MANAGEMENT CONTROL
IN A
HEALTHCARE CONTEXT

Ms. Michelle Carr

BBS. MBS.

A dissertation submitted to Dublin City University Business School

In partial fulfilment of the requirements for the degree of DOCTOR OF PHILOSOPHY

Supervisors:

Professor Bernard Pierce

&

Professor Barbara Flood

May 2016

DECLARATION

I hereby certify that this material which I now submit for assessment on the programme of study leading to the award of a Doctor of Philosophy is entirely my own work, that I have exercised reasonable care to ensure that the work is original, and does not in the best of my knowledge breach any law of copyright, and has not been taken from the work of others save to the extent that such work has been cited and acknowledged within the text of my own work.

Signed: _____ **ID. Number_____**

Ms. Michelle Carr

Date: _____

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

First and foremost, I wish to express my sincere gratitude to my two supervisors, Professor Bernard Pierce and Professor Barbara Flood. Both went beyond the call of duty in ensuring that my research journey was challenging and rewarding in equal measures. Thank you for your confidence in me and your patience.

I owe a tremendous amount to all the members of the Department of Accounting, Finance and Information Systems in UCC for their help and support.

I am extremely grateful to the individuals from Woodford Hospital for participating in this study. Their honest and candid insights made this study possible.

I wish to thank my family and friends who have listened to my obsession with this PhD. A very special thank you, to my mom, for her continuous support and help, you are a constant source of inspiration and guidance.

Thank you to my ever supportive husband, Tomas. Your confidence in me is often what kept me going.

A final special thank you to my beautiful children, Oisin and Lauren. You ensured that I never lost perspective and could always make me smile and laugh.

LIST OF ABBREVIATIONS

ABC	Activity Based Costing
BSC	Balanced Scorecard
CCB	Cost Containment Board
CCP	Cost Containment Plan
CEO	Chief Executive Officer
CIM	Clinicians in Management
DoH	Department of Health
ECB	European Central Bank
EU	European Union
HIQA	Health Information and Quality Authority
HIPPE	Hospital Inpatient Enquiry
HSE	Health Service Executive
IMF	International Monetary Fund
ISA	Integrated Service Area
ISD	Integrated Service Directorate
MoH	Minister of Health
NCPC	National Clinical Programmes of Care
NHO	National Hospitals Office
NPM	New Public Management
NSP	National Service Plan
RAPM	Reliance on Accounting Performance Measures
RDO	Regional Director of Operations
RTE	Raidio Teilifis Eireann

LIST OF APPENDICES

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

During an acute recession in Ireland, healthcare organisations were subjected to increasing pressures to provide more services for less money, highlighting the need for resources to be utilised efficiently and for effective management control. This presents quite a rare research opportunity, and the objective of this study is to use it to explore the design and operation of management control practices in what the literature already recognises to be one of the most complex and under-researched contexts, healthcare, particularly in a situation where such a system is under considerable stress. The study of such extreme examples can cast additional light into effective management control in practice beyond that typically available under more "normal" conditions. To achieve the research objective, an in-depth case study of a large, acute, public hospital was conducted. Using qualitative research methods within an interpretive framework, it sought to explore the many complexities associated with the hospital context and to identify possible linkages between contextual factors and the operation of management control practices.

The study demonstrates that the economic and fiscal crisis was perceived to have initiated a change in the attention provided to, and use made of, management control information. National healthcare management were perceived to have placed a higher emphasis on cost reduction targets and to use budget information in an inflexible manner. Senior hospital management perceived that this style of usage led them to be more focused on budget information and the achievement of budget targets, but they also perceived higher job-related stress and tense working relationships with national management. Senior hospital management were reluctant to replicate an inflexible style of budget usage within the hospital, but driven by the need to meet national cost reduction targets and frustrated by organisational arrangements, they adopted a centralised style of usage. It was recognised that while initially successful in removing organisational slack, this approach may lead to harmful side effects in the longer term. For example, clinicians were found to be apathetic towards the use of management control practices.

The study contributes to the literature by highlighting how management control practices were perceived to operate during an economic and fiscal crisis. Further, addressing some limitations of previous research, it examined perceptions concerning multiple control practices at different organisational levels and among different professional groupings in the hospital, including senior hospital management, services managers, clinicians and clinician managers.

CHAPTER 1: INTRODUCTION

1.0 Introduction

The purpose of Chapter One is to set the context for this piece of research. The motivation for the research is discussed in Section 1.1. In Section 1.2, the selection of the Irish hospital sector as an appropriate and opportune setting is explained. An overview of the research design is provided in Section 1.3. In Section 1.4, the structure of the dissertation is outlined. Section 1.5 concludes the chapter.

1.1 Motivation for the Study

As an economic sector, healthcare now ranks among the largest in many countries (Cardinaels and Soderstrom, 2013). In the 1960s, healthcare expenditure accounted for less than 4 per cent, on average, of Gross Domestic Product (GDP) across OECD countries. Yet, by 2007, this had risen to 9.6 per cent and, in twelve OECD countries, it accounted for over 10 per cent of GDP. Healthcare expenditure as a percentage of GDP has fallen across most OECD countries since 2007 (OCED, 2013). The financial crisis that emerged in late 2007 had developed into an economic and fiscal crisis by 2008. As the economic and fiscal climate worsened, a focus was placed on reducing healthcare expenditure. However, simultaneously, such expenditure was also being subjected to significant additional upward pressure. This pressure derived from a number of demographic and structural developments, such as the progressive ageing of the population, autonomous increases in healthcare demands, the impact of lower incomes and higher unemployment and increased public expectations. Although this situation posed challenges, it also highlighted the need for healthcare expenditure to be utilised efficiently and for the operation of management control practices to become a key component of the strategies implemented to ensure sustainability.

Management accounting research highlights many difficulties and challenges associated with the operation of management control practices. In particular, empirical studies demonstrate that any single management control practice is an imperfect tool and, therefore, each must be used in a way that takes account of its limitations and is appropriate to the particular circumstances. A failure to consider the implications of these issues has been shown to have the potential to create a wide variety of harmful side effects (Merchant and Van der Stede, 2011). The findings of these studies have, however, not been unequivocal and a number of methodological and theoretical challenges have been made to this body of literature (Berry, Coad, Harris, Otley and Stringer, 2009; Chenhall, 2003; Ferreira and Otley, 2009; Fisher, 1998; Malmi and Brown, 2008; Merchant and Otley, 2007). Furthermore, little is known about the operation of management control practices during an economic and fiscal crisis (Hopwood, 2008; Van der Stede, 2011; 2015). In addition, the management control literature

has been developed within a private manufacturing-oriented context, which is contextually very different from healthcare (Abernethy and Lillis, 2001).

Healthcare provides a complex setting, which poses challenges for the operation of management control practices. For example, the concept of management control presupposes measurement but, in healthcare, measurement with reliability and precision is often not considered possible. Moreover, healthcare is not a standardised commodity and providing it involves many complex operating processes. Capturing this complexity in management control practices is, therefore, problematic. Healthcare is also an emotive issue and, as a result, attracts considerable media attention. This focus has resulted in the healthcare sector becoming more visible to the public, thereby raising expectations regarding the quality and availability of services. Finally, the control of core operating processes by dominant professionals creates a difficulty for the operation of management control practices in this field. Clinicians are primarily oriented towards providing effective clinical care for individual patients but management control practices are oriented towards the efficient and effective use of resources for all patient groups, as well as the overall needs of the healthcare sector. This conflict is also compounded by the fact that core operating processes in healthcare depend on the expertise of clinicians, thus granting them a significant degree of autonomy.

Empirical research examining the operation of management control practices in a healthcare context is relatively scarce and diverse in nature (Abernethy, Chua, Grafton and Mahama, 2006). The extant literature demonstrates that management control practices often play a symbolic role in a healthcare context and that the operation of such practices can result in harmful side effects (Broadbent, Jacobs and Laughlin, 2001; Jacobs, 2005; Jones and Dewing, 1997; Nyland and Pettersen, 2004). However, weaknesses in prior studies of the healthcare context are evident and many of these reflect similar flaws to those of the broader management control literature (Cardinaels and Soderstrom, 2013).

In this way, a need for healthcare expenditure to be utilised more efficiently, combined with a lack of clarity with respect to the operation of management control practices in a healthcare context provided the primary motivation for this study. The research objective is discussed in Section 4.1.

1.2 The Irish Healthcare Sector

The Irish healthcare sector was subjected to a substantial Reform Programme in 2003. The principal objective of the Programme was to improve the availability and quality of healthcare services by 'improving the planning, management, delivery and evaluation of services and their respective accountability arrangements' (Department of Health, 2003, p. 23). While the Department of Health (DoH) retained overall responsibility for the development of healthcare policy, a new Health Service Executive (HSE) took full operational and budgetary responsibility for the management and delivery of healthcare services. The Health Reform Programme and the establishment of the HSE, however, occurred during a period of unprecedented economic and fiscal prosperity in Ireland, with healthcare expenditure increasing by 62 per cent between 2002 and 2007.

In 2008, at the onset of the global financial crisis, the collapse of the overexposed banking and construction sectors precipitated an economic and fiscal crisis that required a Financial Support Programme from the European Union (EU), the European Central Bank (ECB) and the International Monetary Fund (IMF) (collectively known as the Troika) with a total value of €85 billion. Accessing funds was made subject to compliance with certain conditions set out in the Programme Documents. Amongst other economic and fiscal reforms, the control and reduction of healthcare expenditure were cited as being of critical importance (DoH, 2010). As a result, strict budget reduction targets were imposed, which included a 12 per cent reduction in healthcare expenditure during the period 2008 - 2012. Hospital expenditure was reduced by 24 per cent during this period (HSE, 2013). Consequently, the Irish healthcare sector in general, and Irish public hospital organisations in particular, were compelled to operate within unprecedented budget constraints.

Creating conditions for the more efficient use of healthcare expenditure became a fundamental component of the strategies implemented to ensure sustainability. Key priorities identified to meet this challenge were a greater focus on accountability and the better management of healthcare resources. The operation of management control practices was considered by the HSE to be central to these initiatives (HSE, National Service Plans 2008 - 2013). Consequently, for this study, the Irish hospital sector was deemed an appropriate and opportune setting in which to explore the operation of management control practices during an economic and fiscal crisis. The Irish hospital sector is discussed further in Section 3.1.

1.3 Research Design of the Study

It is clear that the management of healthcare expenditure needs to become more efficient as, otherwise, healthcare demands will undermine public finances. The recent economic crisis and its impact on fiscal budgets have exacerbated the pressures on these services and made the issue more urgent. With this in mind, this study sought to explore the operation of management control practices in a healthcare context during an economic and fiscal crisis. To achieve this, the Irish public hospital sector was selected as an appropriate setting. As little was known about the operation of management control practices in an Irish hospital context, a preliminary phase of investigation was conducted. Utilising Ferreira and Otley's (2009) Performance Management Control framework, the preliminary phase of the study aimed to develop an understanding of the type of management control practices that were operational in the research context being studied and to acquire a broad understanding of the factors influencing the operation of these practices. These objectives were achieved by exploring the perceptions, thoughts and encounters of individuals at distinct hierarchical levels in a large, acute, public teaching hospital. The preliminary phase provided valuable insights into the research context. In particular, its findings established that three management control practices were operational: (i) budget control, (ii) activity control and (iii) operational control. They also revealed that the operation of these management control practices had mixed implications. Although the perceptions of each interviewee were fundamentally similar vis-à-vis the complex nature of the hospital context, the findings suggested that perceptions and attitudes towards the operation of management control practices differed.

Careful analysis and reflection on the preliminary findings, combined with a critical review of the empirical literature, helped to shape the scope and design of the main phase of empirical work. From a research design perspective, the preliminary findings indicated that a single qualitative case-based research approach would be appropriate. It was, therefore, decided to conduct in-depth interviews with organisational members, including hospital managers, clinician managers, nurse managers and non-management clinicians. In addition, a wide range of organisational documentation and archival records were gathered and analysed. By these means, the study sought to develop an improved understanding of the topic in order to provide insights that contribute to the literature on management control and management accounting in healthcare. The research design is further discussed in Section 4.4.

1.4 Dissertation Structure

Chapter Two locates the study within the domain of management control research. It provides a review of the management control literature, which will form the study framework. Chapter Three reviews the characteristics of the hospital context and examines the suitability of management control practices for that environment. This chapter also reviews the relevant empirical literature in relation to the operation of management control practices in hospital organisations.

Chapter Four presents the research objective of the study. In addition, it provides a discussion of philosophical trends in management accounting research and the particular theoretical basis on which this research study is founded. This chapter also describes the process of selecting an appropriate research approach. Finally, it explains the research design of the study and presents a justification of the research methods used within an interpretive framework.

Chapters Five and Six present the findings of the preliminary and main study phases respectively. Each commences by providing a description of relevant developments regarding the organisational context and management control practices. Chapter Five presents the findings from interviews conducted in the preliminary phase of empirical study. Chapter Six presents the findings from interviews conducted in the main phase of empirical study.

Chapter Seven draws together the study's findings in order to identify implications for the management control and management accounting in healthcare literature.

Chapter Eight provides a summary of the study's conclusions and presents its contributions. It also examines the study's implications, strengths and limitations and makes suggestions for future research.

1.5 Conclusion

This chapter has provided an overview of the study reported in this thesis. It has delineated the motivations for the study and presented the thesis structure, outlining the contribution of each chapter to the study as a whole. The next chapter locates the study within the domain of management control research to set out its foundation.

CHAPTER 2: MANAGEMENT CONTROL

2.0 Introduction

Management accounting researchers have long recognised the significance of management control practices in enhancing organisational performance. As a result, a rich history of theoretical and empirical research is evident in the domain of management control (Berry *et al,* 2009). The purpose of Chapter Two is to provide a review of this literature in order to yield insights into the types of management control practices implemented by organisations, as well as to highlight those factors that influence their operation in different situations. The chapter is organised as follows. In Section 2.1 the domain of management control is considered. This includes a discussion of the various definitions and typologies of management control practices. In addition, it examines the theoretical frameworks that have been developed in the literature and considers the functional and dysfunctional outcomes of management control. A critique of empirical management control research is provided in Section 2.2. Section 2.3 traces the development of contingency theory and discusses its impact on management control research. Section 2.4 concludes the chapter.

2.1 The Domain of Management Control

2.1.0 Introduction

In broad terms, management control practices are designed to help an organisation adapt to its environment and to deliver the results desired by its stakeholders (Otley, Broadbent and Berry, 1995). An organisation that is 'in control' is likely to perform well in meeting its objectives, regardless of whether these objectives are to maximise shareholder returns, heal the sick or educate the young (Merchant and Van der Stede, 2011). Beyond this general understanding, however, definitions and classifications of management control vary widely. The purpose of this section is to examine the most prevalent of these definitions and classifications.

2.1.1 Management Control Definitions

The literature contains a large number of definitions of management control (Fisher, 1998). In the 1960s, Anthony (1965, p .17) separated management control from both strategic planning and operational control and defined it as 'the process by which individuals ensure that resources are obtained and used effectively and efficiently in the accomplishment of the organisation's goals'. Effectiveness can be understood in terms of achieving pre-defined objectives, while efficiency relates to the extent to which those objectives are achieved economically. Anthony's (1965) terminology and framework guided management control research and teaching for many decades and have tended to encourage a strong emphasis on

financial accounting-based management control practices. However, wider definitions of management control have emerged over the years as researchers have adopted a variety of different approaches to its study. Simons (1995, p. 5) defines management control as 'the formal, information-based routines and procedures individuals use to maintain or alter patterns in organisational activities'. Some researchers have outlined very broad conceptions of management control. For example, Chenhall (2003, p. 129) describes management accounting as a 'collection of practices such as budgeting or product costing', management accounting systems as the 'systematic use of management accounting to achieve some goal' and management control systems as 'a broad term that encompasses management accounting systems and also other controls such as personnel and clan controls'. On the other hand, Merchant and Otley (2007, p. 785) note that management control can include factors such as strategic development, strategic control and learning processes and conclude that it is 'anything designed to help an organisation to adapt to the environment in which it is set and to deliver the key results desired by stakeholder groups' to 'keep organisations on track'.

Many researchers have also highlighted the behavioural implications of management control. For example, Flamholtz, Das and Tsui (1985, p. 36) describes it as 'attempts by the organisation to increase the probability that individuals will behave in ways that lead to the attainment of organisational goals'. Meanwhile, Merchant and Van der Stede (2011, p. 8) characterise it as 'including all the devices or systems individuals use to ensure than the behaviours and decisions of their employees are consistent with the organisation's objectives and strategies'. Abernethy and Chua (1996, p. 573) adopt a similar approach in stating that a management control system comprises 'a combination of control mechanisms designed and implemented by management to increase the probability that organisational actors will behave in ways consistent with the objectives of the dominant organisational coalition'. In their exploration of the wide variations and inconsistencies regarding how management control has been defined, Malmi and Brown (2008, p. 290) propose a definition of management control that includes 'all the devices and systems individuals use to ensure that the behaviours and decisions of their employees are consistent with the organisation's objectives and strategies'. This definition is supported by Ferreira and Otley (2009, p. 267) who define management control as the 'evolving formal and informal mechanisms, processes, systems and networks used by organisations for conveying the key objectives and goals elicited by management, for assisting the strategic process and on-going management through analysis, planning, measurement, control, rewarding and broadly managing performance, and for supporting and facilitating organisational learning and change'.

While definitions of management control have evolved, the central question has remained the same: how can management control practices be developed to help ensure that an organisation achieves its objectives? For clarity, in this study, the term 'management control practice' is used to describe devices that organisations use to ensure that individuals work to achieve the organisation's strategic objectives, while the term 'management control system' is used as suggested by Merchant and Van der Stede (2011) to refer to the portfolio of management control practices that may be used by an organisation to this end. It is important to recognise that management control practices come in many different forms, from simple operating procedures to more elaborate performance evaluation processes. Researchers have categorised these management control practices in a variety of ways. The next section will discuss this work.

2.1.2 Management Control Typologies

The forms through which management control manifests itself in organisations have been classified in a variety of ways. For example, Hopwood (1974a) categorised control as administrative controls, social controls and self-controls. Administrative controls denote the formal rules and standard procedures used to regulate the behaviour of individuals within the organisation. This type of management control focuses on the output resulting from the behaviour rather than the behaviour itself. In contrast, social controls develop informally in order to regulate individuals' behaviour. In other words, by establishing social relationships with colleagues, individuals may become socialised into accepting the dominant norms and values within their social network. Finally, self-controls refer to those rules that are internalised whereby individuals will typically behave according to the established norm. However, Ouchi (1979) categorises management controls into behavioural controls and output controls. Behavioural controls refer to personnel surveillance and direct supervision that monitors individuals' activities. Output controls, then, denote the monitoring of output results through written records. In his study of a supply division, Ouchi (1980) identifies three types of management control mechanisms: market mechanisms, bureaucratic mechanisms and clan mechanisms. Market mechanisms regulate control through their ability to precisely measure and reward individual contributions. Bureaucratic mechanisms rely upon a mixture of close evaluation with a socialised acceptance of a common objective.

Ouchi (1980) describes clan mechanisms as relying upon a relatively complete socialisation process that effectively eliminates goal incongruence between individuals. Similarly, Macintosh (1994) categorises management controls into five categories: bureaucratic, charismatic, market, tradition and collegial. Bureaucratic controls emphasise hierarchy,

procedures, rules and record-keeping and are suitable to situations characterised by certainty and no ambiguity. Conversely, charismatic controls are appropriate where objectives are unambiguous but the means by which they are to be achieved are uncertain. Typically, charismatic controls are associated with revolutionary change and it has been suggested that a fundamental element of this type of control is the importance of a charismatic leader. Market controls are characterised as acting as the disciplinary glove on the invisible hand through the organisation's performance in the market. Control by tradition suggests that beliefs, rights and norms are handed down and generally followed in the interests of the greater good. Finally, collegial controls relate to specific groups possessing privileged authority (e.g. clinicians) where the administrators are themselves subject to this control.

