and the data is sent monthly. This supports a consistent electronic set-up throughout the New Zealand health care sector. However, according to one manager they have used different systems
locally: “We don't have the same information system across the country. We have some systems that are the same, but not all. That would be nice, though, because different systems cause huge waste and definition issues and all that. I think we are better off having common financial systems but a common performance management system does not exist.” Apparently there are several different systems in place and some work nationally and others do not. Nevertheless, focus is on performance measures in the New Zealand health care system. The government has issued six particular health targets within the areas of cancer, diabetes, immunisation and emergency waiting rooms. These performance measures are strictly followed and reported across district health boards on a quarterly basis. All interviewees have had great focus on these six targets rather than on budgets and activity level which have been the focus of attention in Denmark. There are no sanctions or rewards in the New Zealand health system. However, all DHBs are expected to stay within the budgets. The performance and funding are decoupled in New Zealand but both are taken extremely seriously. “We have a serious select committee which is made up of politicians. Once a year we will get a book of questions from that committee. You have to go through and answer all. It is a political process. Some are financial and some are management questions. There are probably 700 questions. Then later, you (DHB) have to meet the select committee in Wellington. It is a very formal process and all the media are there, TV cameras and so on.” This implies a far more complicated system than the Danish system where all elements are integrated in performance measures and accountability. Budgets are, in general, not in focus but are taken very seriously and all DHBs know that the consequence of running deficits is resigning. The DHB’s responsibility includes the entire health sector in a specific district, i.e. primary, secondary, tertiary and private health care, co-ordination and so on. This total responsibility has reduced the competitive elements and facilitated a strategic and sustainable process. For example, each DHB continuously makes 5-10 year strategy plans.
As described above, the processes are very different in New Zealand and Denmark caused by differences in responsibility set-up, experience and culture. Also the contents of the reforms play a large role since their altered focal point results in different outcomes.

Content

The primary content of the reforms and health care changes has been based on management performance systems along with cost systems and funding systems for the different health entities. Therefore performance measures and funding are central factors. New Zealand and Denmark both have a history of using yearly incremented block grants. In New Zealand this changed in 1985 when the area health boards funded the hospitals, from 1993-2000 the purchasing authorities provided the funding and in 2000 the purchase was transferred to the district health boards. Since 2000 the DHB as well as the primary health care under the DHB are paid by a population funding formula that takes demographics, social elements and population mix into account. There is, however, a part of primary health which is funded on the basis of activity, i.e. the patient fee paid for GP consultations. Further, they have a proportionately small utilisation-based funding that focuses on different projects within the DHBs. Various supportive committees have been set up to assist the DHBs in financial matters. The DHBs are free to decide how to spend the money received. The only requirement is that they stay within the budget. There are no sanctions or rewards. Given the DHB focus and responsibility this system seems to leave room for managerial and strategic focus that centers on the patients. The main content of reforms in New Zealand focuses on targets and performance measures. In addition to the six main health targets more than 100 KPIs have been defined. These targets are very central to the everyday management. As one interviewed manager said: “So what we do is that we meet here every Monday, the executive team, for three hours and go through all targets. We go through who is doing what and how things look like now. From a patient safety perspective we have a series of things that we are committed to and a series of indicators that
we want to focus on. If they are red we expect to see more detailed information on it.” A specific meeting room, where weekly meetings were held, was presented to illustrate how they managed particular performance indicators. In this meeting room the main targets were hanging on boards on the wall. Each target was either green or red depending on the current situation and whether the target had been met. Detailed descriptions of each target, its state and future actions were provided underneath along with the names of allocated persons responsible for the individual target. Thus a very proactive and organised attempt had been made to meet various performance measures and targets. As stated by the interviewee, this process was new and this is not how it is done in all DHBs but a structured attempt to meet the content from the Auckland DHB.

Until 2004, Danish hospitals were paid according to an agreed budget. If the budget was not met there were no sanctions. However, with the Structural Reform, hospitals are now mainly paid in accordance with a DRG although 77% of the hospital financing comes from a block grant from the state to the regions. This block grant is based on the activity in previous years. In recent years, demands have been made for an increase in activity levels by up to 4%. The regions control the hospital funding. A general model is the 50/50 model where hospitals have to pay back 50% if they do not perform under DRG and they receive 50% more if they perform better. Thereby DRG becomes the center of attention in the Danish health system and the reward/punishment system tends to generate self-reinforcing upward or downward spirals, all of which leads to confusion and stress. As one hospital manager states, “The thing about activity and economics is that the goal becomes the goal. We don’t discuss what the goal itself really is and whether it is useful”, which illustrates a decoupling between activity registration and understanding. In Denmark, the funding and responsibility centres are also divided. Municipalities are responsible for primary and home care. Moreover, municipalities have to pay 20% of hospital expenditures when a citizen is admitted to the hospital. This is supposed to motivate municipalities to improve primary care (Danish
The reforms and focus on funding have resulted in various performance indicators such as waiting lists, number of patients treated, days of hospitalisation etc. However, these performance indicators have not been set centrally by the ministry but are a differentiated local way of managing.

Denmark has recently introduced two quality indicators but these are purely focused on timelines and include, for example, the time of sending a patient information letters. Denmark does, however, have a national council of quality. It was established in 1999 and looks at patient safety standards and active patient involvement (Downie et al. 2006). However, none of our interviewees mentioned the national council.

In New Zealand a recent focus on quality led to the establishment of the Health Quality and Safety Commission in 2010 with the purpose of facilitating collaboration and coordination of the total sector including clinicians, provider organisations, DHBs and the Ministry of Health and to set up commonly agreed quality indicators. The commission focuses on general patient safety indicators such as mortality, infections at hospitals, operation faults and other indicators related to patient safety. So New Zealand has abandoned the earlier competition in health care and replaced it with a consensus on patient care and a safety focus. This agreement is manifested by the New Zealand Health Quality Commission’s statement: “Competition and punishment in health care are counterproductive. We aim at co-operation and quality alignment on all levels”. Along with the responsibility of the DHBs combined with New Zealand’s experience with strong and failed competitive moves in the 1990s this creates a common understanding and focus that extend beyond finances.

In Denmark, on the other hand, the division of responsibilities between regions and municipalities gives competitive incentives. The regions and municipalities also have responsibilities other than just health care which makes the Danish model different from the New Zealand model. The Danish
health sector has never operated on a competitive market and is therefore not familiar with the pros and cons of such a competitive situation.

**Time**

During the 1980s both New Zealand and Denmark had a governmental focus on commercialising parts of the publicly owned entities. However, New Zealand could enforce such changes more freely and quickly while they were not implemented in Denmark until the 1990s. In New Zealand, just three years after an extensive turnaround of the health sector, it was realized that it had some flaws which were changed in 1996. The New Zealand market method experiences in the 1990s and the adverse consequences in 2000 led to a new focus in the New Zealand Health Strategies, which are still in force today. Along with the frequent changes of the national health boards during the past 30 years this shows a willingness to adapt and indicates a flexibility which does not exist in Denmark to the same degree. In Denmark, however, a long history, a strong working culture and a powerful profession have been the dominating factors (Kirkpatrick 2011; Kragh Jespersen et al. 2002; Nørreklit et al. 2006). These characteristics have resulted in delays in the introduction of market-oriented ideas in the Danish public system and not until 2004 – 2007 are those market models tested, i.e. nearly fifteen years later than New Zealand. Similarly, the Danish health care system did not respond immediately to unsuccessful experiences caused by the 2004 Structural Reform. It continued in the same track with some minor changes since 2010. The reason is to be found in the far more extensive, close-knit and historically rooted Danish public sector. The working cultures are based on hundreds of years of tradition and any changes therefore become very difficult to implement.
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<th>New Zealand</th>
<th>Denmark</th>
<th>External trends</th>
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<tr>
<td><strong>1980s</strong></td>
<td>- Financial crisis initiating several governmental documents</td>
<td>- Strong professions</td>
<td>Focus on NPM – efficiency, management and budgets (World Health Organization 1978)</td>
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<td></td>
<td></td>
<td>- Budget responsibilities at the profession level</td>
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<tr>
<td><strong>1990s</strong></td>
<td>- Frequent changes</td>
<td>- Minor attempts of NPM</td>
<td>Increased NPM focus – normalised within public sectors (World Health Organization 2000)</td>
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<td></td>
<td>- Market-oriented health care</td>
<td>- Continuous strong profession</td>
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<td></td>
<td>- Withdraw from model three years later</td>
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<td></td>
<td>- Strong political power</td>
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<tr>
<td><strong>2000s</strong></td>
<td>- Focus on patients, population-based funding</td>
<td>- Dividing responsibility centres</td>
<td>Beginning of quality focus within health care (World Health Organization 2006)</td>
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<td></td>
<td>- 20 DHBs with full responsibilities</td>
<td>- Focus on budgets</td>
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<tr>
<td></td>
<td>- Focus on stability</td>
<td>- Increased competition</td>
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<td></td>
<td>- Strong political power</td>
<td>- Growing administrative power</td>
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<tr>
<td><strong>Current</strong></td>
<td>- Focus on combined quality across DHBS</td>
<td>- Focus on some quantitative quality indicators</td>
<td>Quality focus in day care</td>
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The above table shows some general external and global trends. These trends, however, do not manifest themselves in the same way in the individual nations due to different traditions, political involvement, cultures and power relations (Kragh Jespersen et al. 2002). As Shapiro and Bedi (2007) observe, different events can change ideologies and this is seen in both countries. The political ideology in New Zealand at the beginning of the 1990s was centered on the quasi-market methods which were thought to create the most efficient health care. This led to a competitive element of splitting provider and purchaser roles with increased focus on contracts between the parties. The result of this ideology has turned out to be negative as efficiency is not sustained and as health care focus has decreased. From 2000, the ideology in New Zealand changes towards a greater concern for and focus on the public patients. In Denmark, however, the opposite shift can be seen. After more than twenty years, the public and the health care sector itself have gradually accepted an economic focus in health care and have abandoned their resistance to administrative and competitive elements.
5. Conclusions and perspectives

The objective of this study has been to analyse the NPM development and implementation in Denmark compared to New Zealand, the differences and similarities and in particular the time difference in NPM reform implementation and the outcome of this time difference. The contingency model developed by Pettersen (2004) has assisted in this comparison. The model contributes to a holistic framework which is suitable in this type of study on the socio- and national political reform level. The extra time variable has given a useful longitudinal element which has enabled us to enhance the understanding of the present situation of both countries’ health care systems. It has proven to be a flexible framework which would be appropriate for similar comparative studies. In order to understand the different outcomes, however, some explanatory categorisations are listed below.