Merchant (1985) and Merchant and Van der Stede (2011) distinguish between result, action, personnel and cultural controls. Result controls involve defining the output that individuals are expected to deliver that influence the actions taken, as they cause them to be concerned about the consequences of such actions. Action controls evaluate the means taken to achieve the objective as opposed to the result in itself. In this way, action controls prohibit undesirable behaviour (behavioural constraint), derive desired behaviour from plans (pre-action review) and monitor behaviour directly by observation or formal controls (action accountability). Personnel controls are primarily constructed so that individuals will design the desired task satisfactorily on their own, in contrast with cultural controls which shape organisational norms. Cultural controls take into account recruitment, training and promotion of norms to reinforce individual self-control. This typology is used in Section 3.2 to discuss the operation of management control practices in the context of the hospital sector.

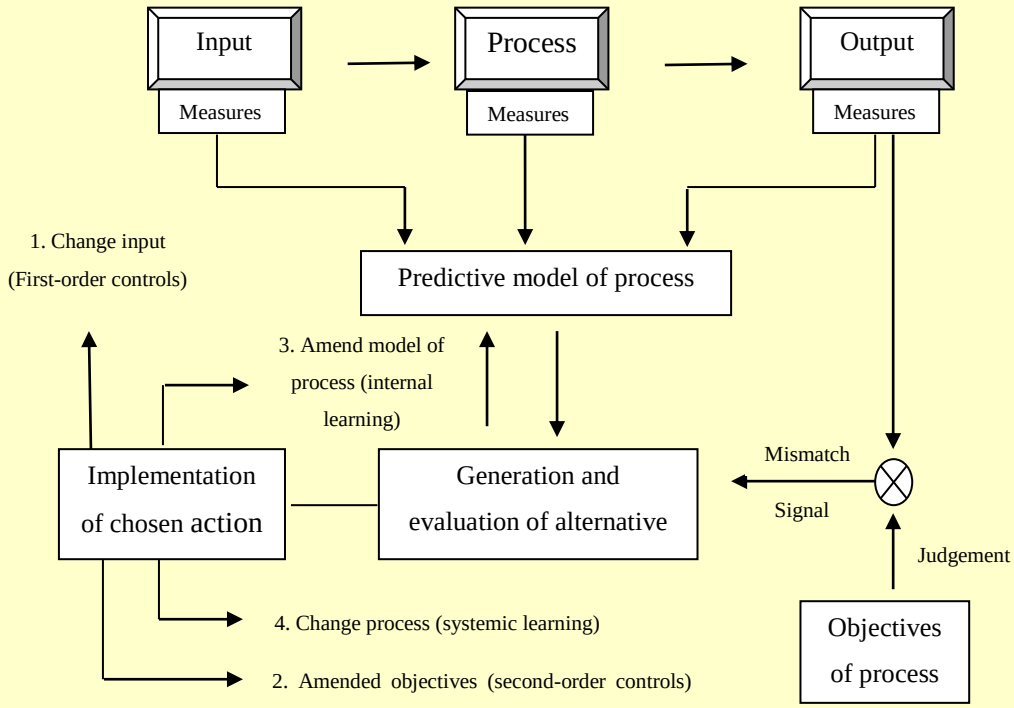
This exploration of management control typologies indicates the broad range of management control practices that may be employed to ensure that management control is achieved. Moreover, many of the classifications have strong similarities and different management control typologies are often discussed synonymously (Malmi and Brown, 2008). Consequently, management control frameworks have been developed to facilitate the study of management control practices. These will be examined in the following section.

2.1.3 Management Control Frameworks

Given the breadth and complexity of issues emerging in the area of management control, researchers have developed frameworks to give greater clarity to the study of management control practices. Drawing on the work of cyberneticians, Otley and Berry (1980) have identified four essential criteria that must exist for a process to be deemed under control: (1)

the system must have an objective; (2) it must be possible to measure results in relation to that objective; (3) the system must have a predictive model; and (4) a number of alternative actions must be available for selection. Figure 2.1 presents the four required conditions for control in Otley and Berry's (1980) cybernetic control framework.

Figure 2.1: Cybernetic Control Framework



Source: Otley and Berry (1980, p. 236)

This cybernetic model incorporates both feedback and feed-forward control. Feedback control involves detecting deviations or errors in actual outcomes, compared with planned outcomes, and instigating any required corrective action as a result, while feed-forward control involves detecting deviations or errors in predicted outcomes, compared with planned outcomes, and similarly implementing any corrective action deemed necessary to achieve the planned outcome (Otley and Berry, 1980). Thus, feedback control is retrospective while feed-forward control is prospective in nature.

Otley and Berry (1980) argue that their framework contains the essential building blocks of a traditional management control system; that is, the setting of objectives, the preparation of budgets, performance measurement, feedback and feed-forward regulation mechanisms, the calculation of variances and the consideration of alternative courses of action. However, they also recognise the limitations of this framework and cite four main drawbacks in this regard: (i) objectives are difficult to define and not easily reconciled between varying groups within

an organisation; (ii) predictive management control practices are often imprecise and inaccurate and there are usually several conflicting predictive control models within a given management control system; (iii) identifying an appropriate measure with which to compare actual results and desired objectives is a complex decision and may lead to organisational conflict as it will may not always be considered appropriate for such measures to be financial in nature; and (iv) for a control system to be effective individuals must be persuaded to implement the required actions. These challenges are indicative of an overarching issue in designing control practices, namely, individuals are themselves self-controlling systems and, therefore, may react in ways that are difficult to predict. Yet, despite these limitations, this framework represents a significant step forward in relation to the management control concepts proposed by Anthony (1965). In particular, it facilitates a holistic approach to management control, which relates strategic objectives to day-to-day operational processes and continuously revisits each stage of the process as events develop.

A further framework that merits discussion is the Levers of Control framework developed by Simons (1995). This framework was inductively derived from case studies and related discussions with individuals at a senior management level. According to Simons (1995), there are four key types of control, termed levers, and senior individuals must make explicit decisions about the relative appropriateness of each. The four types of control identified in the framework are: belief systems, boundary systems, interactive controls and diagnostic controls. Belief systems set the core values and contribute to the overall culture and ethos of an organisation. They instil in an individual the central aspirations of an organisation in terms of the values it aspires to create. To achieve this, they may operate through devices such as mission statements and overall corporate policies. Boundary systems involve the setting of limits and rules which employees are then discouraged from exceeding or infringing. Simons (1995) describes belief and boundary systems as the 'yin and yang' of organisational control. In his view, beliefs are warm, positive and inspirational in nature but are controlled by the dark, cold constraints of boundary systems. Diagnostic control is manifest in the processes of variance accounting or management by exception that are typically implemented by senior management to track the progress of individuals, departments or units by measuring their performance against pre-defined targets. In contrast, interactive control is manifest by organisational learning and the process of developing new ideas and strategies. Interactive control is used to distinguish strategic failure from inadequate strategic implementation. In this regard, interactive controls are intended to give early warnings that a given strategy is no longer appropriate to a given situation and hence needs revision.

Empirical research has tended to focus on the interactive and diagnostic elements of the Levers of Control framework and the use of specific management control practices. For example, Tuomela (2005) found that the 'Balanced Scorecard' (BSC) can be used both diagnostically and interactively. Notably, he concludes that context is very important as his study found that resistance to change developed as new information made actions more visible, power structures shifted and workload increased. Similarly, in their case study organisation, Abernethy and Brownell (1999) found that budget control practices were used both diagnostically and interactively. Abernethy and Brownell's (1999) study, using data collection from CEOs in 63 public hospitals, also showed that an interactive style of budget use can mitigate the disruptive performance effects of the strategic change process. Subsequently, Henri (2006) has explored the differences in impact between using management control practices interactively and diagnostically. This study found that the diagnostic use of management controls had a negative effect on strategic capabilities (i.e. market orientation, entrepreneurship, innovativeness and organisational learning) and that interactive use had a positive effect. In addition, Bisbe and Otley (2004) examined the relationship between the interactive use of management control practices and innovation and found that the direction of the relationship was contingent upon the level of innovation in the organisation. For high-innovation organisations, the interactive use of management control practices was negatively associated with innovation, while in low-innovation organisations the analysis suggested the opposite direction of relationship. Research has also explored the belief and boundary elements of the Levers of Control framework. In this regard, Collier (2005) found that informal controls such as group norms, socialisation and culture were more important than formal controls. Furthermore, Widener (2007) found evidence of interdependence and complementarity between all four levers of control and hence argues that the full benefit of management control arises when they are used both diagnostically and interactively.

Empirical research has identified a number of strengths and weaknesses associated with the Levers of Control framework. In terms of strengths, Langfield-Smith (2008, p. 220) asserts that the framework provides a complex conceptualisation of 'the use of management control practices to manage behaviour and effect strategic change'. Moreover, Ferreira and Otley (2009) contend that the Levers of Control framework is useful in offering a broad perspective of management control by taking account of the range of controls employed and how they are used by various organisations. However, with regard to its weaknesses, Collier (2005) maintains that, while the framework attempts to include informal groups, the

conceptualisation of belief systems does not encompass other informal controls such as group norms, socialisation and culture. A further limitation noted is that the framework is strongly focused on the top level of management and is difficult to translate at lower hierarchical levels (Ferreira and Otley, 2009).

Otley (1999) sought to ensure that a holistic view of management control practices was preserved and, therefore, proposed the Performance Management framework. It is founded on the premise that good results are likely to be produced by many alternative management control system configurations and, hence, studying only one aspect of management control system design at a time will tend to introduce statistical noise into the results. For example, Otley (1999) argues that the light use of one control practice (e.g. budget control) may be counterbalanced by the heavy use of an alternative control practice (e.g. the Balanced Scorecard) and vice versa. Therefore, he suggests that it is only when the overall management control system is considered that meaningful connections between the use of management control practices and the overall results can emerge. The Performance Management framework is based around five central questions:

i. What are the key objectives that are central to the organisation's overall future success and how can it evaluate its achievement of each of these objectives?
ii. What strategies and plans have the organisation adopted, what are the processes and activities that it will require to successfully implement these and how will it assess and measure the performance of these activities?
iii. What level of performance does the organisation need to achieve in each of the areas defined in questions (i) and (ii) and how will it set appropriate performance targets for them?
iv. What rewards will individuals (and other employees) gain by achieving these performance targets or, conversely, what penalties will they suffer by failing to achieve them?
v. What are the information flows (feedback and feed-forward loops) that are necessary to enable the organisation to learn from its experience and to adapt its current behaviour in the light of that experience? (Otley, 1999, p. 366)

Otley (1999) applies this framework in discussing three major management control practices - budget control, the Balanced Scorecard and economic value added - to demonstrate how each practice takes different approaches to each of the five main areas. A number of key strengths of the Performance Management framework have been highlighted. In particular,

the framework has been commended for the breadth of management control issues it encompasses and for its integrated nature (Stringer, 2007). Furthermore, it has been found to be straightforward in its application and the areas it addresses are considered meaningful at different levels of management (Ferreira and Otley, 2009). However, a number of weaknesses have also been highlighted. For instance, the Performance Management framework has been criticised for its failure to consider the roles of vision and mission in management control given that this issue was deemed a key element in Simons' (1995) Levers of Control framework. An additional criticism made is that it fails to recognise the importance of management control use, despite the importance given to this factor in the literature (Hopwood, 1974; Otley, 1978; Simons, 1995). Finally, it has been noted that the interconnections between the different management control practices have not been explicitly addressed in the framework (Malmi and Granlund, 2009; Stringer, 2007).

A subsequent model was proposed in the Performance Management and Control framework developed by Ferreira and Otley (2009). Drawing from a further set of case study data, this framework was intended to refine the insights of Otley (1999) and Simons (1995) to produce a more developed framework. For this purpose, they expanded the original five questions proposed to 12, eight of which related to the management of the objectives and the means by which this would be done. The other four questions relate to the underlying issues that influence the operation of management control practices. Based on a range of findings in the literature, Ferreira and Otley (2009) propose that variables relating to external environment, strategy, culture, organisational structure, size, technology and ownership structure all influence the operation of a management control system. Through these factors, the framework is designed to provide a broad view of the key aspects of management control practices and to form the basis upon which further investigation can be developed (Ferreira and Otley, 2009). Ferreira and Otley (2009) contend that the 12 questions proposed constitute a heuristic tool to facilitate the rapid description of significant aspects of management control system development. The 12-question Performance Management and Control framework is outlined below:

1. What is the vision and mission of the organization and how is this brought to the attention of managers and employees? What mechanisms, processes, and networks are used to convey the organisation's overarching purposes and objectives to its members?

2. What are the key factors that are believed to be central to the organisation's overall future success and how are they brought to the attention of managers and employees?
3. What is the organisation structure and what impact does it have on the design and use of performance management systems (PMSs)? How does it influence and how is it influenced by the strategic management process?
4. What strategies and plans has the organisation adopted and what are the processes and activities that it has decided will be required for it to ensure its success?
5. How are strategies and plans adapted, generated and communicated to managers and employees?
6. What are the organisation's key performance measures deriving from its objectives, key success factors, and strategies and plans? How are these specified and communicated and what role do they play in performance evaluation? Are there significant omissions?
7. What level of performance does the organisation need to achieve for each of its key performance measures (identified in the above question), how does it go about setting appropriate performance targets for them, and how challenging are those performance targets?
8. What processes, if any, does the organisation follow for evaluating individual, group, and organizational performance? Are performance evaluations primarily objective, subjective or mixed and how important are formal and informal information and controls in these processes?
9. What rewards financial and/or nonfinancial will managers and other employees gain by achieving performance targets or other assessed aspects of performance (or, conversely, what penalties will they suffer by failing to achieve them)?
10. What specific information flows feedback and feedforward, systems and networks has the organisation in place to support the operation of its PMSs?
11. What type of use is made of information and of the various control mechanisms in place? Can these uses be characterised in terms of various typologies in the literature? How do controls and their uses differ at different hierarchical levels?
12. How have the PMSs altered in the light of the change dynamics of the organisation and its environment? Have the changes in PMSs design or use been made in a proactive or reactive manner. How strong and coherent are the links between the components of PMSs and the ways in which they are used.

The Performance Management and Control framework (or earlier versions of it) has been used by Silva and Ferreira (2010), Stringer (2007) and Tuomela (2005) to structure case findings. Certain criticisms of the framework should be noted. Malmi and Granlund (2009) point out that it offers little guidance on the interconnections between the questions. In addition, Collier (2005) highlights the need to understand the antecedents, background and organisational context of the design of a management control system. The concern arising is that management control research may remain focused on the formal system design, rather than the system in use. Berry *et al*, (2009) argue that many of these criticisms could be overcome by using an in-depth and longitudinal field study approach, so that a range of control issues are able to emerge.

Broadbent and Laughlin (2009) have built on and extended the framework of Ferreira and Otley (2009) by focusing on the contextual factors that influence the nature of a management control system. Their conceptual Performance Management framework highlights the key role played by alternative models of rationality that allow any management control practice to be described conceptually and empirically as either 'relational' or 'transactional'. They argue that a relational management control practice is driven by the exercise of communicative rationality between stakeholders to debate and arrive at a consensus on the objectives to achieve. This has led to the discursively agreed definition of performance indicators based on substantive rationality which could, if discursively agreed, accommodate quantitative measures to typify performance indicators but more often employs qualitative indicators, with which stakeholders are more comfortable. It also relies on transactional rationality in the choice of means to achieve those objectives, performance indicators and targets. Thus, the key characteristic of this management control practice is that stakeholders have 'ownership' of it, which drives action in an organisation working under a reflexive authority structure. A transactional management control practice is driven by instrumental rationality to define objectives, which take on the characteristics of being highly functional and directed to specific outcomes. In this context, 'ownership' is associated with either a particular sub-group of stakeholders, or is linked to an abstract requirement that appears not to be owned by anyone. Performance indicators are defined through formal rationality, which tends to be more associated with precise and quantitative forms of measurement. Implicit in a transactional management control practice is a reliance on legal-rational authority structures to ensure compliance. Broadbent and Laughlin (2009) argue that this typecasting facilitates a better understanding of empirical situations, as well as providing a means of evaluating any management control practice by raising alternatives for comparison.

2.1.4 Management Control Outcomes

The development of management control practices is believed to result in a wide range of improved organisational outcomes; however, providing a definition of a successful management control practice is complex. Zimmerman (1997, 2001) conceptualises the development of management control practices as purposive and argues that it produces two distinct outcomes: (i) improved decision-making and (ii) improved control. Improved decision-making is achieved by providing information to reduce ex-ante uncertainty. This enables decision-makers to improve their selection of actions by facilitating better informed effort (Kren and Liao, 1988). Improved control outcomes stem from the assumption that individuals act in their own best interest rather than that of their organisation. Management control practices are, therefore, developed by management to increase the probability that individuals will behave in a manner that will enable organisational goals to be achieved efficiently and effectively (Flamholtz, *et al*, 1985). Management control practices are designed to serve this purpose by providing information ex-post about the action decisions made by subordinates. This information is then used to change subordinate behaviour by influencing the actions taken so that organisational outcomes can be effectively achieved. Management control practices are thus deemed to have achieved positive organisational outcomes if they are likely to be used and to satisfy individuals, who then can approach their tasks with enhanced information. As a consequence, individuals make better decisions and achieve organisational goals more successfully.

However, organisational outcomes are not easily measured and studies have concentrated on different functional and dysfunctional outcomes of management control practices. Researchers have assessed the effects of management control practice on functional outcomes such as job satisfaction (Aranya, 1990), performance (Brownell and Dunk, 1991), and motivation (Kenis, 1979). Chenhall (2003) categorises management control outcomes into issues related to the usefulness of management control systems, behavioural outcomes and organisational outcomes and argues that there is an implied connection between these outcomes. However, Chenhall (2003, p. 136) also contends that there are 'clear leaps in logic' made between useful management control practices and enhanced organisational performance and that the usefulness of a management control practice will depend on the appropriateness of the practice to the context of the organisation. Furthermore, Chenhall (2003) suggests that achieving the goals of the organisation and achieving the operative goals may not necessarily be the same. In other words, attempting to align strategy with operations by translating official goals into operative goals, which cascade down the

organisational hierarchy, is a challenge that has largely been ignored by the literature. He also refers to the issue of complexity of goal formulation, including the difficulty of measuring particular goals, which may result in goals that are easier to measure becoming dominant. Finally, Chenhall (2003) identifies the difficulty of satisfying the multiple and competing goals that may be imposed on the organisation by external and internal stakeholders.

The dysfunctional outcomes associated with management control practices were first identified in an influential study by Argyris (1952) of factory supervisors in four production organisations. The study demonstrates that budgeting induces behavioural and organisational side effects that could be regarded as dysfunctional from a management control perspective, with dysfunctional referring to outcomes that are not in the organisation's best interest. The supervisors in this study perceived budgets as sources of pressure and tension, forcing them to narrow the focus of their attention strictly to problems of their own departments. He reported that subordinate feelings around budget pressure derived from three main factors: the propensity of superiors to emphasise the need to meet the budget (budget emphasis); the raising of budget standards to a more challenging level once they are met; and the inflexible nature of the budget documents, which failed to disclose the real reasons for the budget variances. Consequently, the supervisors expressed negative attitudes towards their superiors and towards budget procedures, which in turn caused dysfunctional side effects such as absenteeism and interpersonal conflict.

Argyris (1952) also suggests that dysfunctional side effects may be viewed as individual defensive routines, meaning that individuals activate a human theory of control to deal with embarrassment or threat and engage in responses he terms 'individual defensiveness'. Such actions, in turn, lead to the creation of organisational defensive routines, which Argyris (1952, p. 505) describes as 'any routine policies or actions that are intended to circumvent the experience of embarrassment or threat by bypassing the situations that may trigger these responses'. He suggests that the best way to overcome organisational defensive routines is to design management control practices that individuals agree are likely to be achieved, thereby signalling budget participation as a means of addressing the harmful outcomes associated with budget control. Finally, Argyris (1952) indicates that economic conditions will influence budget emphasis. His study found that budget personnel acknowledged that when economic conditions were poor, budget pressure increased. Argyris' (1952) study remains important for two primary reasons: firstly, it demonstrates the need to complement technical budgeting with knowledge of human behaviour; secondly, it suggests that

dysfunctional behaviour is not just a natural human tendency, creating a need for control practices, but that it could in fact be provoked by the use of management control practices. This study was, therefore, an important milestone in management control research, which has sought to examine the outcomes associated with the operation of management control practices. Furthermore, Argyris (1952) provides a broad foundation, and, indeed, motivation for future studies (Briers and Hirst, 1990). Much of the subsequent research is discussed in the following sections.