Including the timing differences, the study has identified local differences, but global similarities. This is in line with Pettersen’s (2004) study. Pettersen observes that the same kinds of reform formulas and ideas are translated into different local settings. This is in fact global trends that are manifested differently in the local settings. At the reform and political levels it has been identified that a global trend of requiring health entity managements to be financially responsible is present during the 1980s with an increased focus on costs during the 1990s and a refocus on quality during the 2000s. However, the processes and contents of reforms differ on the local level. The contingency analysis shows several interrelated reasons for these differences; the medical society is much more historically ingrained in the Danish system than in the New Zealand system; public health care was founded earlier and with more local focus in Denmark than in New Zealand, which has affected the structure; the political versus professional power struggle where Denmark has a history of a much stronger profession than New Zealand; the tendency of New Zealand to make
stronger and more comprehensive political reforms; and finally the way laws are passed, i.e. through majority vote in New Zealand and by consensus in Denmark.

Addressing the study of Pollitt and Boukeart (2011), the local differences can be partially explained by their categorisation as marketisers and modernisers. Marketisers represent the more profound NPM adopters that have a heavy market reform focus. An example is the New Zealand market reform in 1993 which was based on the Upton paper from 1991. These are the first and second wave adopters. This type of radical changes in the public health care system is also manifested in the rhetoric of the reforms which address ‘users’. The radical changes and aim of achieving far-reaching alterations are also demonstrated through the rapid changes in New Zealand and combined with its marketiser category New Zealand is what Hood and Peters (2004) refer to as a ‘hare’. The ‘hares’ overreach themselves and make great steps forward. When surprises and paradoxes emerge they quickly dismiss the previous idea and discontinue the initial plan and thereby achieve less in the long run. We see this in the present situation where the extreme surprises and negative experiences with the extensive market reform in the 1990s have made economic issues such as keeping within the budget taboo. Monetary issues were not brought forward by any of the interviewees nor at any meeting attended in New Zealand, and if the issue was brought up it was quickly discharged.

The modernisers, on the other hand, represent continental European countries where the state is ‘an irreplaceable integrative force in society, with a legal personality and operative value system that cannot be reduced to the private sector discourse of efficiency, competitiveness, and consumer satisfaction’. (Pollitt and Boukaert 2011, p.117). These are the third and fourth wave adopters. Though Denmark is not included in the description by Pollitt and Boukeart, some of the modernisers’ attributes fit well to the Danish situation, particularly when compared with New Zealand. The modernisers generally adopt NPM later than the marketisers, but they do it in a more
integrated and lasting way, which fits Hood and Peter’s (2004) description of the ‘toitoise’. The ‘tortoises’ move slowly but steadily. As seen in Denmark the adoption of a more comprehensive NPM reform, the Structural Reform, did not happen until 2007, presented in 2004. In Denmark economic issues and budgets are not taboo; on the contrary, most of the interviewees were very focused on costs and budgets, and the future prospects of changing the accounting rhetoric is not noticeable. Efficiency is also represented in several of the interviewees’ statements as an integrated part of their work, which is in line with the integrated activity based costing funding allocation.

Contrary to Pollitt and Boukaert’s statement that continental European countries totally dismiss private sector techniques and discourses, we did see a concern related to internal competition between the regions in Denmark. However, the rhetoric surrounding the patients is not as market focused as was seen in New Zealand in the 1990s and patients are still referred to as ‘patients’ and not ‘users’ and hospitals are referred to as ‘hospitals’ and not ‘providers’. However, at the present time, competition exists internally in Denmark and not, at least explicitly, in New Zealand. The competition in Denmark has not been established through a market based reform that prepared the ground for the competitive behaviour but rather as a result of the structural setting where responsibilities are divided between regions and communities, and the funding allocation which is based on activity level. These two set-ups in the Danish health care systems result in a central focus on costs spent, budget observance and activity level. The Danish health system thus has a much greater management accounting focus than New Zealand. In the interviews provided for this study, this focus does not provide the solid and steady implementation of NPM reform as suggested by Pollitt and Boukaert (2011) and Hood and Peters (2004). On the contrary it suggests, as one of the interviewees mentioned, a focus on the means, accounting techniques, rather than the end, the patients and quality treatment. Focus on other performance measures from a national perspective is extremely limited. The supplementary punishment and reward system integrated in the funding leads to large differences in the autonomy of hospital managements. Although Denmark still have
decentralised organisations, the state has taken over the role of a budget dictator (Downie et al. 2006).