2.1.5 Summary

This section introduced the domain of management control and outlined the various definitions proposed by researchers relating to it. It also discussed typologies or categorisations that have been used to structure the field. The management control frameworks described represent the progression of thought in management control theory. These frameworks have been suggested as particularly suitable research tools for examining the operation of management control practices in a holistic manner (Ferreira and Otley, 2009). Finally, the evaluation of management control practice outcomes in terms of functional and dysfunctional side effects was introduced.

2.2 Management Control - Empirical Research

2.2.0 Introduction

The purpose of this section is to provide a review of the management control literature, which has highlighted the many difficulties and challenges associated with the operation of management control practices.

2.2.1 Management Control Issues

2.2.1.1 Budget Control

Budgeting has long been viewed as an integral part of management control and proponents of budget control argue that it provides a mechanism to weave together the many disparate threads of an organisation into a comprehensive plan (Hansen, Otley and Van der Stede, 2003). Groot and Selto (2009) describe budget control as the practice of developing the financial and non-financial aspects of future plans of action by management. Budgeting is purported to support planning by compelling an organisation to make decisions about the level of resources available for the planning period and the allocation of resources to different parts of the organisation. Furthermore, budgeting supports operational planning by helping to anticipate potential problems and to prepare solutions to resolve them. The budget

also fulfils management control purposes by specifying objectives, targets and processes with the aim of creating a better understanding of, and adherence to, organisational control, which helps budget holders in the coordination of their activities with other related organisational entities (discussed in Section 2.2.1.3). In addition, as the budget period progresses, budgets are used as the basis of performance evaluation. For example, variance analysis compares actual performance with planned performance for the purposes of understanding the magnitude and causes of the differences between them and the related costs and revenues. The variance analysis can then be used for learning, taking corrective actions, performance assessment and reward decisions (discussed in Section 2.2.1.2). Consequently, in theory, the budget process should proceed logically through a series of sequential stages. Nonetheless, the empirical literature has recognised the difficulties associated with fulfilling the multiple functions of budgets and a discussion of the main issues influencing the operation of the budget control process will be provided in the following subsections.

2.2.1.2 Accountability and Controllability

Budget control practices are implemented in order to hold individuals (or sometimes groups of individuals) accountable either for their actions or for the results produced by them or by their organisations. Being held accountable means that individuals are rewarded when performance is favourable to the organisation and punished where it is unfavourable. Merchant and Otley (2007) recommend that, in an accountability-oriented budget control practice, individuals whose behaviour is being controlled should be informed of what is expected of them prior to the performance period and an appropriate determination of target difficulty and level of required participation should be taken into consideration (further discussion in Sections 2.2.1.3 and 2.2.1.4 respectively). After the performance period has ended, superiors should monitor the performance reports of the activities for which the individuals were being held accountable and should reward good performance and penalise bad performance. In this way, the rewards and penalties, or punishments, associated with a management control practice are frequently suggested to be an important means for motivating and improving the performance of individuals.

Rewards include factors valued by individuals and thus may come in many forms. For example, extrinsic rewards include salary increases, bonuses, promotions, praise and public recognition, while intrinsic rewards stem from an individual's inner feelings, such as satisfaction and accomplishment. Punishments also come in multiple forms, including

criticism, loss of autonomy, the absence of rewards received by others (e.g. salary increases) and, in extreme cases, loss of the individual's job. The relationship between rewards, motivation and performance has been demonstrated to be complex; however, there is agreement that the primary reason for organisations' use of reward systems is to ensure that their employees' efforts are channelled into activities that facilitate the achievement of organisational objectives (Flamholtz *et al,* 1985). Bonner and Sprinkle (2002) assert that monetary incentives increase effort and performance by focusing individuals' efforts on a particular relevant task. Furthermore, they argue that the linking of effort with a task impacts on performance in three ways: (i) through effort direction, in terms of the tasks on which individuals focus; (ii) effort duration, referring to the length of time devoted by individuals to the task; and (iii) effort intensity, meaning the amount of attention individuals devote to the task. Research also suggests that extrinsic rewards and punishments only produce temporary compliance and that intrinsic rewards are more powerful and enduring (Deci, Koestner and Ryan, 1999). Nevertheless, the vast majority of organisations have implemented some form of reward system, which suggests that intrinsic rewards alone do not typically produce adequate motivation (Merchant and Van der Stede, 2011).

The controllability principle is also regarded as one of the strongest aspects of a budget control practice and is considered to be directly relevant to evaluations of individuals' performance. Most commonly discussed as a normative principle, the controllability principle stipulates that individuals should only be evaluated based on factors within their control (Merchant and Otley, 2006; Merchant and Van der Stede, 2011). Therefore, if uncontrollable factors, such as unforeseen changes in the environment or decisions taken by others in the organisation, affect individuals' results, the controllability principle implies that the impact of these factors should be nullified in the performance evaluation of the individuals concerned. According to Merchant, Van der Stede and Zheng (2003), this nullification process may take two forms. It may occur ex ante, whereby performance measures are selected that exclude items that individuals cannot control. Alternatively, it may occur ex post, whereby adjustments are made to remove the impact that unforeseen uncontrollable factors may have had on individuals' performance. Two main arguments are proposed by Merchant *et al,* (2003) in support of the utility of applying the controllability principle by an organisation. Firstly, it provides a reliable assessment of managerial performance. Since the profits of a division are the result both of its manager's efforts and of uncontrollable factors, this factor may not be considered a good surrogate for effort unless the impact of uncontrollable factors is neutralised (Choudhury, 1986). Secondly, the controllability principle helps organisations influence the behaviour of individuals because it

is intrinsically linked to the idea of equity and fairness, which is deemed a fundamental condition underpinning the effectiveness of a performance appraisal (Ittner and Larcker, 2001).

Prior literature suggests that non-application of the controllability principle leads to decreased motivation and increased role stress, which results in dysfunctional behaviour among individuals (Dent, 1987; Merchant, 1989). Dysfunctional outcomes emerge mainly in the form of manipulation of data as described by Merchant (1989) and Jaworski and Young (1992). Merchant (1990) reports that when individuals feel that a management control practice is unfair, they may engage in behaviour to protect themselves that is harmful to the organisation, such as manipulating data or creating budget slack. Birnberg, Turopolec and Young (1983) divide dysfunctional behaviour into six broad categories, namely 'smoothing', 'biasing', 'focusing', 'gaming', 'filtering' and 'illegal acts of falsification'. More recently, Jaworski and Young (1992) have classified dysfunctional behaviour into two categories: gaming and information manipulation. Gaming refers to choosing 'an action which will achieve the most favourable personal outcome regardless of the action the superior prefers' while information manipulation refers to 'subordinates altering the free flow of information, reporting only those aspects of an information set that is in their best interest or, in the extreme, falsify data and company records' (Jaworski and Young, 1992, p. 18). Merchant (1989) also argues that applying the controllability principle can prevent the organisation form adopting an 'excuse culture' whereby individuals spend their time trying to convince superiors that their performance stems from uncontrollable factors rather than their own freely chosen actions.

Despite the theoretical arguments supporting it, empirical studies indicate that the controllability principle is not always strictly applied (Dent, 1987; Drury and El-Shishini, 2005; Merchant, 1989). Individuals are frequently expected to achieve financial objectives that incorporate, to varying degrees, factors outside their control, while year-end adjustments for the effects of uncontrollable factors in performance assessment reviews are often only partially applied (Merchant, 1989). Furthermore, it must be acknowledged that uncontrollable factors are not always easy to evaluate. For example, Giraud, Langevin and Mendoza (2008) differentiate between three types of uncontrollable factors in their study: horizontal interdependencies (i.e., decisions made by other individuals in the company); vertical or hierarchical interdependencies (i.e., decisions made by superiors); and external factors (i.e., unforeseen changes in the economic and competitive environment, such as natural catastrophes, etc.). The results of their study show a significant difference according

to whether uncontrollable factors are external to the company or internal (interdependencies and hierarchical decisions), with the percentage of individuals wanting the impact of internal factors to be completely neutralised found to be far higher than that for external factors. Burkert, Fischer and Schaffer (2001) investigate whether application of the controllability principle equally affects the role perceptions of top-level and lower-levels individuals. They suggest that top-level individuals cope with uncontrollable factors more effectively. Overall, research has demonstrated that there are considerable impediments to the application of the controllability principle, leading to the conclusion that 'the principle of controllability is more honoured in the breach than its observance' (Marginson and Ogden, 2005, p. 49).

2.2.1.3 Budget Targets

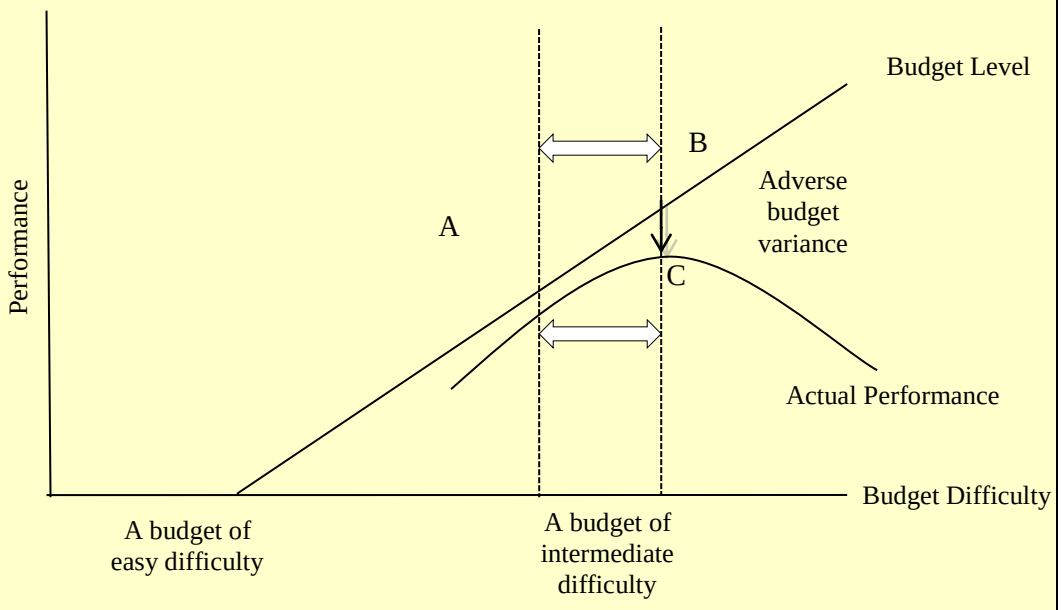
There is a wealth of empirical evidence indicating that the existence of a defined, quantitative goal or target is likely to motivate higher levels of performance than when no such target is stated. In an influential study, Stedry (1960) claim that actual performance was dependent on the point in the budgeting process at which the budget holder's own personal goals or aspiration level were set. Three levels of target difficulty (easy, medium and difficult) were reported. The evidence suggests that, if individuals receive the imposed budget goal before setting their personal aspiration level, their performance will be highest in pursuing the difficult budget goal because they then adopt this goal as their own aspiration level. In contrast, if individuals receive the imposed budget after setting their own aspiration level, then the difficult budget goal does not result in higher performance levels than the medium budget goal. This is because individuals tend to retain the (lower) level of aspiration that they chose initially.

Hofstede (1967), based on an examination of the effects of participative budgeting in relation to budget goal difficulty, propose that budget goal difficulty has a non-linear effect on motivation to achieve the budget. Furthermore, he found that maximum motivation levels occur when budget goal difficulty is moderate (neither very easy nor very difficult). In addition, budget goal difficulty was found to have no effect on job satisfaction, while participation exerted a positive effect on motivation to achieve the budget. However, contemporaneous, Locke (1968) conducted a series of experiments investigating the relationships between targets, motivation and performance and concluded unequivocally that the harder the goal, the higher the performance levels. Emmanuel, Otley and Merchant (1990) suggest that the relationship between budget difficulty and performance may be described as an inverted U-shape, as illustrated in Figure 2.2. They demonstrate that performance was at its highest point (point C) when the budget level of performance resulted

in certain adverse budget variables (B-C). Budget levels below or above this level resulted in lower performance levels.

Hirst (1987) suggest that, where task uncertainty is high, setting budget targets is less effective in promoting task performance than where task uncertainty is low. Shields and Shields (1998) model a direct relationship between three variables (the difficulty or tightness of the standard, participation and standard-based incentives) and job performance, and an indirect relationship using job stress as an intermediated variable between the three variables and job performance. For the direct relationship, the tightness of the standard was modelled as having a positive relationship to performance but, for the indirect relationship, the tightness of the standard was modelled as having a positive effect on job stress, which has a negative effect on job performance, meaning that overall standard tightness has a negative effect on job performance. The results of this study suggest that tighter standards are associated with lower performance.

Figure 2.2: The Effect of Budget Difficulty on Performance



Source: Emmanuel et al, (1990, p 185)

2.2.1.4 Budget Participation

As mentioned above, research has also investigated the role of participation in the budget-setting process. Brownell (1982) defines budget participation as a process through which an individual is involved with, and has influence on, the determination of his or her budget. Participation is sometimes referred to as bottom-up budget setting, whereas a non-

participatory approach, whereby individuals have little influence on the target-setting process, is called top-down budget setting. The importance of budget participation as a means of improving performance has been studied extensively in the literature. As noted above, Stedry's (1960) findings indicate that, for difficult budgets, performance is improved if individuals set their own aspiration levels after, rather than before, the budget is finalised. Therefore, it appears that participation in budgeting may ensure that an individual's mind remains open throughout the budget process, giving them ownership of the budgets they design and leading to improved final results.

Based on goal-setting theory, Locke and Schweiger (1979) claim that budget participation increases budget goal commitment. They argue that the opportunity to engage with and have influence on the budget-setting process increases an individual's feeling of control over and involvement in the budgets produced. This view is consistent with that of Shields and Shields (1998, p. 59), who suggest that 'budget participation increases an individual's trust, sense of control and ego-involvement' with the organisation, which 'leads to less resistance to change and greater acceptance of and commitment to the budget decision'. Shields and Shields (1998) also argue that budget participation provides an opportunity for individuals to gather job-relevant information to facilitate their decision-making. In this regard, Kren (1992) suggests that budget participation provides cognitive benefits that enable subordinates to clarify and comprehend the means by which objectives can be fulfilled. Furthermore, Shields and Shields (1998, p. 58) point to the existence of a positive relationship between budgetary participation and job satisfaction and argue that 'the act of participation allows an individual to experience self-respect and a feeling of equality arising from the opportunity to express his or her values'. Finally, as highlighted by Magner, Welker and Campbell (1996, p. 43), budget participation may result in more realistic plans and more accurate budgets as it 'allows individuals to introduce private information into the budget process, thereby enhancing the budget's quality'. However, empirical evidence supporting the value of participation in budgeting has been inconclusive. While participation has been advocated as a means of giving individuals a greater sense of accountability, it may also lead to budget slack and poor performance. Merchant (1990, p. 301) defines budget slack as 'the excess of the amount budgeted in an area over that which is necessary'. In contrast, Lukka (1988, p. 282) states that a budget with slack is one in which the 'figure had been intentionally made easier to achieve in relation to the forecast.' According to Schiff and Lewin (1970), individuals create slack in budgets through a process of understating revenues and overstating costs. Although the amount of slack varies over time and between companies, Schiff and Lewin (1970) indicate

that it might account for as much as 20-25 per cent of a division's budgeted operating expenses.

To address the conflicting results, research has concentrated on studying factors that influence the effectiveness of participation. Hopwood (1974a, p. 6) identifies the importance of task characteristics in determining the appropriateness of participation and argues that 'in highly programmed, environmentally and technologically constrained areas, where speed and detailed control are essential for efficiency' participative approaches may have much less to offer. In contrast, in areas where flexibility, innovation and the capacity to deal with unanticipated problems are important, participation in decision-making is of greater value and may confer an immediate benefit. The personalities of the participants in the budget process have also been suggested to exert significant influence on whether participation leads to improved performance. Merchant (1985) found that authoritarian individuals are unaffected by participative approaches while high participation is effective for individuals with a high need for independence. Studies have also explored the impact of environmental uncertainty on the efficiency of participation. For example, Mai (1989) found that level of participation should be commensurate with level of job difficulty. This study shows that participation was effective when both job difficulty and environmental uncertainty were high but that high participation was ineffective when job difficulty was low. These findings suggest that the level of participation required to derive the maximum value from budgeting should be adjusted to the circumstances of the budget holder's environment. The behavioural implications of budget participation will be examined further in Section 2.3.3.

2.2.1.5 Perceived Usefulness & Relevance

The importance of user perceptions of management control system design has been well recognised in the management control literature (Pierce and O'Dea, 2003). Prior studies have discussed four main attributes of management control practice design: scope, timeliness, level of aggregation and information that assists with integration (Chenhall and Morris, 1986; Bouwens and Abernethy, 2000). The scope of a management control practice refers to its dimension of focus, quantification and time horizon (Chenhall and Morris, 1986; Gordon and Narayanan, 1984). A traditional budget control practice provides information that focuses on events within an organisation and will be quantified in monetary terms, relating to monetary data. In contrast, a broad scope management control practice will provide information related to the external environment and other non-monetary factors. Broad scope information has long been recognised as being of value to individuals involved in decision-making (Gordon and Narayanan, 1984; Larcker, 1981; Hayes, 1977). However, an important

finding is that the value of broad-scope information can differ significantly between functional areas. Mia and Chenhall (1994) reported the perceptions of marketing individuals that showed significantly higher levels of uncertainty than those of production individuals and conclude that 'the beneficial effect on managerial performance of using broad scope MAS information is moderated by differentiation of activities in ways that isolate uncertainty within particular functions' (p. 10). Their study shows that a higher usage of broad scope information is associated with enhanced performance for marketing activities but not for production. In a related study, Pierce and O'Dea (2003) investigated the perceptions of the usefulness of management accounting information in 12 manufacturing organisations in Ireland. The findings demonstrate that individuals anticipate less need for management accounting information unless it becomes broader in scope and more flexible, timely and user-friendly. In addition, a high degree of consistency was found in the perceived deficiencies of current information, regardless of whether comments related to relatively new systems such as Activity-Based Costing (ABC) or more traditional areas such as budgeting. In contrast, Bouwens and Abernethy's (2000) study, which examined linkages between strategic choice, interdependence and management control design, revealed that the scope dimension is not important for operational decision-making, which was contrary to their general expectation and findings of earlier research (e.g. Abernethy and Guthrie, 1994). In addition, their analysis revealed only minor differences in management control use between production and sales individuals. The issue of timeliness was the only area where a significant difference was found.

Timeliness is specified in terms of the provision of information on request and the frequency of reporting systematically collected information (Kaplan and Cooper, 1998; Pierce and O'Dea, 2003). It has been suggested that timely information enhances the facility of a management control practice to report upon the most recent events and to provide rapid feedback on decisions. Chenhall and Morris (1986) indicate that perceived environmental uncertainty influences the perceived usefulness of timely information. They contend that, in uncertain situations, individuals are likely to find that the need to respond rapidly to unpredictable events changes and, as a consequence, timely information is perceived as becoming particularly significant. Hilton (1979) modelled the value of management control information in a cost-volume-profit decision setting and found that the more timely information, the greater the perceived value. For example, it was suggested that if information is reported monthly rather than quarterly, individuals can address concerns that arise between quarters, rather than waiting until the end of the quarter.