At the local level, i.e. the health care provider level, the two countries are similar in that they share a concern in relation to registration procedures. In both countries differences in registration processes and even systems exist. This is a technical element which influences several aspects of the NPM reform implementation and sustainability. In both countries data entry is vital. New Zealand focus on several performance measures, particularly six national health targets which are constantly compared and concluded upon. In Denmark activities, hospital cost allocations and waiting lists play a crucial role in the state’s funding allocation decisions. Therefore the registration systems play a central part in the success of NPM reform which calls for in-depth future studies in various perspectives, but especially in the translation and role of accounting information.

As Pettersen (2004) observed in the Nordic countries generally, the Danish health care professionals do not participate actively in the NPM reform process after the Structural Reform, although prior to the reform that had been the tradition. In New Zealand several of the district health board members are physicians and thereby the profession takes active part in the NPM implementation. Furthermore, most of the members of the DHBs are elected by the public and virtually run the health districts. Further studies on this participation and its effect versus the non-participation in the Nordic countries could be highly relevant in order to investigate the resistance factors that may be caused by the colonisation factor as Pettersen calls it where changes are imposed on the hospital level versus non-resistance factors among the health care profession. The externally enforced NPM reform development, however, is dual. In both New Zealand and Denmark there are some imposed outer frameworks especially with regards to level of funding. But in both countries the way these funds are applied is fully up to the health care provider in Denmark and the district health board in New Zealand which implies a freedom on type of management. Even though the New Zealand
district health boards are held accountable through various performance measures, how they contribute to these performance measures is up to the DHBs. Even more freedom exists in Denmark as the health providers are held accountable for a smaller number of performance measures. In fact, a study by Bech showed that hospital management in Denmark experienced larger freedom during the Structural Reform development (Bech 2006).

Despite the historical reasons and different backgrounds, the New Zealand ability to make fast transformations makes them suitable as trend-setters as they were during the 1990s. New Zealand may in fact continuously be a trend-setter with the recently increased focus on harmony in the health sector and a specifically integrated focus on quality in several areas. In 2006 WHO issued a report on Quality of Care (World Health Organization 2006). The definition of health care quality in this report points to six different working areas of quality in health care; effectiveness; efficiency; accessibility; patient-centeredness; equitability; and safety. The present trend in New Zealand as well as in Danish health care is to focus on quality with an integrated focus on efficiency which is also found in the Danish system. The New Zealand Health and Safety Committee attempts to cover all these six areas and to ensure that they have national focus and that no area is more important than the others. They are all combined and should motivate better health care.

This study has shown that nations only draw on other nations’ experiences to a limited extent despite the time lags and different waves of NPM implementation. Denmark does not seem to draw on New Zealand experiences explicitly. The adaptation and alignment of management accounting tools and philosophies take much longer to get effect in Denmark. However, for New Zealand and Denmark there could be lessons to learn from each other. When a nation like Denmark finally decides to implement NPM, other nations and early adopters are considerably more advanced and their experiences can be insightful. Recently, Denmark has also experienced the need to focus on quality but until now their effects in this respect is less developed than in New Zealand. In addition
to the history and culture of a country another reason could simply be the experience factor. A country needs to learn by itself how a philosophy works in order to develop its own most suitable approach. External trends have been the only dynamic contingent with a cyclically recursive effect.

This study has compared two reforming health care systems. However, it has some limitations. First, it does not provide information on the results and/or consequences of the reforms at the clinical level which is a central aspect of health care assessments. Further research should therefore examine procedures and impacts of reforms at the clinical level. Another limitation is the different experiences within areas of each nation. The interviews made in Denmark have all been conducted within a few selected regions, and in New Zealand they have been held with members of a few District Health Boards. There could be regional differences in experience, opinion and focus.

Despite its limitations, the present study has contributed to clarifying the continuous importance of comparative studies on health care reform development. Despite local differences, there are common global interests and similarities. Future studies on other nations would be highly valuable for the definition and development of future health care system reforms and the role of accounting techniques in this development.
References


Borum, F. 2006. Forsknings i sygehuse under forandring.


Appendix 1: Interviews and attended meetings

7 interviews have been made with hospital financial management in Denmark. Two of these have earlier regional background. These interviews are:

- May 3rd 2011, Eydfinn Heinesen, Chief of patient data and DRG, Aarhus hospital
- June 20th 2011, Thorkild Mogensen, Chief of Financial operations, Viborg hospital
- June 22nd 2011, Kim Mikkelsen, Chief operating officer, Aalborg hospital
- June 22nd 2011, Hans Thomsen Schmidt, Coordinator, Region Vest hospitals
- June 24th 2011, Christian Sauvr, Financial and Planning Chief Executive, Region South hospitals
- June 24th 2011, Claus Davidsen, Financial and Planning Chief Executive, Horsens hospital
- June 30th 2011, Rund Hertslund, Chief operating officer, Hjørring hospital

7 interviews have been made with members of District Health Boards, Financial Managers and Head of Boards. These interviews are:

- September 2nd 2011, Ajit Arulambalam, Planning and Funding Manager, Auckland Health District
- September 10th 2011, Michael Hale, Health quality and safety commission, Auckland
- November 3rd 2011, Denis Jury, Chief of Planning and Funding, Auckland Health District
- November 4th 2011, Greg Balla, Director of Performance, Auckland Hospital
- November 10th 2011, Toni Ashton, Professor of Health Economics, The University of Auckland
- December 12th 2011, Greg Coster, Chair of Manukau Health District
- December 22nd 2011, Debbie Holdsworth, Chief of Planning and Funding, Waitemata Health District

Attended meetings:

- September 5th - 6th: Attended symposium in Dunedin on Performance in Health Care
- September 15th 2011, Board meeting, Auckland Health District; attended, presentation, feedback and dialog
- November 30th 2011, Attended Auckland hospital conference, meetings, speeches and presentation
Additional

- Access to Auckland Health District’s databases at Greenlane hospital, Auckland. Was admitted as an internship from September 10th 2011 until January 1st 2012
Appendix 2: Interview guideline Denmark

- Background information
  o employment
  o responsibility
- Current situation of the hospitals finances, performance and structure

- How do you perceive performance measures?
- Are you affected by performance measures in your work?
  o If so how?
    o Have there been changes in quality versus quantity due to performance measures?
    o Which measures are the most important in your work?
- How do you rapport performance measures and costs through the system?
- How do you registrar these performance measures?
- How do you experience changes within performance measures during the past 10 years?
- Are you rewarded by any of these measures?
  o What role does the quantity of patients play?
  o And in relation to funding from the communities?
  o What role does DRG play?
- Does performance measures or DRG affect your bed days?
- Has it affected number of discharges?
- When you receive funding according to DRG, does this get re-activated with re admittance of patients?
- Do you have many readmitted patients?
- How do you control the different hospital departments?
  o Do you have rewards and/or sanctions
  o What do you do when a department is off budget?
- What is your opinion of the current system?
- What changes do you think will occur in the future?
Appendix 3: Interview guide New Zealand

Note: This interview guide is only a guide and it shows the areas of questions. During the interview I am interested in in-depth information on the particular area and perspective that you are familiar with. You may feel free to supplement with what you would like.

Background information

- What is your role in the New Zealand health care system?
- For how long have you been employed with the New Zealand health care?
- What is your experience with New Public Management, the 1993 health act and the 2000 New Zealand Health Strategy?
- What is your responsibility as a unit/institution?
- What is your responsibility as an employer/person?

Funding/ Performance measures

- How would you describe the funding of the New Zealand health care?
- The ministry of Health allocates more than three quarters of the $13.983 billion of public funds to district health boards – how would you describe the allocation of this amount?
- Does this allocation have any influence on the performance measures that are used within this entity?
- Do you have any influence on the performance measures used?
- Which performance measures do you primarily focus on?
- To what extend do you use DRG taxation?
- Do you punish and/or reward according to performance measures or DRG?
- According to the government DHB “plan, manage, provide and purchase health services for the population of their district to ensure services are arranged effectively and efficiently for all of New Zealand” – how do you believe this is ensured?

Co-operations

- There are 20 districts. Do you cooperate with any of the other districts in any way?
- Are there any ‘trading’ of patients between the different districts?
- Do you cooperate with any similar departments?
- What is your cooperation with private health care providers?
- How do private health care providers influence your institution?
- Do you have any cooperation with the community/municipalities?

Behavioral aspects

- Do you think that there exist any particular consequences by the use of performance measures?
- How do you think performance measures influence health care quality?
  - How do you perceive health care quality?

2 http://www.worldatlas.com/aatlas/populations/ctypopls.htm

3 Reference: Health performance symposium in Dunedin, September 5th, 2011 and interview with Chief of planning and funding, Auckland District Health Board.
Chapter 7

Conclusions and perspectives

“Not everything that counts can be measured. Not everything that can be measured counts.”