The third characteristic, aggregation, refers to the level and type of information provided by the management control practice in terms of its ability to supply data about cost objects that vary in size from entire divisions to individual products, components and services. Prior studies generally contend that the ability to provide sufficient detail and flexibility to allow information to be analysed for different purposes is perceived as useful (Karmarker, Lederer and Zimmerman, 1990; Shank and Govindarajan, 1993). Chenhall and Morris (1986) propose that that management control practices that can isolate the effects of specific events on different functions are of greater use to individuals in uncertain environments. Feltham's (1977) study supports these assertions in finding that the expected benefits from decisions based upon more detailed information is generally greater than from decisions based on more aggregated information. Within a healthcare context, Comerford and Abernethy's (1999) findings suggest that, unless budget control practices can identify and aggregate costs for cost-relevant objects (i.e. patients, devices etc.) with reasonable accuracy, managers will not be able to make informed decisions on these issues. In a recent study, Pizzini (2006) examines the association between the type of budget control information provided, an individual's beliefs about the usefulness of budget data and actual financial performance. Four attributes of budget control design were analysed: the level of detail provided, the ability to disaggregate costs according to behaviour, the frequency with which information was provided and the extent to which variances were calculated. Using data from a sample of 277 hospitals, the results indicate that individuals' evaluations of the relevance and usefulness of cost data are positively correlated with the extent to which budget control practices provide greater cost detail, better classify costs according to behaviour and report cost information more frequently. However, only the ability to supply cost detail was favourably associated with measures of financial performance.

A final important aspect of management control practice design relates to the coordination of various segments within an organisation. Integration refers to the ability of a management control practice to manage the interrelationship between segment activities. Chenhall and Morris (1986) contend that integrative information will be perceived as useful by individuals in decentralised organisations and by individuals operating in situations of high organisational interdependence.

2.2.1.6 Non-Financial Performance Measures

It has been suggested that budget control practices have lost relevance in light of the changing business environment (Johnson and Kaplan, 1991). In response, non-financial based management control practices, commonly referred to as Balanced Scorecards have

been developed as a means of providing a balanced presentation of both financial and operational performance (Kaplan and Norton, 1996). Empirical research examining the Balanced Scorecard (BSC) has investigated the cause-effect relationship upon which this management control practice is premised. For example, Norreklit (2000) explored the existence of a cause-effect relationship between the four perspectives and argued that it did not hold and that it was not always true that increased customer loyalty was the cause of long-term financial performance. Bukh and Malmi (2005) also examine this issue and argue that, if establishing significant correlations between measures and causal chains were immediately obvious and easy, the need for strategy or even management would diminish. Empirical research is also somewhat unclear on the benefits of using the cause and effect characteristic in BSC design. Malina and Selto (2001), Malmi (2001) and Ittner, Larcker and Randall (2003) all provide evidence that organisations acknowledge the need to develop cause-effect relationships between each of the four perspectives but also report that few organisations could demonstrate such a relationship following implementation. Furthermore, in their study investigating how the BSC has been used, Ittner *et al*, (2003) find that it is often used differently from how it was intended and, in particular, that future-oriented performance measures are often ignored, while financial measures are emphasised. Epstein and Manzoni (1998) question the ability of organisations to agree on a strategy in the clear terms necessary to enable construction of a BSC. They also contend that developing and maintaining it is laborious and requires high levels of top-management support for its successful development. Lau and Moser (2008) investigated the behavioural responses of individuals to the use of non-financial performance measures contained in the BSC. Based on a sample of 149 individuals from the United Kingdom, the results indicate that the use of non-financial performance measures was perceived as procedurally fair.

Empirical studies have also sought to examine the relationship between the BSC and organisational performance. Davis and Albright (2004), in their study of bank branches, found that the organisational units that used the BSC had better financial performance that those that had not implemented it. A study conducted by De Geuser, Mooraj and Oyon (2009) demonstrates that the BSC has a positive impact on organisational performance. More specifically, the BSC was shown to improve the integration of the management control processes and to empower individuals. However, in contrast, to the Epstein and Manzoni (1999) study, top management support and individual involvement were not found to influence the operation of the BSC.

2.2.2 Summary

This section has demonstrated that the main aim of management control practices is to induce individuals to behave in ways that will lead to the achievement of an organisation's objectives. However, empirical studies have also demonstrated that, where management control practices are used, attention needs to be paid to issues of controllability, accountability, target difficulty, the extent to which individuals are allowed to participate in setting targets and perceptions regarding the relevance and usefulness of management control information. A failure to consider the implications of these issues has been shown to result in harmful side effects.

2.3 Management Control - Contingency Research

2.3.0 Introduction

Since its introduction to the management accounting literature in the late 1970s, a body of contingency literature has developed that relates specific features of management control practices to the particular contexts in which they are found (Fisher, 1995, 1998; Chapman, 1997; Chenhall, 2003). The purpose of this section is to trace the development of contingency theory and discuss its impact on the design and use of management control practices.

2.3.1 The Design of Management Control Practices

Contingency-based management accounting research is founded on the premise that there is no universally appropriate management control system applying equally to all organisations in all circumstances (Emmanuel *et al*, 1990). Rather, it suggests that the appropriateness of particular features of a management control system will depend upon the specific circumstances in which an organisation finds itself. Drawing upon earlier developments in organisational theory, contingency-based management control research has identified the most important variables influencing the design of management control practices. The following subsections will provide a review of this work.

2.3.1.1 External Contingency Factors

The main external factors that have been examined at the organisational level in management control research are the external environment (Chapman, 1998; Merchant, 1990; Hartmann, 2000) and national culture (Harrison, 1993, Van der Stede, 2003). With regard to the external environmental, uncertainty and hostility have been the most widely emphasised aspects investigated. Environmental uncertainty relates to the level of change in the

environment that occurs unexpectedly, such as unpredictable shifts in the economy or unexpected changes in customer demand or competitor actions (Chapman, 1998). Contingency studies related to environmental uncertainty have found that a high level of environmental uncertainty affects organisational structure, performance evaluation and budget control practices. For example, Govindarajan (1984) found that organisations that face higher levels of environmental uncertainty use more open and external management control practices whereas organisations facing lower levels of environmental uncertainty use more formula-based approaches to designing management control. Govindarajan (1984) defines a formula-based approach as an evaluation based solely on meeting various required levels of financial performance. Chenhall and Morris (1986) and Gul and Chia (1994) provide evidence to suggest that the greater the perceived level of environmental uncertainty the greater the need for more sophisticated management control practices that have a 'broader scope'. They define 'broad scope' as encompassing information that is external, non-financial and future oriented. Other studies provide evidence that environmental uncertainty is associated with an emphasis on budgets for evaluation as well as a need for high participation and flexible communication among superiors and subordinates (Chapmann, 1998; Ezzamel, 1990; Merchant, 1990). Where the hostility of the external environment has been examined, environmental hostility produced by intensive competition has been found to emphasise formal control and sophisticated accounting (Khandwalla, 1972; Otley, 1978; Merchant, 1984). In contrast, environmental hostility derived only from suppliers and government was associated with a reduced emphasis on budgets (Brownell, 1985). Such empirical ambiguity has led Chenhall (2003, p. 135) to conclude that the question of 'what the appropriate management control practices for an organisation operating in conditions of uncertainty and turbulence are' remains unanswered.

It has been noted that there is a dearth of knowledge in relation to how externally-induced organisational crises, particularly in relation to economic crises, affect the operation of management control practices (Arnold, 2009; Ezzamel and Bourn, 1990; Hartmann, 2000; Hopwood, 2008:2009; Van der Stede 2011: 2015). Hopwood's (2009) discussion of an unpublished study by Olofsson and Svalander in 1975 suggests that the reporting of internal financial information broadens following the occurrence of an external crisis associated with economic downturn. Financial information is subsequently reported in greater detail, more frequently, for more organisational segments and units and both systematically and in an *ad hoc* manner. Furthermore, they argue that the economic and financial aspects of the functioning of the organisation become amplified to the degree that, whereas previously there may have been competing dimensions of visibility (for example, operational data,

human resource information, marketing and competitor analysis), these alternative sources of information become less significant. Ezzamel and Bourn (1990) conducted a single case study of a UK university confronted with problems caused by drops in external financing and found that, in a crisis, its use of management control practices changed, which they characterise as shifting from a reflexive 'answering machine' mode to a more creative 'idea generating machine' approach. However, they conclude that the management control practices involved did not possess the requisite qualities for either effective pro-active or effective responsive crisis management.

2.3.1.2 Organisational Contingency Factors

The most common organisational factors that have been examined in relation to management control are size (Khandwalla, 1972; Bruns and Waterhouse, 1975; Merchant, 1981), structure (Bums and Stalker, 1961; Lawrence, Lorsch and Garrison, 1967), technology (Khandwalla, 1977; Merchant, 1984; Dunk, 1992) and strategy (Miles and Snow, 1978; Gupta and Govindarajan, 1984; Simons, 1987; Chenhall and Morris, 1995). With respect to organisational size, it has been argued that, as organisations become larger, the need for individuals to handle greater quantities of information increases to a point where they need to institute controls, such as rules, documentation, specialisation of roles and functions, extended hierarchies and greater decentralisation to hierarchical structures (Child and Mansfield, 1972). Khandwalla (1972) found that large organisations are more diversified in product lines and employ more mass production techniques and sophisticated controls. Similarly, according to Merchant's study (1981), large companies are more decentralised and use more sophisticated budget control practices in a participative way. Moreover, Innes and Mitchell (1995) demonstrate that the adoption of Activity-Based Costing (ABC) is much greater in larger organisations.

Chenhall (2003) defines organisational structure as 'the formal specification of different roles for organisational members, or tasks or groups, to ensure that the activities of the organisation are carried out'. Research investigating this aspect has focused on both the extent to which management control practices are consistent with organisational structure and the extent to which organisational structure is consistent with environmental uncertainty, technology and strategy (Chenhall, 2003). As a result, Chenhall (2003) suggests that greater insights into the appropriateness of management control practices are likely to be gained from considering the combined effect of structure and other variables. Different researchers have concentrated on different aspects of structure, such as differentiation (the extent to which sub-unit individuals have control over their sub-unit), integration (the extent to which

sub-unit individuals act in ways that are consistent with organisational goals) (*Lawrence et al*, 1967), mechanistic and organic structures (Bruns and Stalker, 1961), and bureaucratic and non-bureaucratic structures (Perrow, 1970). Merchant (1981) found that performance levels are highest in large, diverse, decentralised firms when an administrative approach to budgeting is used, in contrast with smaller firms where the best performance is associated with a more personal approach. Merchant (1984) extended this study to the departmental level and found that size, functional differentiation (more responsibility over areas of manufacturing) and the degree of automation all lead to greater formality in the budgeting process. Bruns and Waterhouse (1975) also found that large decentralised organisations with sophisticated technologies are associated with a strong emphasis on formal management accounting systems. Meanwhile, Gordon and Narayanan (1984) found that organic structures are best served by broad-scope, future-oriented information.

One of the longest-established relationships between a contingent variable and management control practice design relates to production technology. Technological contingency factors include the nature of the production process, its degree of routine, how well means-end relationships are understood and the amount of task variety (Emmanuel *et al*, 1990). It has been demonstrated that standardised and automated process technologies are best served by more traditional formal management control practices (Khandwalla, 1972). In contrast, organisations producing highly specialised, non-standardised, differentiated products require management controls that 'encourage flexible responses, high levels of open communication within the work force and systems to manage interdependencies used. Uncertainty, the second component of technology, is defined by Thompson (1967) as the interaction of two antecedent conditions: rationality of task instrumentality and clarity of purpose. Task instrumentality refers to the available means for performing the task. According to Thompson (1967), when task instrumentality is well understood and goals are clear and unambiguous, efficiency tests are most appropriate. Conversely, where there is uncertainty in one of the categories, effectiveness measures are more appropriate. However, where uncertainty is associated with both categories, the social test is a more appropriate means of assessment. Where the social test is applied, accomplishment and fitness are assessed using the collective opinions and beliefs of one or more relevant groups, rather than on the basis of efficiency or instrumentality. Thompson (1967) also identifies a third component of technology, interdependence, which is influenced by the pattern of workflow among departments. He notes three patterns of interdependence: pooled (no direct relationship between adjacent processes), sequential (one-way interdependencies), and reciprocal (two-

way interdependencies). Thompson (1967) reports increasing levels of co-ordination difficulty as the technologies become incorporated into more complex interdependencies.

There has also been considerable investigation of strategy as a contingency variable (Dent, 1990, Ittner and Larcker, 1997). Chenhall (2003, p. 150) describes strategy as 'how a business chooses to compete in its industry and tries to achieve a competitive advantage relative to its competitors'. The majority of the empirical research has examined the relationship between strategy and the design of management control practice using different typologies. Examples of these typologies include defenders, prospectors, adapters and reactors, cost leadership, differentiation and build, and hold and harvest. Simons (1987) found that business units that follow a defender strategy tend to place a greater emphasis on the use of short-term financial measures. Similarly, Ittner and Larcker (1997) found that the use of non-financial management control measures for performance evaluation increases as organisations follow an innovation-oriented prospector strategy. Finally, a study by Chenhall and Langfield-Smith (1998) demonstrates that organisations following product differentiation strategies gain benefits from implementing contemporary management control practices, such as the BSC, and strategic management accounting techniques, such as benchmarking and quality control practices. In contrast, they suggest that organisations adopting a low-price strategy can gain from continuing to use traditional management control practices. However, despite the considerable number of studies conducted in the field, it is suggested that a clear understanding of the relationship between strategy and management control practice design remains lacking (Chapman, 1997). For example, Langfield-Smith (1997) argues that the inconsistent way in which control, effectiveness and strategy are operationalised and measured results in fragmented and sometimes conflicting research evidence. Supporting this claim, Chenhall (2003) and Ittner and Larcker (1997) assert that strategy measured as a continuum between organisations ignores the multidimensional nature of strategic choices. Chenhall (2003) concludes that the linkage between typologies of strategy and management control practices is problematic, and that these typologies have lost relevance in contemporary settings.

2.3.2 Reliance on Accounting Performance Measures

A second line of contingency-based management control research has focused on the use made of management control practices and has indicated that this aspect may be more significant than the formal design of management control practices. Building on Argyris' (1952) study, in an effort to isolate the behavioural effects of using management control information, Hopwood (1972, 1973) distinguishes between three supervisory styles: (i) a

budget-constrained style, in which budgets play a key role in evaluating performance and are used in an inflexible manner such that failure to achieve budget goals results in poor evaluations regardless of the reasons for such failure; (ii) a profit-conscious style, in which budgets provide goals to indicate whether performance is good or bad but are used in a more flexible manner and viewed as just one indicator of a longer-term concern with profits; and (iii) a non-accounting style, in which budgets are considered to be of secondary importance and performance is primarily evaluated by reference to non-accounting information.

Hopwood (1972) argues that budget control information for evaluating performance frequently provides incomplete, imprecise or biased information about individuals' behaviour. When budget control information is used to evaluate performance, individuals are likely to experience role conflict due to uncertainty as to how their behaviour affects these measures. This conflict results in stress, poor mental states (e.g. attitude towards and dissatisfaction with budget control practices) and dysfunctional behaviour (e.g. gaming). Hopwood (1972) found that a budget-constrained performance evaluation style causes individuals to experience stress, have poor relations with superiors and peers and manipulate accounting data. He also demonstrated that the budget-constrained style is associated with lower budget-related performance and ultimately concludes that the budget-constrained style in performance evaluation is universally inappropriate. Finally, he holds that, while a profit-conscious style is likely to result in greater efficiency than the budget-constrained style, both are likely to result in greater efficiency than the non-accounting style because 'the possibility does remain that it is still better to place at least some emphasis on the accounting data' (Hopwood, 1972, p. 176).

Otley (1978) sought to replicate Hopwood's (1972) study in a profit-centre environment. Otley's (1978) findings contradict those of Hopwood (1972). No significant relationship between budget emphasis and either job-tension or negative social relations was identified. Furthermore, Otley (1978) found a positive relationship between budget emphasis and budget performance, which undermines Hopwood's proposal that a strict reliance on budget information is always inappropriate. In relation to antecedent variables, Otley (1978) found that management philosophy, environmental conditions and organisational size (in terms of profit, manpower and output) influence the choice of a supervisory style. In particular, in difficult environmental and economic conditions a strong emphasis on meeting the budget (a budget-constrained style) prevails, while in easy and stable conditions a less rigorous approach is adopted, which finding supports Argyris' (1952) earlier case evidence (Section 2.1.4). Onsi (1973) found, in line with Hopwood (1972) that a strong reliance on accounting

information was associated with a greater propensity to create budget slack and to engage in 'creative' accounting, caused by a tendency to enhance the attainability of budget targets. A study by Kenis (1979) investigated the effect of a budget-constrained style on an array of job-related variables, such as job tension and job satisfaction. A strong budget emphasis was found to have a negative effect on tension but, contrary to expectations, several positive effects were also identified. These effects include an increase in managers' motivation to participate in the budgeting process. Similarly, Hirst and Yetton (1984) found that a strong budget emphasis reduces managers' role ambiguity. In a review of the empirical results, Hartmann (2000, p. 455) concludes that the 'results provide rather strong support for the effects of budget emphasis on slack creation and data manipulation'. However, Hartmann (2000) notes that positive effects have also been reported. These conflicting results motivated a significant body of management control research to adopt a contingency perspective in an attempt to understand the conditions under which a strong budget emphasis may be more (or less) effective. This literature, now categorised as 'Reliance on Accounting Performances Measures' (RAPM), has identified a number of contingent factors influencing the appropriate use of management control information, details of which are discussed in the following subsections.

2.3.2.1 External Contingency Factors

Studies have tried to explain differences in the appropriateness of relying on management control information by examining an organisation's external environment. Research examining the external environment has focused on factors contributing to the variability, unpredictability or uncertainty of the external environment. Hirst (1983) suggests that a strong reliance on management control information is inappropriate when uncertainty levels are either high or low. He suggests that, with high uncertainty, management control information is incomplete, which causes job-related tension and poor working relationships. Conversely, low uncertainty causes management control information to result in a loss of individuals' discretionary power, which also leads to conflict and job-related tension. In his investigation of environmental uncertainty, Govindarajan (1984) found that management control information is used less frequently when environmental uncertainty is high; however, later studies examining this issue produced mixed results. Ross (1995) failed to find a negative effect of environmental uncertainty in relation to the appropriateness of management control information. On the other hand, Ezzamel (1990) found a positive relationship. Merchant (1990) also examined the effects of environmental uncertainty and found that, as uncertainty increases, the use of management control practices becomes

associated with more manipulative behaviour. Rather than attributing such behaviour to a negative behavioural response to the use of management control information as previous researchers have done, however, Merchant (1990) concludes that the incidence of manipulative behaviour increases when uncertainty is high simply because budget forecasts are less certain in such environments so individuals are more easily able to conceal this type of behaviour. The evidence regarding the importance of environmental uncertainty in predicting the appropriate use of management control information, therefore, remains mixed and inconclusive (Chenhall, 2003). In particular, both Hartmann (2000) and Chenhall (2003) suggest that reliance on budget control in circumstances of external, environmental uncertainty warrants further investigation.

2.3.2.2 Organisational Contingency Factors

In terms of examinations of the internal environment of the organisation, the majority of this research has investigated the link between the characteristics of task uncertainty and the appropriate use of management control information. Task uncertainty is defined as high where individuals are unsure about the consequences of their actions. Hirst (1983) found that, as task uncertainty increases, management control information progressively loses the capacity to accurately reflect the actions necessary to accomplish organisational objectives. Thus, when uncertainty is high, management control information is relatively incomplete, causing conflict and job-related tension. The study concluded that the appropriateness of RAPM, in terms of job-related tension, is low (high) when uncertainty is high (low). Later studies by Brownell and Dunk (1991) find support for this effect of task uncertainty. Emmanuel *et al,* (1990) distinguish between programmed and non-programmed decisions. They define a programmed decision as one where the situation relating to the decision is sufficiently well understood to reliably predict the outcomes of the decision. A non-programmed decision, then, is defined as one that is dependent on the judgement of individuals because there is no formal mechanism for predicting likely outcomes. Emmanuel *et al,* (1990, p. 125) suggest that management control systems 'are generally constructed on the assumption that the situation in which they will be used is essentially programmable, but in practice the techniques (systems) are used in a much wider variety of circumstances'. They demonstrated that, where the ability to measure output is high and the goals clear and unambiguous, 'tight' management control systems should be used. The term 'tight' is used to refer to management control practices that ensure a high probability that people will act in the best interests of the organisation. Reviews of contingency-based management control research have suggested that uncertainty is important in determining the appropriateness of management control (Chapman, 1997; Hartmann, 2000).