Albert Einstein
Examining the changes and health care implications following NPM reform implementation from a management accounting perspective reveals the increasing and diversified role played by management accounting in NPM evolution. Empirical accounting research has previously been criticised for being unrelated to the social contexts in which accounting methods are introduced (Broadbent and Guthrie 1992; Burchell et al. 1980; Miller 1994; Miller et al. 1991; Miller and O’Leary 1987). Along with the societal changes, the role of management accountants has changed and diffused into social settings such as public sector institutions, and the management control terminology and rationality can be seen in debates at the political level, in the media and in altered professional practices. This demands knowledge about the social context and the relations of management accounting (Burchell et al. 1980; Hopwood 1987, 2009). The critical approach has enabled a holistic view of the social context in which the development of management accounting, through NPM reforms and research, has transformed. Through a triangulation of critical approaches, using governmentality and discourse analysis, into interpretive and explanatory studies, using diffusion theory and contingency theory, this dissertation has addressed the role of management accounting in the development of public health care through NPM reforms from different angles. This has made it possible to broaden our research of management accounting in public health care. Reoccurring issues in the four chapters include (1) paradoxes of management accounting techniques in the social setting of health care, (2) tensions between professions, (3) cultural ‘surprises’ and differences in the NPM implementation, (4) historical discontinuities and linarites, (5) power of management accounting terminology and techniques, (6) the influence of management accountants on this development, and (7) the distinction between definitions of accounting and economics.
One of the recurring core themes of management accounting in NPM reforms is the duality of accounting techniques. On the one side accounting techniques enhance clarity, and enable the ability to compare inputs and outcomes across time and institutions which empowers the decision making foundation. On the other hand accounting techniques simplify the representation of professional and abstract knowledge as highlighted in the study by Blomgren and Sahlin (2007) and referred to by Hood and Peters (2004) as unintended Mertonian effects. The aims of transparency, which Blomgren and Sahlin (2007) highlight, result in different types of numerical classifications and categorisation in order to clarify, compare and convey information to patients and the public. Through this clarification, the information becomes simplified and loses its original complexity, abstract knowledge and this leads to a further risk of losing individual usefulness. In chapter 4, this is shown by the undermining of the profession’s abstract knowledge in the debate of the Structural Reform where numerical terminology is dominant. But the alternative of not classifying and categorising creates a massive informative obstacle for management control which is often seen as lack of optimal use of resources. To facilitate the patients’ free choice, information is most certainly needed (Danish Ministry of Health 2004; Nordgren 2010; Upton 1991; Vrangbæk 2006). Chapters 3 and 6 illustrate how the pursuit of patient’s free choice, better productivity and efficiency during the 1990s resulted in marketisation in New Zealand and the UK in particular, which created a battle field for purchasers and providers focusing on economic gain and numerical performance measures rather than the quality of care which resulted in a quick re-orientation in these countries (Ashton 2001; Boyle 2011). The re-orientation was a result of the realisation of unintended effects of introducing marketisation in public social services. Yet benchmarking and performance measures are maintained, which sustains the dilemma of accounting simplifications versus abstract knowledge, and this again results in averageness creating limitations for growth (Jones 2002; Llewellyn and Northcott 2005). The performance measures introduced in NPM reform further add
to the paradoxes of control. The initial aim of NPM is that of decentralised responsibilities which should provide health care managers and clinicians with accountability making them more engaged in their work and thereby adding to efficiency and a better health care (Gruening 2001; Hood 1995). But the synchronous introduction of performance measures creates a strong centralised control element (Agrizzi 2008; Conrad and Guven Uslu 2010; French 2001; Tanggaard Andersen and Jensen 2010) where health care institutions must provide specific measures at specific levels. After year 2000, a refocus on health care quality leads to greater awareness, but it still generates counter-acting forces in the form of categorisations and quantifications where the abstract complexity of good quality gets lost. The paradoxes of management accounting techniques in social health care service appear to arise from the fact that they do not include the complex social environment. Management accounting techniques are therefore insufficient as a standalone approach, and the techniques of budgeting, costing, and performance measures are not, by themselves, eligible in capturing the social context. They must, however, be combined with elements from the social context of health care. An illustration of such a hybrid formation is seen in the refocus on quality indicators which is a reoccurring theme in chapter 3, 4 and 6.