2.3.2.3 Individual Contingency Factors

Empirical research has also explored the appropriateness of relying on management control by examining the distinctiveness of the individuals involved. The most common individual factors that have been examined in relation to the use made of management accounting are participation (Brownell and Dunk, 1991), personality (Abernethy and Stoelwinder, 1995), subordinate relationships (Hopwood, 1974; Merchant, 1990) and leadership style (Abernethy, Bouwens and van Lent, 2010; Otley and Pierce, 1995). The importance of budget participation in explaining the conditions that render style of use more (or less) effective has received considerable attention. Brownell (1982) suggests that budget participation and reliance on management control information should be matched for optimal performance in the sense that, when participation is high, reliance on management control information should also be high. On the other hand, a low budget emphasis is appropriate in circumstances where there is a low level of participation. He concludes that such a match between budget emphasis and participation is necessary for effective managerial performance. Subsequent studies have attempted to establish a relationship between budget participation, task uncertainty and performance. The findings of this research suggest that the association between budget participation and a high reliance on management control information only holds true in low task-uncertainty situations (Brownell and Hirst, 1986; Brownell and Dunk, 1991). Finally, contrary to expectations, Dunk (1990) and Merchant (1985a) found that budget slack is low when budget emphasis is high. They had expected budget slack to be high under a rigid budget control style.

In a more recent study, Van der Stede (2000) maintains that both arguments for a positive and for a negative relationship between budget emphasis and slack, or other dysfunctional behaviours, may contain a grain of truth. In other words, it is suggested that being able to detect and reduce one form of so-called dysfunctional behaviour might lead to its re-emergence elsewhere in another type that is not as closely monitored or as easily discernible. He argues that most studies have considered only one form of budget-related behaviour, which makes an investigation of potential spill-over effects impossible. In his study, Van der Stede (2000) tested the relationship between a constrained style and two dysfunctional consequences - budget slack creation and managerial short-term orientation. The results demonstrate that reducing one form of dysfunctional behaviour (slack creation) through rigid controls may spill over into another form (stronger management focus on business matters that affect short-term results).

With respect to the personality of the individual, Abernethy and Stoelwinder (1995) examined the effects of goal orientation on the relationship between the appropriate use of management control information, task uncertainty and performance. They hypothesised that a high reliance on management control information would not be effective in evaluating an individual who had not accepted the organisation's goals. They tested this hypothesis using a sample of hospital administrators where 'system orientation may conflict with the professional model of behaviour' (p. 109). This study provides support for a three-way interactive model in which the 'fit' between task uncertainty and the appropriate use made of management control information is dependent on system-goal orientation. In a similar way, Weisenfeld and Killough (1992) propose that an individual's perception of the management control practice is related to the perceived accuracy and fairness of the management control measures and that these perceptions will determine whether the management control practices are viewed as instrumental towards achieving rewards or, alternatively, as a barrier. In a further study examining how differences in the personality of an individual manager affect the use made of management control information, Collins (1982) proposes that the behaviour of superiors and peers explain the performance effects of using management control practices. Specifically, he found that inconsistency in budget emphasis between superiors caused individuals to perceive ambiguity about budget goals, which was detrimental to organisational performance.

Research has also examined the social relationship existing between a superior and an individual in an organisation. Both Hopwood (1974b) and Merchant (1990) investigated the relationship between leadership style and the appropriate use of management control practices. Hopwood (1974b) found support for the proposition that a high reliance on management control information is associated with more considerate and less initiating superiors, but Merchant (1990) failed to replicate these findings. A leader characterised by consideration shows concern for the feelings and ideas of subordinates, while a leader characterised by initiating structure clearly defines the roles of his subordinates. Hopwood's (1974b) evidence indicates that budget-constrained supervisors are less considerate than either profit-conscious or non-accounting supervisors. Further, budget-constrained and profit-conscious supervisors are rated more highly on initiating structure than non-accounting supervisors. Hopwood (1973) also found evidence for a 'contagion effect'. The contagion effect identified by him refers to the tendency of individuals to evaluate their subordinates as they themselves are evaluated. Hopwood (1974b) also posits that, when individuals have personal motivations (e.g. financial incentives) to utilise their supervisor's evaluative style, they will be more motivated to do so than they would without such personal

motivations and, consequently, these may exacerbate the contagion effect. Few studies have sought to establish whether this contagion effect exists; however, one study by Barrett, McDonagh and Granleese (1992) used survey data from 72 senior marketing individuals to show that superiors tend to match their evaluation style with the style used in their own performance evaluation.

Otley and Pierce (1995) examined how subordinates' reaction to management control is influenced by the leadership behaviour of supervisors. A leadership style characterised by high structure and low consideration was found to be associated with the highest level of dysfunctional behaviour for the behaviours examined, while the lowest level of dysfunctional behaviour is associated with a style depicting low structure and high consideration. Furthermore, the study reports that perceived environmental uncertainty was found to moderate these relationships. In a more recent study, Abernethy *et al*, (2010), using data collected from 128 profit centres, studied the effects of leadership style on the use made of management control practice. Top management with a consideration leadership style were found to use management control practices as an interactive communication device to informally reveal their preferences to subordinates and to obtain input from them. The initiating leadership style also influences the interactive communication use of the planning and control system but the usage is less intensive than it is for those with a consideration leadership style. Abernethy *et al*, (2010) conclude that an initiating supervisor uses management control practices to structure the planning process while those with a consideration leadership style will use it to personally interact with subordinates, communicate their strategic preferences and to obtain feedback from subordinates during the process. Hartmann, Naranjo-Gill and Perego (2010), using survey data from 196 middle-level individuals in 11 organisations, investigated the effects of superiors' performance evaluation behaviours on subordinates' work-related attitudes. The results show that an initiating structure leadership style affects subordinates' work-related attitudes through the use of objective performance measures, while a consideration leadership style only has a direct impact on work-related attitudes.

Finally, investigating the role of trust, Hopwood (1974b) found that subordinates report higher trust in their superiors when these superiors measure subordinates' performance strictly against budget. This finding was later confirmed by Lau and Buckland (2001), who show that trust mediates the relationship between the use of budget control information and job-related tension. In both studies, these findings were explained by the fact that subordinates perceive the use of budget-related performance criteria as the superior's attempt

to provide 'precise' and 'honest' performance feedback. Similarly, Ross (1995) found that trust reduces the effect that a high reliance on management control information exerts on role conflict. Hartmann and Spalnicar (2009) found that the formality of the performance evaluation processes matters for trust because it enhances the perceived quality of feedback for subordinates. They found that higher perceived quality of feedback results in higher trust, both directly and via higher perceptions of procedural justice. Overall, they conclude that the relevance of trust in the superior-subordinate setting provides a fruitful avenue for studies in management control.

2.3.3 A Critique of Contingency Research

With reference to contingency-based management control research, Brownell and Dunk (1991, p.703) state that 'the continuing stream of research devoted to this issue constitutes, in our view, the only organised critical mass of empirical work in management accounting research'. However, a number of both methodological and theoretical challenges have been made to this body of research. The main criticisms are set out below.

Narrow Focus: Management control research has been criticised for the narrow focus it has adopted and there have been numerous calls to adopt a broader and more holistic approach (Berry *et al*, 2009; Chenhall, 2003; Fisher, 1998; Malmi and Brown (2008); Ferreira and Otley, 2009). Critics have outlined several implications of this narrow approach. Fisher (1998) argues that if the links between various management control practices are not recognised, then erroneous conclusions will be drawn about how management control practices relate to the contingent variables studied. This concern may also underpin Dent's (1990, p. 10) assessment of contingency-based management research where he argues that, 'while some relationships have been found between some contingency variables and management control practice, on the whole the relationships are weak and the conclusions are fragmentary'. Similarly, Chenhall (2003) argues that the variables considered have not provided consistent explanations of the kind of management control systems that fit differing organisation types or drive performance and concludes by warning that the study of specific elements in isolation has 'the potential for serious model under-specification' (p. 131).

In a similar vein, Briers and Hirst (1990, p. 392) assert that very little is known about the processes by which supervisory styles are chosen and how a particular style affects individual responses. While numerous management control studies have concluded that it is the way in which management control practices are used, rather than their mere existence,

that determines their behavioural effects and effectiveness, few studies have sought to investigate the use made of management control practices. For decades, management control research, in particular RAPM research, has emphasised the importance of the organisational and behavioural consequences associated with the use made of management control practices in performance evaluation (Merchant and Otley, 2007; Berry *et al*, 2009; Ferreira and Otley, 2009). However, an understanding of the types of use made of management control practices remains under-developed and under-researched. Ferreira and Otley (2009, p. 274) argue that 'the concept of use has not been well developed in the literature', while Merchant and Otley (2007, p. 63) claim that few studies have 'conceptualised what style of use actually entails'. Furthermore, while there have been numerous studies on the outcomes of management control, inspired by authors such as Argyris (1952) and Hopwood (1972), the evidence has been described as piecemeal in terms of the types of outcomes studied (Briers and Hirst, 1990).

A third but related point is that accounting researchers have spent much time studying innovations in practice, such as Activity-Based Costing, the Balanced Scorecard and Target Costing, with the goal of explaining their development, adoption and operation. However, Malmi and Brown (2008) argue that studying these practices in isolation may influence any conclusions drawn if the use and impact of a new management control practice relates to the functioning of the existing broader management control system. Malmi and Brown (2008, p. 288) conclude 'by taking a broader package approach to the study of management control systems, researchers will be able to develop better theory of the real impact of innovations such as the balanced scorecard, ABC and target costing'. Similar, Otley (1999) contends that gaining a broader understanding of management control practices operating as a package may facilitate the development of better theory regarding how to design a range of controls to support organisational objectives, control activities and drive organisational performance. Finally, Chenhall (2003) notes that most contingency-based management control research has involved large manufacturing organisations and argues there has been little research investigating the service and government sectors. In particular, Chenhall (2003) argues that the importance of the public sector to the economy and the introduction of managerial approaches to the public sector provide an opportunity for future research.

Poor Theoretical Development: Briers and Hirst (1990, p.385) are critical of the under-development of theory, highlighting 'the inclusion of variables in hypotheses with little supporting explanation'. Furthermore, they point to the use in studies of box diagrams with arrows indicating causally related variables and argue that, although this is a parsimonious

way of communicating connections, the supporting argument given in many studies is only suggestive. They conclude that theoretical development has been piecemeal and has taken a secondary role to statistical analyses, which means that, as a consequence, a complete and holistic understanding of the factors influencing the operation of management control practices remains lacking. Similar arguments have been articulated by Chapman (1997) and Hartmann (2000).

Methodology: Chapman (1997) suggests that contingency-based management control research is viewed as being synonymous with large-scale cross-sectional postal questionnaire studies and claims that the over-reliance on these methods and techniques has led to the lack of an overall contingency framework. He suggests that management control research would benefit from greater levels of integration between quantitative and qualitative research methodologies. In considering RAPM research, Otley and Pollanen (2000) observe the dearth of replication and propose that, in order to maintain the relevance of management control research, it is necessary to focus attention on contemporary management control practices in contemporary organisational contexts. Otley and Berry (1994) recommend that the study of management control practices cannot be fully understood in isolation and that a contextual case-based research approach is more appropriate to developing a fuller understanding of the relative role of management control practices in the management of organisational performance. Otley and Pollanen (2000, p. 495) call for 'more intensive studies of single organisations aimed at elucidating the impact of different accounting control practices within their wider contexts performed over a period of time'. Furthermore, Berry *et al*, (2009) conclude that it is essential that more emphasis be placed on the study of management control practices in the conditions within which they operate. They conclude that the advantages of field studies in this context are considerable and would allow the many factors that influence the operation of these practices to be considered.

Thus, the idea of an organised critical mass of RAPM studies is challenged in terms of both methodological and theoretical problems. Lindsay and Ehrenberg (1993, p. 224) note that 'taken as a whole, this body of research, although typically interesting in seeking to explain discrepancies, does not add up to a coherent body of knowledge or understanding'.

2.3.4 Summary

Contingency-based management control research explores the notion that there is no universally applicable management control practice that serves all organisations; rather, particular contingencies dictate the best design and use in particular circumstances. Based on

this understanding, researchers have investigated how different contingency factors impact on the design of management control practices. The findings have been varied but they are generally supportive of the existence of a relationship between contextual variables such as the external environment, organisational size, strategic characteristics, organisational structure and the design of management control practices. A second stream of contingency-based management control research concludes that it is the way in which management control practices are used, rather than their mere existence, which determines their behavioural effects and effectiveness. However, despite considerable empirical attention devoted to the issue, researchers appear not yet to have reached definitive conclusions as to behavioural and performance effects of budget emphasis (Hartmann, 2000). Table 2.1 provides a summary of the key aspects of these studies, organised by contingency factor.

Table 2.1 : Summary of Management Control Contingency Research		
Design of Management Control Practices		
Contingency Factor	**Author (s)**	**Key Findings**
External environment	Chapman (1998) Merchant (1990) Hartmann (2000)	The more uncertain the external environment the more open and externally focused the management control practice.
Organisational size	Khandwalla (1972) Merchant (1981)	Large organisations are associated with more divisionalised organisational structures, formalisation of procedures and specialization of functions.
Organisational structure	Burns and Stalker (1961) Lawrence *et al*, (1967)	Large organisations that have more decentralised structures are associated with more formal, traditional management control practices. Decentralisation is associated with management control characteristics of aggregation and integration.
Technology	Khandwalla (1972) Thompson (1967)	Technologies characterised by more standardised and automated processes are served by more traditional formal management control practices. Technologies characterised by high levels of interdependence the more informal the controls including fewer statistical planning reports and informal coordination, less emphasis on budgets and more frequent interactions between superiors and subordinates.
Strategy	Dent (1990) Ittner and Larcker (1997) Chenhall *et al*, (1998) Chenhall (2003)	Strategies characterised by conservatism, defender orientations and cost leadership are more associated with formal, traditional MCS focused on cost control, specific operating goals and budgets and rigid budget controls, than entrepreneurial, build and product differentiation strategies.

Reliance on Accounting Performance Measures		
Contingency Factor	**Author (s)**	**Key Findings**
External environment	Hirst (1983) Govindarajan (1984) Ross (1995) Ezzamel (1990) Merchant (1990) Ross (1995)	The more hostile and turbulent the external environment the greater the reliance on formal controls and an emphasis on traditional budgets. Where management control practices focused on tight financial controls are used in uncertain external environments they will be used together with an emphasis on flexible, interpersonal interactions.
Participation	Brownell (1982) Brownell and Dunk (1991) Van der Stede (2000)	Budget participation and reliance on management control information should be matched for optimal performance. Functional consequences may result from information sharing and from a positive effect on subordinates' goal-acceptance and motivation. Dysfunctional consequences may result from subordinates' attempts to negotiate slack into their budgets.
Sub-ordinate relationships	Hopwood (1974) Merchant (1990) Otley and Pierce (1995) Ross (1995)	Subordinates' reaction to management control is influenced by the leadership behaviour of supervisors. Reliance on accounting performance measures is matched with more considerate and less initiating structure leaders. Reliance on accounting performance measures is appropriate when managers trust their supervisors.
Personality	Abernethy and Stoelwinder (1995) Weisenfeld and Killough (1992)	Individual goal orientation will influence the use of management control information.
		Source: Author

2.4 Conclusion

Chapter 2 has demonstrated that management control is an essential function in a contemporary organisation and that it is usually reliant upon management control systems that comprise multiple control practices that operate together simultaneously. However, empirical research has found that any management control practice is an imperfect tool and, therefore, must be used in a way that takes account of its limitations and is appropriate to the particular circumstances. In this way, this chapter sought to develop an improved understanding of the issues that influence the operation of a management control system. The next chapter will examine the characteristics of the hospital context and the suitability of management control practices in relation to it. In addition, it will provide a review of the literature exploring the complex organisational, external and individual influences on the operation of management control practices in a hospital context.

CHAPTER 3: MANAGEMENT CONTROL IN A HOSPITAL CONTEXT

3.0 Introduction

The purpose of Chapter Three is to review the characteristics of the hospital context and to examine the suitability of management control practices for this setting. Section 3.1 first describes the nature and importance of the Irish hospital sector before examining the complexities that influence the operation of management control practices within it. Section 3.2 discusses the issue of management control in a hospital context. Section 3.3 reviews empirical research exploring the responses of management and clinicians to the operation of management control practices in hospital organisations. A critique of the research discussed is provided in Section 3.4. Section 3.5 presents the conclusions to the discussion.

3.1 The Nature and Importance of the Irish Hospital Sector

3.1.0 Introduction

The specific nature of hospital organisations may render them unsuited to management control practices, as such practices can be extremely difficult to implement within this setting (Ouchi, 1979). This section provides a brief introduction to the Irish hospital sector and discusses the unique challenges that organisations operating in this context must address in order to implement management control practices.

3.1.1 The Irish Hospital Sector

Similar to many developed economies, Ireland witnessed a substantial decline in national income during the late 2000s. The collapse of the banking and construction sectors at the onset of the global financial crisis precipitated an economic and fiscal crisis that required a Financial Support Programme from the European Union (EU) and the International Monetary Fund (collectively known as the Troika) with a total value of €85 billion. Access to these funds was subject to compliance with the conditions set out in the Programme Documents. Along with other economic and fiscal reforms, the control and reduction of healthcare expenditure was stated as being of critical importance (DoH, 2010). Consequently, strict budget reduction targets were imposed, which included a 12 per cent reduction in healthcare expenditure during the period 2008 - 2012. Hospital expenditure was, in fact, reduced by 24 per cent during this period. In addition, it was estimated that, by December 2013, there were at least 12,000 fewer individuals employed in the Irish healthcare sector than there had been in 2007 (HSE, 2013).

The economic and fiscal crisis also had broader consequences for the Irish hospital sector. Ireland's unemployment rate grew from 4 per cent in 2008 to 14 per cent in 2013 (Central

Statistics Office, 2013). As a consequence, the number of individuals registered for medical cards increased exponentially, with half a million more individuals registered in 2013 than in 2008 (Burke, Thomas, Barry, Keegan 2014). In addition, sharp increases in private health insurance (PHI) premiums combined with deteriorating incomes resulted in the number of individuals purchasing private health insurance reducing, with 245,000 fewer individuals covered in December 2013 than in December 2008 (Health Information Authority, 2013). Overall, this analysis indicates that the number of individual's dependent on public hospital services increased as a consequence of the economic and financial crisis. The growth of Ireland's ageing population also placed increasing pressure on hospital services. The population figure for those aged 65 and over rose to 623,200 in 2013, compared to 467,000 in 2007 (Central Statistics Office, 2013). The population also increased by 1 per cent each year during 2007-2013 (Central Statistics Office, 2013). The cumulative effects of these demographic pressures were estimated to have caused a 10 per cent increase in demand for hospital services (Smyth, 2015).

As a result, the Irish healthcare sector and, in particular, public hospitals organisations were compelled to operate within unprecedented budget constraints. Although this situation of reduced expenditure and increased demand for hospital services posed challenges, it also highlighted the need for hospital expenditure to be utilised efficiently. Key priorities identified in addressing this challenge included a greater focus on accountability and the more effective management of hospital resources. The operation of management control practices was considered by the HSE to be central to these initiatives (HSE Service Plans, 2008 - 2012). The next section discusses the method used to implement such healthcare reform agendas.

3.1.2 Healthcare Reform and Change

For the past two decades, the focus of many developed countries, including Ireland, has been on public sector reform and it continues to be so. A central element of this strategy has been the pursuit of improved performance of public services and this has particular relevance to this study of management control in healthcare. The label, New Public Management (NPM), has been used to encapsulate these types of changes in public management. Different researchers have defined NPM in different ways, such that 'sometimes NPM seems to be like an empty canvas; you can paint on it whatever you like' (Ferlie, 1996, p. 261). Hood (1991), a seminal theorist on NPM, suggests that, while NPM has been a significant global trend in international public administration since the mid-1970s, its intellectual origins can be traced back to a much earlier period. Typifying NPM as a 'marriage of opposites', Hood (1991,

p.45) characterises it as a synthesis between post-World War II 'new institutional economics' and 'business-like public sector managerialism'. While the search for consensus on an exact definition of NPM has fuelled academic debate since the early 1980s, one common feature of NPM reform has been a growth in the power and influence of management control practices. Hood (1995, p. 94) asserts that 'accounting is a key element in this new conception of accountability, since it reflects high trust in the market and private business methods and low trust in public servants and professionals whose activities therefore need to be more closely costed and evaluated by accounting techniques'. However, the increased prevalence of management control practices in healthcare prompted Power and Laughlin (1992, p. 132) to issue a note of caution highlighting the potential for management control to 'subvert existing value systems and to redefine the world or social space which it enters'. In this regard, Power and Laughlin (1992) identify healthcare organisations as being at particular risk. Specific sources of complexity in this context are highlighted in the next section.

3.1.3 Sources of Complexity

In many respects, Irish healthcare structures and functions are similar to those existing in other developed countries but there are some unique important differences that have implications for management control practices. This section outlines the key features of the Irish hospital sector. It is important to note that many of these factors have evolved from a long history of incremental policy decisions, influenced by economic and non-economic factors as well as by specific institutions, such as the Catholic hierarchy and the medical profession.

3.1.3.1 Healthcare Principles and Goals

The priorities of the Irish healthcare sector are set out in a report issued by the Department of Health (DoH) in 2001 entitled 'National Health Strategy - Quality and Fairness' (DoH, 2001). It outlines a strategy that adopts a holistic systems-based approach to addressing health needs, focusing on health and social well-being and encompassing both public and private providers of health services, in addition to any other individuals or institutions with a role to play in the health of the population. A number of actions are proposed in the context of the central aim to 'deliver a healthier population and a world-class health system' (DoH, 2001, p.15). Specifically, the overarching vision articulated by the 2001 report is 'a health system that supports and empowers you, your family and community to achieve your full health potential. A health system that is there when you need it, that is fair, and that you can

trust. A health system that encourages you to have your say, listens to you, and ensures that your views are taken into account' (DoH, 2001, p.8).

3.1.3.2 Governance and Organisational Arrangements

The Irish healthcare sector was subjected to substantial organisational reform in 2005. This Reform Programme was instigated partly in response to the recommendations of a number of key reports produced regarding the Irish healthcare sector, most notably the Brennan (2003) and Prospectus (2003) reports. The principal objective of the Reform Programme was to improve the availability and quality of healthcare services by 'improving the planning, management, delivery and evaluation of services and their respective accountability arrangements' (Health Service Reform Programme, 2003, p. 23). It also set out the key bodies to be involved in the reformed healthcare system, namely, the DoH, a newly established Health Service Executive (HSE) and a new regulatory agency, the Health Information and Quality Authority (HIQA). Following the Reform Programme, the DoH assumed a stewardship function for the healthcare sector and provided support to the Minister for Health (MoH), who is politically accountable for the healthcare service. The DoH is also responsible for strategic policy and planning, the evaluation of resource allocations and the development of an effective legislative and regulatory framework for the sector. HIQA was established in 2007 and is responsible for promoting quality and safety in Irish healthcare services.

Following the enactment of the Health Act (2004), the HSE was mandated to manage and deliver health and personal social services. The HSE Board is the national governing body of the organisation, with the CEO occupying the role of accounting officer. At a national level, there are eight directors who are responsible for leading the planning, monitoring and evaluation of services, as well as developing standards and best practice. The Integrated Service Directorate (ISD) was charged with overall responsibility for the primary care and hospital services. There are four ISDs, each of which is led by a Regional Director of Operations (RDO). The RDO is responsible for ensuring that, within each region, all of the resources available to the HSE are used in the most appropriate way possible to meet the needs of the people living in that region. Each area is also led by an Integrated Service Area (ISA) manager, who is responsible for the operation of both primary care and acute hospital services in their area.

The HSE is bound by specific legal requirements set out in the Health Act (2004), which govern the relationship between the DoH and the HSE. Under the Health Act (2004), a

National Service Plan (NSP) must be prepared according to the form and manner directed by the Minister and must: (i) indicate the type and volume of health and personal social services to be provided by the HSE during the period to which the plan relates; (ii) indicate any plans related to capital proposed by the HSE; (iii) contain estimates of the number of people to be employed by the HSE for the period and the services to which the plan relates; (iv) contain any other information specified by the Minister; (v) comply with any directions issued by the Minister; and (vi) align with the policies and objectives of the Minister and the Government.

During the past decade, there has also been a continued impetus from the HSE to encourage clinicians to become involved in the management of Irish hospital services (Mc Dermott, Callanan and Buttimer, 2002). This policy was predicated on the fact that clinicians are the major resource consumers in hospitals, with their decision-making accounting for up to 70 per cent of hospital expenditure (Abernethy and Stoelwinder, 1995; Broyles and Reilly, 1988; Cardinaels *et al*, 2004). As a result, it has been argued by the HSE that clinician involvement in managerial roles will lead to improved managerial decision-making and resource-management by linking executive and operational issues (Fitzgerald and Stuart, 1992). The Clinicians in Management (CIM) initiative was introduced by the DoH in 1998. This initiative aimed 'to move decision-making closer to the point of service delivery, to move the patients closer to the centre of decision-making and to improve the quality of care' (Smith, 2005). Specifically, it aimed to 'provide for balanced involvement in decision-making between doctors, nurses and allied health professionals and to decentralise the responsibility for managing resources down to local units with their direct participation' (Office for Health Management, 2001, p.1). To this end, it advocated that clinicians should be given responsibility for service delivery and resource allocation through clinician sub-units. To formalise and consolidate the principles of CIM, the DoH introduced clinician directorates as the accepted method for the organisation of hospital services and the involvement of clinicians in decision-making about service and resource management (O'Shea, 2009). The primary purpose of the clinician directorate structure was to incorporate clinicians into hospital management and to balance clinician decision-making power with financial responsibility (Willcocks, 1994). However, the extent to which clinician directorates have been operationalised in Irish hospitals remains unclear (O'Shea, 2009).

Therefore, while many structural reforms were introduced during the past decade to govern the Irish hospital sector, the two main reforms highlighted in this section, the Health Act (2004) and the clinician directorate structure were among the key reforms that influenced the operation of management control practices in the sector.

3.1.3.3 Hospital Service Delivery

Hospital services are delivered through both public and private hospitals. There are over 48 public hospitals and 21 private hospitals in Ireland (DOH, 2011). Of the 48 public hospitals, 34 are public hospitals that are owned and operated by the HSE. The remainder are public voluntary hospitals that are owned by voluntary organisations and provide services to the HSE based on service-level agreements. While both public HSE and voluntary hospitals receive funding from the HSE, a key difference between them relates to their governance structure. Brennan (2003, p. 21) explains that public voluntary hospitals are 'publicly funded but privately owned'. In public HSE hospitals, individual managers manage the delivery of services and are directly accountable to the HSE. In this way, the HSE effectively has a dual role as both funder and manager of services delivered by public HSE hospitals. Private hospitals are independent and receive no direct State grant funding. In 2012, there were 13,576 inpatient beds and 2,063 day-beds in the 34 public hospitals. The number of individuals who receive inpatient or day-case treatment is estimated to be 1.43 million each year, while 2.4 million individuals attend hospital outpatient departments each year (HSE, 2013).

3.1.3.4 Resource Allocation

Each year, the HSE prepares an annual budget document, the Statement of Revenue Requirements, which sets out the funding requirements for the forthcoming year. This statement is submitted to the DoH in order to inform the Department of Finance of these matters during its formulation of Government Estimates. The annual financial allocation (i.e. budget) provided to each Government Department is known as 'the Vote'. On its establishment in 2005, the Health Vote was transferred from the DoH to the HSE and, as a result of this process, each public hospital receives an annual budget grant allocation from the HSE in return for undertaking activity levels as specified in the NSP. Both the activity levels and the budgets are determined on the basis of preceding years, with adjustments for items such as inflation, public pay alterations or any other new developments.

All public hospitals also participate in the Casemix Programme. The Casemix Programme involves both the measurement of individual hospital output captured by the Hospital Inpatient Enquiry (HIPE) system and the comparison of cost and activity between peer-group hospitals. Hospitals are arranged into four distinct categories in order to ensure comparisons are made based on similar entities: 'Teaching' (8), 'Non-Teaching (25), 'Maternity' (3) and 'Paediatrics' (2). This system was introduced to facilitate comparisons of

similar hospitals and, in particular, to ensure that hospitals with significant teaching costs were not disadvantaged through comparisons with non-teaching hospitals (Casemix, Ireland, 2010). Each hospital's cost-per-case is compared with the national mean to provide a Value for Money measure. The national mean is based on diagnostic-related groups (DRGs), groups based on clinician diagnostic categories. Those having costs per DRG that are lower than the national mean within the relevant hospital group gain additional funding, while those with costs higher than the national mean lose funding, but this is small relative to the main annual budget allocated to each hospital. Despite consecutive governments advocating the need to replace the current block grant allocation mechanism with the Casemix Programme, progress has been slow (Wiley, 2005).

3.1.4 Summary

This section provided a brief overview of the Irish hospital sector, highlighting its key features in terms of governance, organisation, resource allocation and service delivery. Developing an understanding of how this complexity influences the operation of management control practices is important given the relative size and significance of the hospital sector in relation to the economy as a whole.

3.2 Management Control in a Hospital Context

3.2.0 Introduction

In Section 2.1.2, the typology proposed by Merchant and Van der Stede (2011) was described as categorising management controls into: (i) action controls; (ii) personnel controls; and (iii) result controls. This typology is adopted in this section to discuss the operation of management control practices in the context of hospital organisations.

3.2.1 Action Controls

Action controls relate to the observation of individuals' actions as they carry out their work (Merchant and Van der Stede, 2011). In hospitals, these include structural constraints, such as passwords that restrict access or updating information sources only to authorised personnel. Pre-action reviews involve the scrutiny and approval of action plans of individuals before they are permitted to undertake a course of action. Examples include the approval by management of a clinician's plans for the purchase of a new piece of medical equipment. Action accountability, then, involves defining which actions are acceptable and which unacceptable in order to reward acceptable actions and punish unacceptable actions.

Examples of action accountability measures in hospitals include instruction manuals, quality standards and action plans for different activities.

Action controls have been found to be most appropriate where cause and effect relationships are well understood so that it can be reliably predicted that following certain specified procedures will produce certain desired outcomes (Chapman, 1997). An examination of the operation of action controls in the context of hospitals necessitates recognition that service provision involves the operation of many complex processes of different types, ranging from administrative tasks and protocols to services provided to patients by clinicians such as assessment and treatment. In this regard, hospital operating processes are highly complex and dynamic, involving many interconnected elements that exert a mutual influence on each other. Uncertainty in cause and effect relationships occurs when it is difficult to predict with certainty the outcomes that will result from particular actions taken. This may be due to incomplete knowledge concerning the input/output relations or the highly interdependent nature of work processes with multiple inputs, which makes it difficult to programme workflows. In this way, the role of action controls differs across different sub-units in the context of a hospital organisation.

3.2.2 Personnel Controls

Merchant and Van der Stede (2011) define personnel controls as those that enable employees to perform well by building on their natural tendencies to control themselves. A fundamental issue in implementing personnel controls in the context of hospitals is the conflict of interest between the different stakeholders involved in the management of a hospital organisation. Glouberman and Mintzberg (2001) characterise the internal organisation of hospitals as comprising four different professional groups: clinicians, nurses, management and trustees. Cardinaels and Soderstrom (2013) suggest that each professional group evaluates a hospital's decision from its own standpoint and that the differing perspectives can result in conflict between groups.

In considering the operation of management control practices, conflicts of interest between management and clinicians are particularly important. Eldenburg, Hermalin and Weisbach (2004) and Mintzberg (1997) indicate that fundamental divergence between the viewpoints of clinicians and management primarily occurs in relation to how resources should be deployed. Furthermore, clinicians who are classified as 'dominant professionals' are primarily oriented towards providing effective clinical care for individual patients, while the management group are oriented towards the efficient and effective use of resources for all

patient groups, as well as the overall needs of the hospital system (Mintzberg, 1997). These conflicts of interests have implications for the operation of management control practices, which aim to control resource usage for the hospital as a whole (Chua and Preston, 1994). The conflict is also compounded by the fact that the core hospital operating processes depend on the expertise of clinicians, thus granting them a significant degree of autonomy. Further, the training and education of clinicians have long emphasised their role in advocating for their patients to ensure that they receive effective care. In order to be patient advocates, however, clinicians believe that they must also maintain clinician autonomy to determine the care needed (Baker and Denis, 2011). The literature has given considerable attention to examining this issue, which is reviewed in Section 3.3.

3.2.3 Result Controls

Result controls relate to the gathering and reporting of information concerning the outcomes of work efforts. Establishing such controls requires the selection of performance measures. However, as highlighted in Section 2.2, the selection of performance measures is a difficult and onerous task. While most private organisations have finance-related goals focused on maximising profits and satisfying stakeholders, hospital organisations tend to adopt more broadly defined mission statements. For example, as highlighted in Section 3.1, 'equity and fairness' is a stated principle of healthcare policy in Ireland but such abstract objectives are unfocused and, therefore, difficult to measure. This creates a political environment where preferences in hospitals are continuously challenged and debated, which ultimately translates into ambiguity at the micro-level of hospitals themselves as they attempt to respond to the political agenda through resource allocation decisions (Robinson, 2001).

The operation of result controls also requires performance to be measured but in hospitals measurement, reliability and precision in this regard are not always attainable. For example, 'quality of care' is an important healthcare outcome but it can be difficult to measure and interpret. In addition, patient service outcomes (including both care and cure of the patient), in contrast with other service products, are intangible and cannot be packaged or stocked (Abernethy *et al*, 2006). The highly emotive nature of discussions around the healthcare sector also poses difficulties for the operation of output control practices. As an emotive issue, healthcare attracts considerable media attention. This focus has resulted in the sector becoming more visible to the public, thereby raising expectations regarding the quality and availability of services. Finally, the operation of output controls in hospitals is complicated by the fact that the organisational charters of these organisations typically preclude the use of monetary incentives as a mechanism for achieving goal congruence, rendering the

implementation of any system of reward or punishment a very complicated task (Eldenburg *et al*, 2004).

3.2.4 Summary

The lack of clarity around hospital objectives, the conflicting goal sets and the problems in measuring and comparing outputs of hospitals render the operation of management control practices complex in this setting. However, the Irish hospital sector is not alone in seeking to address management control issues and there is much to learn from prior empirical studies. The next section presents a discussion of the research focusing on the operation of management control practices in a hospital context.

3.3 Responses to Management Control Practices

3.3.0 Introduction

Section 3.2.2 highlighted that conflicts of interests arising between management and clinicians are a fundamental issue influencing the operation of management control in a hospital context. This section provides a review of the empirical research examining how management and clinicians respond to the operation of management control practices in this setting.

3.3.1 Management Attitudes and Responses

Relatively, few studies have investigated how management in hospitals respond to budget control practices. Abernethy and Brownell (1999) used data collected from 63 Chief Executive Officers (CEOs) in public hospitals to explore the use made of budget control information in adapting to organisational change. Adopting the typology of Simons (1990), they found that organisational performance is enhanced if management control practices are used interactively. In particular, the study suggests that the interactive use of budget control information by management is effective in supporting the learning and adaptation required when strategic change is implemented. It should be noted that Abernethy and Brownell's (1999) study focused entirely on top-level managers and it was acknowledged that the results may be sensitive to the managerial level selected and that identifying the conditions that influence the use made of management control practices at middle management level would be beneficial.

In a related study, Naranjo and Hartmann (2007) collected data from 218 CEOs of public hospitals in Spain to explore how the composition of the top management team influences

the use made of these practices. The results indicate that CEOs with a predominantly clinical background focus more on non-financial information for decision-making and prefer an interactive style in using management control practices as, together, these support flexibility strategies. Conversely, the results suggest that CEOs with a predominantly administrative background are more effective in establishing cost-reducing strategies due to their greater inclination to consider financial information combined with a diagnostic use of management control practices. Naranjo and Hartman (2007) suggest that hospital performance would improve if top managers (i.e. members of the Board of Directors) actively stimulated dialogue among clinicians and management to 'demystify' management control practices and create a broader sense of ownership of them.

Finally, King, Clarkson and Wallace (2010) explored linkages between organisational characteristics, budget control and organisational performance. Based on survey data collected from 144 primary care providers, the findings show that a manager's use of budget control is positively related to the size and structure of the organisation (i.e. decentralisation). Furthermore, for those organisations that use budget control practices, the extent of use is positively related to a cost leadership strategy and negatively associated with perceived environmental uncertainty. King *et al*, (2010) conclude that organisational performance was positively associated with the use of management control practices by administrative management in the study context.

Thus, little is known about how members of management respond to the operation of management control practices, despite these individuals playing a pivotal role in the everyday delivery of hospital services. The next section will discuss empirical studies examining the responses of clinicians in this regard.

3.3.2 Clinician Attitudes and Responses

A considerable amount of research attention has been devoted to understanding the responses of clinicians to the operation of management control practices (Cardinaels and Soderstrom, 2013). UK and American papers dominate the literature on clinicians' attitude towards cost information. This research shows that clinicians have a poor understanding of the cost of the resources they use. Fowkes (1985) found that 77 per cent of clinicians in their study had no knowledge of the true costs of the drugs that they were using. O'Connell and Feely (1997) found that the majority of clinicians were unable to accurately estimate the costs of the medicines they used. More recently, Ryan, Yule, Bond and Taylor (1996) found that only one third of the clinicians studied were able to accurately estimate the costs of

drugs. Ryan *et al,* (1996) also report that clinicians underestimate the costs of expensive drugs and overestimate those of inexpensive drugs. At a macro level, empirical studies have also examined the effects of management control practices on national hospital expenditure. Covaleski, Dirsmith and Michelman (1993) argue that, despite various attempts at cost containment, hospital costs in the US have continued to escalate.

There is also evidence that the provision of accurate cost information alters clinician behaviour. For example, Cohen, Lillenberg and Neuhausse (1982) investigated if providing clinicians with budget control information relating to their x-ray and laboratory tests would lead to a reduction in test usage and if this effect would diminish when the feedback of budget information ceased. The study sample comprised four teams of clinicians, each working in similar inpatient units. It was reported that test usage fell during the study period in all four teams. Furthermore, in the one team that had an 'interested leader', test usage continued to decrease after the study ended. Cohen *et al, (1982)* conclude that the introduction of budget control information would not assure reductions in test usage and argue for the necessity of educating clinicians about the potential benefits of management control information as, without this intervention, budget information will be ineffective. Subsequently, in a cross-sectional analysis of hospitals, Eldenburg (1994) also investigated the response of clinicians to budget control information. Differences in expenditure patterns were analysed in relation to the types of budget information received. The results suggest that hospitals that provide clinicians with their own case costs and some comparison information have significantly lower average charges than hospitals that do not. Eldenburg (1994) concludes that the provision of disaggregated and benchmarking information is necessary to induce a reputation effect that may influence behaviour and reduce overtreatment.

Prior studies have also examined clinician responses to the operation of budget control practices. Jones and Dewing (1997) describe the findings of a longitudinal study of a large acute hospital in the UK, which demonstrated the effects of implementing management control practices in an organisation with a deeply embedded clinical culture that is at odds with the control objectives associated with these practices. The findings showed that clinicians in the study sought to resist these practices and to continue their day-to-day activities as before. It was acknowledged by the authors that part of the difficulty in implementation was the quality and relevance of the management control practices; however, they suggest that the main obstacle to successful implementation is the difficulty of effecting change in an entrenched professional culture where priorities do not reflect

efficiency-related concerns. Furthermore, they argue that the professional training of these clinicians had imposed powerful controls on their behaviour which they internalised, including an emphasis on patient welfare and a desire to adopt the best medical practice available. Control in relation to budget targets was found to be of secondary interest and was exercised only when budget targets were in danger of being exceeded. Instead, clinicians discussed control in terms of patient progression through the system, with no evidence of linkages between budget information and quantities. Their findings support the earlier work of Coombs (1987) in the context of Swedish hospitals.