(2) As described in this dissertation, the management accounting techniques and the use of budgets, performance measures and accounting management control systems dominate in the NPM introduction. This creates tensions between the administration and the health care profession stemming from social context impacts. The diffusion theory used in chapter 5 illustrates the increasing focus on the social context in accounting literature. The continued importance of including social changes and implications in research studies within management accounting is shown and supported by earlier literature reviews such as Broadbent and Guthrie (Broadbent and Guthrie 1992, 2008) along with several research papers by for example Hopwood (Burchell et al.
The tension between administration and the health care profession along with a need for research on the NPM effects in non-English speaking countries laid the foundation for chapter 4 on the influence of management accounting terms through NPM intensification. The chapter illustrates how the dominant discourse in this particular Danish setting is closely related to management accounting and leads to a constant monetary focus. The arguments are revealed through quantitative and descriptive facts leaving little or no room for discussion. The dominating management accounting role and perspective challenge the profession and the physicians do not participate in the debate. The profession’s core identity is challenged in the sense that they have to distinguish between types of patients and costs of patients which conflicts with the doctoral oath. Moreover, the health care profession is being challenged simply by becoming objects of dictated control mechanisms which, for example, was found by Abernethy and Stoelwinder (1995) in an Australian study. They found that conflicts emerge as control systems are designed to control the health care professionals’ behaviour. The chapter 4 study indirectly applies these tensions through the Danish history of a strong profession which is challenged through a Structural Reform since their original power is transferred to system and administrative power which is further sustained through Fairclough’s (1992) meta discourse of democratisation. The professional tensions are a result of the paradoxes described above. But there are other types of tensions in the discussion of the development of management accounting tools; chapter 3 addresses the global health reform development through WHO documents. Through these documents pressure is put on nations to increase health care service levels worldwide. Those documents address all UN nations and not just Anglo-American and central European nations. Therefore tensions and NPM pressure in non-English speaking nations are relevant for our understanding of the diversified role and influence of management accounting.
(3) The issue of cultural surprises discussed by Hood and Peters (2004) is a natural effect of social changes. Chapter 4 discusses the Danish setting and the ‘Structural reform’ and opens up for reform discussion, political and structural challenges along with diverse implemental experiences in a, so far, unexplored nation in a management accounting context. Chapter 6 proceeds from chapter 4 to investigate the Danish and the New Zealand health systems, their developments and changes over time along with the time diverse NPM implementation and experiences. It is found that the history, cultural setting, power relations and political-administrative structure play a large role for the working culture in health care and thereby its development, experiences and eagerness for change; this is also supported by a study on professions and NPM by Kragh Jespersen et al. (2002). While New Zealand is more adaptable and flexible in its NPM approach, Denmark has a stronger profession and opposition prior to 2000 which prolongs the process of NPM implementation and results in a delay in experience and thereby current state. The study shows how an extreme reform implementation in New Zealand has led to a taboo of management accounting and economic expressions. Denmark, on the other hand, has an open competitiveness that is seen in the regions that “trade” patients. This is contrary to the studies of Pollitt and Boukaert (2011) who claim that European Webern nations are modernisers who resist market forces and elements within public health care. The contingency model used in chapter 6 provided a suitable frame for the comparative study of New Zealand and Denmark and enabled a holistic focus by highlighting comparable elements at a socio-political level. Chapter 6 has contributed to the non-English studies of NPM development, but as seen in chapter 3, there is a large potential for studies in non-English speaking nations. The developing and transitional countries displaying different national backgrounds than currently researched nations would be of great value in the exploration of management accounting influences, and they would likewise add knowledge to the different cultural surprises in this investigation.
(4) Chapters 3 and 5 in particular read into the historical discontinuities and non-/linearities. Both chapters show discontinuity regarding the marketisers (Pollitt and Boukaert 2011), that is the Anglo-American nations, but not concerning management accounting techniques such as budgets and performance measures. These techniques are sustained despite the re-direction from market reforms to collaboration. This is also seen in chapter 6 where New Zealand has several hundreds of performance measures and particularly six health targets. Denmark, on the other hand, does not have the same focus on multiple performance measures, but an increased focus on budgets and activity costing. These different ‘management accounting outcomes’ witness some of the contextual influences on NPM development. The social context in which the NPM reforms are developed and implemented influences both content and form of reform and the outcome and implementation process, confirms earlier studies on the variation of themes (Hood 1995; Hood and Peters 2004; Kirkpatrick 2011; Pollitt and Boukaert 2011), but nevertheless this dissertation still observes a diffusion and spread of management accounting terminology and techniques despite the contextual influence. The various spreads of management accounting techniques are dynamic and take different forms and constant redirections but they are powerful since they endure any reform change occurring. The NPM learning process is also a historical theme where nations learn from the different Mertonion unintended effects and constantly try to redirect. This is seen in the dismissal of market reforms, but also in the recent increased global focus on health care quality rather than health care performance.

(5) The powerful persistence of management accounting techniques is also shown through the discourse analysis in chapter 4. The discourse theory has made it possible to analyse the rhetoric use of management accounting terminologies, which has revealed its strong powers. The management
accounting techniques and terminology are powerful since they bring clarity and simplicity through numerical translations of processes and outcomes. Management accounting is therefore useful in order to clarify important points, e.g. to further political goals. When translated into numerical forms like performance measures, activity costs or budgets, health care activities, governmental aims and service quality become enforced since they become descriptive rhetoric manifesting facts which cannot be argued against. It thereby creates numerical assumptions for rational decision-making. These findings are supported by earlier studies (Arnold et al. 1994; Flyvbjerg 1998; Kurunmäki 2008; Miller and Napier 1993; Neu 2006; Porter 1996). The study by Neu (2006) on public discourse within the domain of education, for example, illustrates how financial and accounting numbers justified and defended specific participants interests in the public sphere. This is what Kurunmäki (2008) refers to as financial and accounting literacy where the accounting vocabulary is accessible to all. But exactly as pointed out by Kurunmäki (2008) a need for distinguishing between accounting and account ant is present. (6) For example, the power clash between the management accounting rhetoric and the medical profession’s terminology is complex since the rhetoric of management accounting is supported by other professions such as politicians. Therefore, it is not a direct management accountant power as a profession, but the powerful rhetoric of management accounting ‘language’ is the central issue of management accounting techniques prevalence. An example can be given in Denmark where management accountants at hospitals were interviewed. A few, that is one or two, seemed to be able to influence decisions, but the others were taking the role of victims who had order dictated from the hospital management or from the political level. This witness a weak power and influence from management accountants. In New Zealand, management accountants were hard to find at all in the health care sector. Most CFOs and other financial controllers had non-accounting backgrounds such as political or medical. Thus there has been little practical influence from management accountants in the NPM implementation of
management accounting techniques. Chapter 5 also shows a reactive role of management accountant researchers on NPM reform making rather than a pro-active role. Reforms were discussed at a scientific level after becoming effective and rarely resulting in any change. In other words the management accountants only have a vague role whereas the role of management accounting techniques and rhetoric is very strong and is broadly adopted by other professions. The adoption of management accounting techniques and rhetoric by other professions is also supported by Samuel et al. (2005) who concludes that it is not economists or accountants as profession that introduces market mechanisms and economic rhetoric in health care, but ‘scientific knowledge’ attached to universities, and “accordingly, professional practice remakes society in the rational image of a scientific laboratory” (Samuel et al. 2005, p.274). It is a combination of jurisdiction of engineers, economists and accountants as long as costs is seen to be the problem in health care (Samuel et al. 2005). The issue of costs, however, becomes complex when added to the social context of health and the effectiveness becomes blurred when, for example, performance measures become the goals rather than tools for reaching the goals of good health care. This indicates that other professions need to be better at using management accounting techniques, but also a need for increased understanding of the power of management accounting techniques and of the way management accountants may shape and influence the future use and understanding of these techniques through public health care reforms.