Preston, Cooper and Combs (1992) also report the emergence of tension between clinicians and management as a result of the implementation of a management control practice. They suggest that the implementation of management control practices increases managers' awareness with regard to medical outcomes and enables them to exercise greater control over hospital organisations. Realising that the shift in authority is embedded in management control practices, clinicians, therefore, seek to limit the legitimacy of the management control practices on the grounds that they inhibit or distort the exercise of clinical professional judgement. In a study of three Finnish hospitals, Kurunmaki (1999) describes how 'financial augmentation' has become an accepted practice and the language of management control has become dominant. Furthermore, she argues that management control is an integral part of the struggle for power and control in the Finnish hospital sector. The study found that management control information was being used to redistribute symbolic and economic capital between clinicians and management, thereby shifting power and authority away from the former to the latter. Previously, clinicians had exercised significant control over hospital matters through the professional freedom they enjoyed. The redistribution of power, which involved a gradual shift of control from clinicians to administrators, was regarded by clinicians as undermining of their professional judgement and an unnecessary interference with their authority. This reaction generated a strong resistance to, and covert circumvention of, management control practices by clinicians.

Broadbent *et al*, (2001) further explore clinician resistance to management control practices. They found that these practices 'do not sit easily' with clinicians and they have, consequently, used various strategies to resist them. Their analysis highlights three key issues. Firstly, when clinicians perceive a regulative threat to their professional freedom, resistance is inevitable. Secondly, the actual nature of this resistance tends to manifest in the emergence of, as Broadbent *et al*, (2001) term them, 'absorbing groups'. These groups will, either internally and privately or externally and publicly, absorb and resist these changes.

The choice of the absorbing group between internal and external processes is contextually determined. They conclude that this choice is likely to be related to the perceived intensity of the threat in relation to normative interpretive schemes. It seems from the findings discussed above that there is compelling evidence to suggest that clinicians have demonstrated an antagonistic attitude towards management control practices due to the fact that these practices are perceived to be a fundamental threat to the values of the medical profession and are hence to be resisted. However, these findings have not been unequivocal.

In a subsequent study, Kurunmaki, Lapsley and Melia (2003) observed the impact of accounting in hospital organisations. The study analysed two different hospital contexts, in order to understand the alternative phenomena occurring within them and hence provide an accurate description of the ability of accounting to influence and penetrate clinical culture and the impact of accounting in terms of its use in decision making. Kurunmaki *et al,* (2003) note that the incremental nature of Finnish reforms is associated with the gradual implementation of accounting processes within hospital organisations and the progressive involvement of clinicians with it. They suggest that this context has favoured the emergence of the phenomenon of 'accountingisation'. Accountingisation describes the ability of accounting to penetrate the clinical culture and modify it. It results in the acquisition by medical professionals of accounting skills and expertise which can then be combined with their existing clinical knowledge.

In a subsequent study also set in both the UK and Finland, Kurunmaki (2004) analysed the adoption of accounting and control systems by clinicians through a longitudinal qualitative study carried out over a ten-year period. He observed that clinicians in the Finnish setting absorbed management control information while, in the UK setting, clinicians employed management control information as a defensive shield. Kurunmaki (2004) claims that the clinicians in Finland welcomed and adopted management control practice to the point that they became hybridised. She explains the differences in the accounting professions in the following way. In the UK, highly professionalised accountants have sought and succeeded in retaining control over accounting practices and their jurisdiction; however, with a less formalised and powerful accounting profession in Finland, cost and management accounting have been understood as being available to any individual or occupational group. Therefore, Kurunmaki (2004) claims that Finnish clinicians have willingly adopted management control practices as part of their legitimate competencies leading to a hybrid profession.

Jacobs (2005) sought to address the question of whether Kurunmaki's (2004) theory was valid in Germany, Italy and the UK. The study focused on the education, training and socialisation of clinicians and sought to determine if these issues needed to be altered to accord with the Finnish system where hybridisation had occurred. However, Jacobs' (2005) results contradict the findings of Kurunmaki (2004) with regard to hybridisation. The findings challenge the assumption that there is simply a clash between the values of accounting and medicine and indicate that, in some settings, clinicians are willing to engage with management control practices while, in others, they delegate responsibility for these activities to a subordinate. Kurunmaki's (2004) assertion that clinicians' adoption of management control practices is explained by the nature of the accounting profession is not supported by Jacobs (2005), who found, rather than a universal change in attitudes, a small groups of clinicians who were relatively happy to engage with the activities and responsibilities associated with management control practices. Jacobs (2005) concludes that attempts to bring about a change in clinician responses should, therefore, focus on the education of clinicians and argues that these changes should encourage clinicians to consider how issues of cost, budget and resource management could be understood as a part of their role, as opposed to a specialist area of interest of a polarised group of clinician managers. Llewellyn's (2001) study explores how the medical profession absorbs accounting information by focusing on the leadership of medical departments. Using the metaphor of a 'two-way window' to understand the aspirations and activities of clinical directors, the study reports that clinical directors simultaneously work with sets of ideas from both clinical practice and management. She concludes that clinical directors can relatively easily occupy the 'two-way space', the only issue being a lack of financial management expertise, which can be overcome by providing adequate professional training.

In the ongoing debate about the responses of clinicians to the operation of budget management control practices, overall, clinicians have been found to be antagonistic towards the operation of management control practices. Management control practices have been perceived as a fundamental threat to the values of the medical profession and, consequently, have often been resisted **(**Kurunmaki, 1999; Broadbent *et al*, 2001) but studies have also reported clinicians to be accepting of the need for management control (Kurunmaki, 2004; Llewellyn, 2001). This research has demonstrated a certain willingness amongst clinicians to accept greater responsibility and to be centrally involved with budget control practices.

3.3.3 Contextual Factors Influencing Clinician Responses

This section reviews the findings of previous research examining how contextual factors influence the responses of clinicians to the operation of management control practices.

3.3.3.1 Organisational Factors

Empirical research highlighting the need for management control practices to consider the organisational context has, for the most part, adopted a rational perspective. The rational perspective views management control in hospital organisations as purposive; that is, designed and implemented to facilitate decision making and control. This research has stressed the importance of designing organisational structures and management control practices to match the organisational context.

Abernethy and Vagnoni (2004) investigated the impact of authority structures in this regard. Their study was based on survey and interview data collected from clinician managers in two large public teaching hospitals in Italy. It examined the relative importance of formal authority delegated by management to clinicians and informal authority derived from the power and influence that clinicians maintain within the hospital. The findings indicate that the formal delegation of authority to clinicians has a direct impact on the use of budget control information for decision making. Abernethy and Lillis (2001) used data collected from CEOs and medical directors in hospitals to examine interdependencies between strategy, structural autonomy and management control design. Their findings suggest that strategy choice has a direct influence on top management's decision to grant autonomy to lower level managers and that this, in turn, influences the importance attached to measures of performance. The issue of autonomy was examined by Silva and Ferreira (2010). They found that hospital organisations that were financially and administratively dependent on a parent organisation were characterised by weak hierarchical controls, poor information-flow mechanisms and low levels of accountability. Their results indicate that a lack of direction, low motivation and, in some circumstances, poor managerial ability were key control problems in the case organisations studied. The evidence also suggests that the strength and coherence of the links between the different elements of management control practices were generally poor. Silva and Ferreira (2010) conclude that, to be effective, it is necessary to ensure that strong hierarchical controls, good information-flow mechanisms and high levels of accountability are developed to support these practices.

Studies have also explored the effects of uncertainty on the operation of management control practices; for example, using data collected from hospital accounting information system groups, Kim (1988) investigated how task predictability influences user satisfaction regarding the information provided. Task predictability was defined as the number of exceptions arising in the work carried out, or the frequency of occurrence of unexpected or novel events. The evidence suggests that, in healthcare, where tasks are predictable, formal administrative controls such as budget control practices are appropriate. However, where tasks are unpredictable, more impersonal forms of control and co-ordination are found to work best. Kim (1988) also reports that matching the design of management control practices to the decision contexts faced was significantly associated with improved organisational performance as measured by user satisfaction in this study. Abernethy and Stoelwinder (1990) selected a broader sample of hospital managers, including managers of departments providing clinical services directly to patients (e.g. medical, surgical or paediatric) and clinical support services (e.g. laboratory services, medical imaging or food services). They demonstrated that budget control practices were used to a significantly lesser extent in the direct clinical departments than in support departments. On this basis, they argue that the judgement required for decision making in clinical departments limits the relevance of budget control information, as these practices are based on the assumption that input-output relations can be pre-specified in financial terms.

The issue of task interdependence was investigated by Mai and Gayol (1991). Using survey data from 31 public hospitals in New Zealand, the impact of span of control and perceived task interdependence was investigated. The results suggest that span of control influences the usefulness of management control practices by means of their perceived task interdependence. It was found that the information needs of each particular manager need to be considered if management control information is to be used to assess the consequences of alternative means of achieving an identified outcome. Mai and Gayol (1991) suggest that this may be achieved by involving the manager in the design of budget control practices but concede that further research is required to determine the validity of this claim. Previously, Bourn and Ezzamel (1986) had highlighted the design difficulties associated with management control practices in UK hospital organisations. They found particular difficulties in the identification and measurement of outcomes and the treatment of overheads. Bourn and Ezzamel (1986, p. 66) concluded that the management control practices under examination were inadequate and ‘grossly incomplete’, with the result that ‘the quality of much of the underlying data was often dubious’. More recently, based on a sample of 277 US hospitals, Pizzini (2006) examined the association between cost-system

functionality, clinicians' beliefs about the relevance and usefulness of cost data and actual financial performance. The results reveal that clinicians' evaluations of the relevance and usefulness of cost data are positively correlated with the extent to which systems can provide greater cost detail, better classify costs according to behaviour and report cost information more frequently. However, only the ability to supply cost detail was found to be positively associated with measures of financial performance, including operating margins, cash flow and administrative costs.

Ballantine, Brighall and Modell (1998) compare and contrast management control practices operating in the UK and the Swedish hospital systems. As demonstrated in their case studies, it was found that the effectiveness of multidimensional management control practices in hospitals depends heavily on the information system infrastructure in place and the degree of integration between different organisational levels. Moreover, they found that tensions emerge in attempting to balance the provision with the use of financial and non-financial information. Finally, Abernethy, Horne, Lillis, Malina and Selto (2005) describe how to design management control practices that actively involve clinicians and nurses. Their study adopted a multi-method approach to identify the key factors that should be considered in the design. It also sought to elicit expert knowledge from relevant individuals and to reflect this in the design of the management control practices. They organise the key success factors found into three categories: human, production processes and external factors.

Aidemark (2001) investigated the use of the Balanced Scorecard (BSC) in Swedish hospital organisations. Based on interview and archival data, widespread support for the BSC's use was found and, overall, the participants considered it to be an appropriate management control practice. Aidemark (2001) contends that the BSC replaces the previously applied one-sided financial measurement with a management control practice that not only focuses on considering a balance of judgements in relation to the organisation but also on optimising the use of clinician judgement. In a follow-up study, Aidemark and Funck (2009) examined a hospital organisation where the BSC had been implemented for over ten years. The interview data was unanimous; during the ten-year period, enthusiasm for the BSC and management control had increased. The explanation for the continued interest in measurement in this way may be found in three particular aspects of the process: (i) decentralisation of the development of the measure; (ii) management interest, demand and support; and (iii) the flexibility of the design and use of the BSC. Jiang, Lockee, Bass, Frazer and Norwood (2009) argue that 'oversight' has an important impact on the operation of the BSC in healthcare. Based on a survey of managers at 490 hospitals, the study

demonstrates that a hospital scores better on quality in terms of process of care and mortality rates when top managers (i.e. members of the Board of Directors) focus on performance evaluation. Furthermore, the authors suggest that quality performance improves when the BSC links the performance evaluations of senior executives with clinical quality and patient satisfaction indicators.

The development and diffusion of ABC principles in hospital organisations have been widespread and Casemix funding has constituted the vehicle through which such organisations have implemented ABC principles. Advocates of Casemix funding practices have cited many favourable outcomes. For example, Duckett (1995) asserts that the implementation of Casemix practices has led to a more equitable distribution of financial resources. Casemix funding is also argued to introduce incentives for greater efficiency and effectiveness. Bourn and Ezzamel (1986) found that hospitals in which costs are higher than the prices paid for services improve performance rapidly. Furthermore, Duckett (1995) demonstrates that many of the intended incentives inherent in Casemix funding practices did induce the desired efficiency improvements in the hospital organisations studied. Fetter and Freeman (1986) argue that the introduction of Casemix funding in their study made hospital actions more visible and led to improved accountability. In addition, this increased visibility provided a basis for organisational rewards and sanctions. Fetter (1991) suggests that Casemix funding introduces incentives for the efficient utilisation of services, as well as efficiency and effectiveness in the delivery of those services. Lehtonen (2007) claims that Casemix funding improves hospitals' ability to engage in prediction of costs. This study also found that some organisations were able to compare different service providers, thereby gaining more control of the costs of specialised healthcare. In addition, it was found that clinicians had become more resource conscious and were increasingly aware of the financial implications of their activities. Eldenburg, Soderstrom, Willis and Wu, (2010) examined clinician responses to implementation of the ABC system developed and designed with clinician input. They analysed changes in resource utilisation in the treatment of cataract patients and found changes in practice patterns in that clinicians redeployed resources towards more severely ill patients and reduced the average length of hospital stay. The study also provides preliminary evidence of improvements in financial performance.

However, evaluations of the introduction of Casemix practices have also raised a number of concerns. Combs (1987) highlights certain unfavourable outcomes that are associated with Casemix practices, such as reduced length of patient stay, increase in hospital admissions and the reduced prioritisation of outcomes not related to efficiency, such as quality of care.

Doolin (1999) explored the implementation of Casemix funding in a large public hospital in New Zealand and found that clinicians distrusted the validity of Casemix information. Furthermore, clinicians expressed little interest in using it to inform their decision-making. It was reported that Casemix funding in the hospital had been largely dominated by financial and costing perspectives and had produced little information of perceived clinical relevance or benefit. The low regard that many clinicians had for management control information and the occupations associated with its generation and processing also presented a major difficulty in enrolling clinicians. Lehtonen (2007) and Eldenburg *et al*, (2010) both argue that the key to the successful implementation of Casemix funding practices is the ability to persuade clinicians to become centrally involved in its management and development. They claim that integrating clinical and financial accountability and assigning responsibility for the implementation to clinicians will serve this purpose. Furthermore, they emphasise the importance of allowing freedom of choice and flexibility in the adoption of the practice as a means of facilitating alleviation of conflict and settling of disputes. Finally, Eden, Lay and Maingot (2006) and Cardinaels, Roodhooft and Herck (2004) have demonstrated that there is little motivation to adopt ABC when the national financing and resource allocation system is still based on retrospective budgeting. Cardinaels *et al*, (2004) also discovered that the responses of clinicians to ABC could largely be explained by hospital-specific characteristics such as an awareness of problems regarding the existing budgeting practices and contracts governing clinician payment. They conclude that hospital management should not underestimate the level of clinicians' willingness to be involved in the design of management control practices.

Overall, empirical research that has adopted a rational perspective has highlighted the need for management control practices to consider the organisational context in which these practices are operating. Such studies have asserted the need for valid, comprehensive, relevant and timely information on which these practices may be based (Mai and Gayol 1991; Pizzini, 2006). Others have argued that the success of their design is dependent on the level of task uncertainty (Kim 1988; Abernethy and Stoelwinder 1990), hierarchical autonomy (Silva and Ferreira, 2010) and information flows (Ballantine *et al*, 1998). However, empirical research in this domain generally ignores the historical and political contexts in which organisations are located and treats them as closed systems. In contrast, studies that adopt a critical perspective locate their research in a precise historical context and interpret their findings in the light of the research context. The next section discusses this body of research.

3.3.3.2 External Factors

Research adopting a critical/social perspective generally views the implementation of management control practices as part of a political and social regime that enables governments to question the prevailing modes of organising medical practices and to introduce managerial discourse into the everyday practices of organising and managing hospital delivery. This research adopts a critical/sociological viewpoint. In particular, this perspective analyses how the external environment attempts to colonise the clinical culture by means of management control practices, and how clinical culture reacts to this colonisation. In many instances, this perspective has been associated with NPM reforms.

Based on a combination of quantitative and qualitative data collected in Norwegian hospitals, Pettersen (2001) found that the limited importance attached by the Norwegian County Council to the achievement of budget targets affected its role in this regard. The County Council considered the budget only as a formality; it argued that the only priority was to produce a handwritten document, regardless of whether anybody was aware of the content. Consequently, the County Council did not consider the ability to stay within budget constraints as a matter of importance and did not link overspending to any penalty. As a result of this approach, clinicians, equally, did not perceive the importance of staying within budget constraints. Similar conclusions were drawn by Nyland and Pettersen (2004) in investigating the link between budget control information and decision-making processes at both strategic and operational levels in a large Norwegian hospital. They found that clinical responsibility was associated with professional ethics and norms, whereas managerial responsibility was based on individual responsibility and adherence to rules. The rhetoric used by staff revealed that management control practices were important, but that adverse performance results did not have negative effects on the evaluation of the performance of clinician managers. Furthermore, they found that poor budget performance was viewed as a means of acquiring more resources. Nyland and Pettersen (2004) also note that the presence of informal feedback mechanisms such as ‘coffee-room talks’ influences the effectiveness of management control practices.

In a comparative study of management accounting in intensive care units in the UK and Finland, Kurunmaki *et al,* (2003) found certain commonalities between the countries in terms of intensive care problems but also significant differences, which were attributed to contrasts in the role of management control practices between the two countries. They noted that the absence of an established management accounting profession and the willingness of healthcare professionals in Finland to assume the accountant’s role was accompanied by a

commitment to financial targets and an acceptance of financial responsibilities. This was contrasted with the UK hospital, where it was found that healthcare professionals continued to have primacy. This dominance was strengthened by the use of management control information to enhance their position. They described the resulting dynamic as *'accounting as a legitimating function'* in which accounting facts, figures and arguments were assembled to project a defensive shield around the activities of healthcare professionals (Kurunmaki *et al,* 2003, p. 19). In terms of responses, a study conducted by Abernethy and Chua (1996), looking at both management and clinicians, found that these are not only contingent on the organisation's technical environment but also on its institutional environment. In an Irish context, Robbins (2007) identified and developed explanations for obstacles to the implementation of performance practices. Using data from a case study of an Irish acute public hospital, she argues that a lack of robust financial information systems has undermined and impeded the introduction of NPM principles and created tension and frustrations between management and clinicians.

3.3.3.3 Individual Factors

Considerable attention has been given to empirically assessing the consequences of introducing management control practices in contexts where the pursuit of efficiency is often in conflict with the professional objectives of the healthcare professionals involved. Using survey data collected from a large public teaching hospital in Australia, Abernethy and Stoelwinder (1995) investigated the level of clinician orientation towards budget control practices. The Abernethy and Stoelwinder (1995) study suggests a reluctance on the part of clinicians to accept management control practices, related to their ability to identify with efficiency-based goals. They, therefore, suggest that incorporating clinicians into the formal management structure would enhance the orientation of clinician managers towards management control practices and, consequently, they would be more likely to accept resource management. Abernethy (1996) built on the research of Abernethy and Stoelwinder (1995) and explored whether an individual's managerial orientation was more important for the effective use of formal accounting controls or non-accounting forms of control. The study employed questionnaire data obtained from 63 clinician managers in four large Australian teaching hospitals. Accounting controls in the study included budgeting and standard operating procedures. Non-accounting controls related to the informal interactions that occurred between organisational members during task performance. From its findings, the study concludes that the implementation of socialisation strategies designed to enhance an individual's managerial orientation will improve the effectiveness of accounting controls in hospitals. However, the findings also suggest that increasing an individual's managerial

orientation to enhance the effectiveness of accounting forms of control may reduce the effectiveness of some bureaucratic forms of control (i.e. the use of standard operating procedures).

Comberford and Abernethy (1999) extended the research of Abernethy and Stoelwinder (1995) by examining the conditions necessary to facilitate the effective involvement of healthcare professionals in the budgeting process. Specifically, they argue that the development of a commitment to managerial values can mitigate the potential for conflict when individuals with a high commitment to professional goals and values become involved in the budgeting process. In this context, they propose that top management must create the necessary level of trust if tendencies to pursue self-interest are to be contained. If this is not achieved, they contend that clinicians will be unwilling to share information or cooperate in the achievement of organisational goals and are likely to delay or even sabotage the implementation of any such initiatives. Finally, a study by Bouillon *et al,* (2006) examines the importance of goal congruence with management control practices using a theoretical framework that draws upon both agency theory and stewardship theory. The results indicate that managers, clinicians and nurses are not motivated by individual opportunism alone and that goal congruence does not depend solely upon the selection of appropriate performance measures and incentives to remove inefficiencies and moral hazards; rather, the study concludes that hospitals realise significant performance improvement only when nurses, clinicians and management reach a consensus on strategic direction.