(7) In addition to the discussion of the deviating roles of management accounting and accountant is the definition of management accounting. In this dissertation management accounting often have overlaps with economic issues. Though management accounting stems from neo-classic economics (Ryan et al. 2002), according to Hopwood (1992) accounting is a way in which relevant information provides for economic decision-making processes. In other words, accounting constitutes a frame
for presenting information which makes it an assistant tool, whereas economics take this information and make monetary decision making upon it. Management accounting techniques such as performance measures, budgets and costing techniques are specific types of calculation methods indicating the role as means. The information, that management accounting techniques present, is often related to management accounting itself, especially in the discussion of efficiency, savings and productivity. However, if we divide the accounting techniques with the economic decision making, the example of New Zealand health care system in chapter 6, reinforces the sustainability of management accounting, since monetary issues are taboo, but performance measures are highly relevant and used across the entire health sector. Adding to this is the two major key elements of NPM; accounting information and marketisation. Marketisation has been disregarded in health care in New Zealand and the UK, but management accounting information prevails. This means that despite the state of NPM, teasing out the management accounting element identifies a powerful and succeeding profession. Thus the management accountants have ample opportunities to manifest themselves in this area.

**Limitations**

Instead of including New Zealand and world-wide research an alternative approach to this dissertation could have been to make a purely national study of Denmark. However, since the methodological approach used in this dissertation is different from most PhD dissertations within management accounting (Lukka 2010; Ryan et al. 2002), it was found necessary to investigate the research domain more in depth which was done partly in chapter 3 and more thoroughly in chapter 5. This proved how crucial the social settings are and this could only be further supported and illustrated by comparing two different settings. Using a more streamlined positivistic approach would also have been a possibility but that could not have answered the research question regarding
the changes and implications of NPM introduction, at least not in a social context. It is clear, though, that many pages are used in this dissertation in order to argue for the methodological approach. This dissertation contributes to a foundation for future PhD dissertations by applying a more critical perspective and it therefore not only contributes to management accounting research in health care, but also to the research discussion and foundation for using approaches other than those of mainstream accounting.

The theories applied have been applicable; however, the use of Foucault’s concept of governmentality (Foucault 1972, 1994; Raffnsøe et al. 2008; Simons 1995) along with Fairclough’s meta discourses (Fairclough 1992) proved to be somewhat limited in a transnational research including developing and transitional nations. Other theories are needed in these type of historical papers and universal developments. Additionally, both Foucault’s thoughts and Fairclough’s metadiscourses are dated back to the 1970s and 1980s which limit the relevance in current analysis due to changing societal environments. However, their ideas bring interesting and relevant parts forward such as the role of the nation (governmentality) along with global trends (meta discourses) which explain parts of the present.

An important limitation is that the analysis is focused on Anglo-American, Danish and other Scandinavian reforms and documents. Due to language barriers, it has not been possible to include central European countries and developing and transitional countries. This naturally limit the conclusions drawn, though an effort has been made to find English literature on some of those nations which is presented in chapter 3.

This dissertation’s focus has been on management accountings role on the socio-political level which reveal little on the actual practical level of medicine. Additional interviews in hospital settings could have provided more solid information on the actual manifestations of management
accounting in practice. However, due to a holistic and historic informative need this was not pursued in this dissertation. Additionally, a focal point of the political reform level has been kept.

**Future Research**

Through collection and digestion of data and information, and through the development of data into useful knowledge contribution, the writing of the present dissertation has been an explorative learning process. The thesis has proven many gaps and issues within health care and there are many research opportunities in continuance of this PhD dissertation and several research opportunities have been described above. In general, the eternal conflicting issue of social services and accounting is interesting, relevant and suitable in the modern dynamic society. The continuous changes and learning processes in the health care sector through health reforms also provide an interesting research field in the pursuit of understanding the role of management accounting. With the integration of social context such as understanding the health care environment, history, national settings and work relations in management accounting research, the complexity of the role of management accounting and the intricacy of management accounting research evidently become intensified. Isolated management accounting techniques are important research applications which can be useful in practice. In order to improve these management accounting techniques in different institutional settings, research should focus on identifying important social practices which influence the optimal use of management accounting techniques. This dissertation, for example, has shown how global institutions like the WHO play a significant role in the development of management accounting terminology and techniques in worldwide public health care. This contributes to the understanding of management accounting in NPM reforms where management accounting techniques should be used as tools to reach the common goal of improved health care equality, accessibility and health care service quality and avoid becoming the goal in itself. Further
research into the definitions of management accounting could apply knowledge for the use of management accounting in health care both by management accountants themselves but also for other groups in society adopting the management accounting rhetoric.
References


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