3.3.4 Summary

Overall, the management accounting literature presents a view of clinicians demonstrating antagonistic attitudes to management control practices. In this regard, it has been argued that control practices play a symbolic or ritualistic role in healthcare and that clinicians are reluctant to engage with management control practices (Broadbent *et al,* 2001; Jones and Dewing, 1997, Kurunmaki, 1999; Preston *et al,* 1992). One explanation suggested for this finding is that management control practices are poorly designed and that a great deal of improvement is required before management control information is legitimised in clinical decisions (Pizzini, 2006). A further obstacle identified as influencing their effective use is the absence of identification with the managerial goals and values necessary to engage with management control practices (Comberford and Abernethy 1999; Bouillon *et al,* 2006).

3.4 A Critique of Empirical Research

A number of weaknesses emerge in the previous empirical studies conducted on the operation of management control practices in hospitals. Many of the deficits identified in this review have already been highlighted as shortcomings in the management control literature (Section 2.3.4).

Narrow Focus:

- There has been a tendency in the research to focus on specific management control practices as opposed to adopting a comprehensive and integrated approach (Abernethy and Chua, 1996; Abernethy and Lillis, 2001). It has been suggested that studying the operation of a management control practice independently may skew any conclusions drawn where the operation of a different practice is related to the functioning of the practice under investigation. Understanding how a range of management control practices operate simultaneously in hospital organisations is an important research question that has received little research attention (Lehtonen, 2007).
- Previous studies have been conducted at an organisational, sub-unit or individual level. However, it remains unclear how management control practices relate to each other with regard to organisational hierarchical levels. It would seem likely that the emphasis given to management control practices will differ at different organisational levels (Abernethy and Brownell, 1999; Cardinaels and Soderstrom, 2013).
- Existing research has tended to focus on clinicians to the virtual exclusion of other individuals that interact with management control practices. Significantly, little is known about how management employees interact with management control practices, despite these individuals playing a pivotal role in the everyday management of hospital services (Abernethy and Brownell, 1999*;* King *et al*, 2010).

Methodology:

- The vast majority of the evidence in this field has been accumulated through the use of questionnaires; however, survey-based methodologies are unlikely to capture the richness of this research context. There is an increasing need to use case-based or field evidence to explore the operation of management control practices in a hospital context (Abernethy and Stoelwinder, 1990; Eldenburg *et al*, 2010).
- The majority of the existing empirical research has been conducted in the UK, Australia or Nordic settings. Research in other empirical contexts would be advantageous in yielding

further insights into the operation of management control practices in a hospital context (Eldenburg and Krishnan, 2007).

Poor Theoretical Development:

- There is a scant and fragmented understanding about how contextual factors associated with the hospital context influence the operation of management control practices. Studies have considered an insufficient number of factors at any one time and have thus failed to elucidate how the nature of the hospital context affects the operation of these practices (Abernethy and Chua, 1996). Moreover, the empirical literature has identified an individual's professional orientation as an important factor in understanding the operation of management control in a hospital setting. However, a clear understanding of this factor remains lacking. It has been suggested that qualitative analysis may provide useful additional insights (Abernethy and Stoelwinder, 1991; Abernethy *et al*, 2006).
- It remains unclear how the operation of management control practices has influenced the responses of the various stakeholders in a healthcare context. While the literature provides some insights into clinician responses, the evidence is mixed and somewhat *ad hoc* in its approach. Moreover, little is known about the responses of hospital management to the operation of management control practices (Abernethy *et al*, 2006).
- An understanding of the implications associated with the operation of management control practice in hospital contexts also remains lacking. While there is some evidence to suggest that resource awareness may permeate clinician decision-making, it is not possible to conclusively attribute this outcome to the operation of management control practices. Sufficient evidence has not been provided to determine whether activities associated with management control practices influence the decision-making processes of key stakeholders in hospital settings (Abernethy *et al*, 2006; Cardinaels and Soderstrom, 2013).

3.5 Conclusion

This chapter commenced with a discussion of the nature and importance of the Irish hospital sector and the challenges faced by hospitals in adapting management control practices were highlighted. Empirical studies that have examined the operation of management control practices in a hospital context were reviewed in Section 3.3. This research has demonstrated that, while management control practices may lead to harmful side effects in other sectors, the unusually complex features of hospital organisations make this a particularly challenging context. The next chapter sets out the research objectives of this study along with the research methodology, approach and design adopted.

CHAPTER 4: RESEARCH OBJECTIVE, METHODOLOGY AND DESIGN

4.0 Introduction

The purpose of Chapter 4 is to present the research objective of the study and to describe and justify the research methodology, approach and specific methods adopted. The chapter is organised as follows. The research objective of the study is discussed in Section 4.1. Section 4.2 reviews the philosophical assumptions underpinning the research approach taken. This review will include a discussion of philosophical trends in management accounting research and the particular theoretical basis on which this study is founded. Section 4.3 considers the research approaches adopted to examine management control issues. In particular, it will discuss the calls made for case-study research to be conducted to develop a greater understanding of the operation of management control practices. Section 4.4 elucidates and justifies the research design employed. Section 4.5 concludes the chapter.

4.1 Research Objective

During the first decade of the twenty-first century, a period of economic and fiscal crisis constituted a global phenomenon, during which healthcare organisations were subjected to increasing pressure, mainly as a result of reduced expenditure and increases in demand for healthcare services. Although this situation posed challenges, it also highlighted the need for resources to be utilised efficiently and the operation of management control practices became a key component of the strategies implemented to ensure sustainability (OECD, 2013; 2015). However, a number of features of healthcare organisations pose challenges for the operation of management control practices. These include: the complexity of their core operating processes; the lack of clarity around their objectives; the control by a professional dominant group; and the problems in measuring and comparing outputs.

The management control literature demonstrates any control practice to be an imperfect tool and, therefore, each must be used in a way that takes account of its limitations and is appropriate to the particular circumstances. A failure to do this has been shown to result in harmful side effects (Merchant and Van der Stede, 2011). While, the potential for harmful side effects exists in all organisations, the specific nature of healthcare organisations renders them particularly susceptible (Broadbent *et al,* 2001; Jacobs, 2005; Jones and Dewing, 1997; Nyland and Pettersen, 2004). There is, however, relatively little empirical research exploring the operation of management control practices in a healthcare context (Cardinaels and Soderstrom, 2013). Furthermore, a number of weakness in prior studies of the healthcare setting are evident, many of which reflect similar flaws in the broader management control literature (Abernethy *et al,* 2006).

Therefore, based on the recognition of a need to improve the management of healthcare resources in addition to a lack of clarity surrounding the operation of management control practices in a healthcare context, the research objective of the study was to explore the operation of management control practices in a healthcare context during an economic and fiscal crisis.

4.2 Research Methodology

4.2.0 Introduction

A research methodology encompasses the epistemological, ontological and methodological assumptions that guide the inquiry in a research study (Sauders, Lewis and Thornhill, 2006). The purpose of this section is to highlight the philosophical perspectives available in terms of the study's research approach. Luka (2010) argues that the consideration of philosophical perspectives is important for several reasons. An awareness of the variety of available perspectives helps the researcher to consider additional possibilities in investigating a topic. Furthermore, it is argued that being ignorant of or unreflective regarding a study's philosophical underpinnings may help a researcher be efficient 'inside the box but carries the risk of seeing just the trees, not the entire forest' (Luka, 2010, p. 112). A discussion of the philosophical foundations of social science research is provided in Appendix A.

4.2.1 Philosophical Perspectives of Management Control Research

To explore the different perspectives adopted by management accounting researchers, it is essential to identify the ways in which philosophical perspectives may be categorised. Researchers such as Hopper and Powell (1985), Laughlin and Lowe (1990), and Ryan, Scapens and Theobald (2002) have used Burrell and Morgan's (1979) construction of a general sociological research framework as a foundation on which to explore alternative philosophical perspectives in accounting research. The three main perspectives are regarded as: mainstream, interpretivist and critical (Ryan *et al*, 2002). Management accounting research has been identified as predominantly informed by the mainstream philosophical perspective (Lukka, 2010). This perspective has been described as normative, in that it indicates how management accounting practices should take place and how management accounting systems should be structured. Hopper and Powell (1985) contend that the mainstream or traditional perspective comprises a number of different research approaches, including objectivism, social systems theory and pluralism. Meanwhile, Laughlin (1995) categorises the positivist, realist, instrumentalist and conventionalist research approaches as deriving from a mainstream perspective. In essence, all of these research approaches fall

within the functionalist paradigm, which regards individuals and organisations as external realities that are constrained by the environment they inhabit. Thus, mainstream researchers adopt a positivist epistemological stance and employ nomothetic research methods.

However, nomothetic research methods have increasingly been regarded as an unsatisfactory basis for management accounting research. Chua (1986, p. 601) contends that 'mainstream accounting research possess certain strengthens, but has restricted the range of problems studied and the use of research methods'. In support of this assertion, Baker and Bettner (1997, p. 293) argue that 'the type of research prevalent in the mainstream accounting journals, which is characterised by a positivist methodological perspective and an emphasis on quantitative methods, is incapable of addressing accounting's complex ramifications'. More recently, Lukka (2010, p. 112) has concluded that the current 'homogenising tendencies of management accounting research have inherently limited the scope of intellectual activity'. In this regard, while nomothetic research methods enable research to detect variations between the elements under investigation, they do not allow for an analysis of why such differences and gaps emerge. Furthermore, there has been a tendency by those adopting the mainstream approach to discount contrary research findings as anomalous, rather than to search for contextual reasons to provide a better understanding of actions and events that do not fit the theories or models applied (Lukka, 2010).

As a result, management accounting researchers have called for alternative philosophical perspectives to be considered. One such alternative is the critical perspective. This perspective seeks to critique the status quo by addressing the broader social order of capitalist societies (Bhimani, 2002). According to Laughlin (1987, p. 482), the critical perspective holds that 'the present is not satisfactory, that reality could be better than it is, and that critical theory can create this improvement'. Thus, critical research has been described as pursuit-oriented, with the overall objective to create 'a better accounting' (Gallhofer and Haslam, 1997, p. 74). A second and more prevalent alternative to the mainstream approach is the interpretivist perspective. This perspective attempts to describe, understand and interpret the meanings that human actors apply to the symbols and structures within the settings in which they find themselves (Ahrens and Dent, 1998). In particular, the interpretivist perspective does not regard people as behaviourally consistent or as exhibiting an invariant rationality that presupposes that responses to particular stimuli will be predictable; rather, this perspective seeks to explore how patterns of meaning and diverse behaviours emerge through social interactions. The interpretivist philosophical perspective does not strictly adopt a positivist or anti-positivist epistemology and it can apply both

ideographic and nomothetic research methods in its attempt to seek meaningful results. Puxty (1993, p. 70) succinctly explains that 'an interpretivist approach is one in which a better means of understanding the situation is employed but, once this has been achieved, the normal rules of science apply, which are that, given the objectivity within the situation itself, it must be possible to learn from it for such future situations'. An interpretivist approach to accounting research has been argued to 'straddle paradigms' in that it combines subjective and objective features (Ahrens, 2008).

There are clear similarities between the interpretivist and critical approaches in terms of the subjective value of the social world, though interpretivist research focuses on how accounting is socially created and how the perceptions attached to it preserve the status quo rather than exploring which ideological pressure is influential (Hopper and Powell, 1985). Baker and Bettner (1997) argue that the main difference between interpretivist and critical research is the willingness of the latter to take a particular stance regarding the nature and purpose of research and its political and societal implications, whereas interpretivist research purports to maintain a neutral stance.

4.2.2 Philosophical Perspective of Current Study

As delineated earlier, the research objective of the study was to examine the operation of management control practices in a healthcare context during an economic and fiscal crisis. Management control information, which is derived from management control practices, is human-made and has no natural existence. Thus, management control information is not independent in a physical or positivist sense. Furthermore, management control practices are implemented in order to increase the probability that individuals will behave in ways that lead to the attainment of organisational goals (Merchant and Van Der Stede, 2011). Therefore, any examination of management control requires an understanding of both the decision-making process and the responses of individuals. Acquiring this understanding entails a consideration of how individuals perceive uncertain future realities and how social relations and attitudes affect the process and outcomes of decision making. Consequently, the objective of the research study is not achievable without consideration being given to individual responses and the perceptions prompting them. It is suggested, therefore, that this study falls within the interpretivist paradigm. Such a philosophical paradigm is consistent with and supportive of the study's research objective.

In terms of ontology, the position taken could be identified as 'reality as a contextual field of information' (Morgan and Smircich, 1980, p. 492), which is midway between the polarities

of nominalism and realism. This approach recognises that generalisations about reality are possible, though not guaranteed to exist, yet maintains that these will always be 'skeletal' and require empirical data to make them meaningful (Laughlin, 1995). In terms of epistemology, the study, while avoiding a shift towards either of the two extremities, veers towards anti-positivism in resisting the pursuit of universal laws and holding that an understanding of the social world is best developed by exploring social phenomena through the eyes of participants and in their natural contexts. Such ontological and epistemological perspectives are argued by Laughlin (1995) to be associated with methodologies that adopt a definable approach but remain open to refinement in actual situations. The next section presents a detailed account of the study's research design.

4.2.3 Summary

This section has highlighted the merits of choosing an interpretivist position and demonstrated the critical support for this selection among researchers in the field, who have called for a more interpretivist approach to be taken to management control research. It is argued that the interpretivist approach and its theoretical assumptions are capable of addressing the limitations identified in the mainstream approach, as well as being aligned with the research objective of the current study.

4.3. Research Approach

4.3.0 Introduction

Patton (2002) suggests that consideration should be given to two issues when adopting any one research approach. Firstly, attention needs to be given to the research approaches that are principally applied in the domain being investigated. Secondly, the overarching objective of the study should be carefully considered in order to match it with the most appropriate research approach. The following subsections examine these issues in turn.

4.3.1 Research Approaches in Management Control Studies

Research findings relevant to the domain of management control have been produced using many research approaches - analytical modelling, surveys, archival records and case studies - each of which has its own set of advantages and disadvantages (Merchant and Otley, 2006). For example, research that has applied an economics-based principal-agent theory has used an analytical modelling approach, which involves using mathematical models to search for an optimal solution given a particular set of conditions. The advantage of this analytical modelling approach resides in the rigour of its argument and this literature has made a

significant contribution to identifying variables that should be considered by organisations that are designing control systems (e.g. risk aversion or information asymmetry). However, this research is often criticised as having failed to sufficiently capture the complexity of the setting in order to provide reliable guidance to managers concerned about management control issues (Chenhall, 2003; Scapens, 1990; Otley, 1994).

The survey method has been reported to be the most prominent research approach in management control research. In fact, Van der Stede, Young and Chen (2005) report that, in the period 1982 - 2001, 30 per cent of all published empirical management accounting research used surveys. Survey studies have adopted multiple means of distribution (e.g. mail, internet and telephone) and have facilitated the collection of information from relatively large samples of respondents. Furthermore, surveys have been used to test, refine and explain existing theories, as opposed to being used to explore a new topic or issue and, accordingly, the survey strategy has usually been associated with the deductive approach. Proponents of the survey have argued that it is an appropriate method for testing differences in sample subsets (Van der Stede *et al*, 2005). Furthermore, it has been argued that surveys can be used for studies at multiple levels of analysis, from the entire organisation down to employees at the lowest level (Noeverman, 2005). However, as most surveys involve cross-sectional analysis, drawing causal inferences can be difficult (Chenhall, 2007). This research approach has also been criticised for not being cumulative in its outcomes, as different instruments of measurement have been used in a wide range of different contexts without adequate contextual information being given to enable these differences to be recognised (Chenhall and Smith, 2011; Otley, 1994).

Researchers have also used archival data to conduct relatively large-scale empirical studies. While some studies have employed such data secured from public sources, such as regulatory filings, others have used data obtained from within the organisation. Archival studies have two main advantages: one is that the data is seen as ‘objective’ and untainted by, for example, response, surveyor, interviewer, or cooperating organisation biases; the other is that researchers working with archival data are often able to work with large sample sizes, which allow the use of more sophisticated statistical methods and more reliable generalisation to specific populations of interest (Merchant and Otley, 2006). Because of the availability of public disclosures, particularly in the US, the control-related topic area that has received the most attention from archival researchers relates to the incentivisation and compensation of top management. However, only a small number of researchers (e.g. Ittner

and Larcker, 1998) have been successful in gaining access to organisation databases that are suitable for studying management control-related topics.

There have been calls for management control researchers to adopt case-based methods (Berry *et al*, 2009; Chenhall, 2007; Berry and Otley, 2004). These calls to action appeared to have a near-immediate effect on research activity. Chenhall and Smith (2011) conducted a review of 231 papers published in ten leading management accounting journals between the years 1980 and 2009. An examination of Table 4.1 reveals that, in the period 2000-2009, the number of studies using case-based approaches exceeded those employing surveys for the first time. Similarly, a Management Accounting Research Editorial Report (2010) found that the number of case studies increased in the second decade, at 40 per cent compared to 24 per cent in the first decade. It was, however, argued in the Editorial Review that the distinction between case studies and other field studies is rather arbitrary and that a more appropriate comparison might be the combination of case studies and other field studies, which constituted 39 per cent in the first decade compared to 48 per cent in the second. This perceptible increase was explained by a decline in (descriptive) surveys (Scapens and Bromwich, 2010). The most common purpose of case-based management control research has been theory development, but researchers have also applied this research approach to develop new classification systems (e.g. Simons, 1987) and to develop measures for previously identified concepts (e.g. Banker, Datar and Rajan,1987). The utility of these roles suggests that case-based research will continue to be important.

In the management control in healthcare literature, the most common research approach used is the survey method (Abernethy *et al*, 2006). However, Abernethy and Stoelwinder (1990) argue that this method is unlikely to capture the richness of this research environment. Abernethy and Stoelwinder (1990, p. 23) argue that action research and the use of qualitative methodologies, such as case studies, are being called for in both the organisation and management control literature in order to help 'practitioners understand organisations in a way that will improve practice' and 'contribute to a theoretically and scientifically useful body of knowledge about organisations'. It has also been argued that hospitals are complex organisations, the study of which requires the researcher to be on the site field 'to be able to understand what is going on' (Mintzberg, 1997, p. 12). Abernethy *et al*, (2006, p. 823) advocate a need for diversity in research approach. They argue that case studies have the potential to 'offer fruitful insights into both the design and use' of management control practices in the context of healthcare 'as they permit answers to be sought to explain questions as to why and how particular management control phenomena are observed'.

Table 4.1: Research Approaches within Management Control Studies				
	Editorial Review (2001)	Chenhall and Smith (2011)	Editorial Review (2010)	Chenhall and Smith (2011)
Journals	**MAR**	**AAAJ, AOS, AF, BRIA CAR, JAE, JAR, JMAR, MAR TAR**	**MAR**	**AAAJ, AOS, AF, BRIA CAR, JAE, JAR, JMAR, MAR TAR**
Time period	1990 -1999	1990-1999	2000-2009	2000-2009
Number of papers	178	78	196	121
Analytical: mathematical	13%	1%	30%	0%
Analytical: discussion	14%	5%	11%	2%
Behavioural experiments	4%	13%	2%	10%
Case studies	24%	14%	40%	37%
Other field studies	15%	1%	8%	0%
Surveys	15%	45%	4%	31%
Financial analysis	1%	0%	2%	0%
Historical/archival analysis	6%	1%	1%	2%
Literature review	8%	15%	1%	12%
Multiple methods	0%	5%	0%	6%
	100%	100%	100%	100%
MAR = Management Accounting Research, AOS = Accounting, Organizations and Society, TAR = The Accounting Review, CAR = Contemporary Accounting Research, JAE = Journal of Accounting and Economics, JAR = Journal of Accounting Research, JMAR = Journal of Management Accounting Research, and EAR = European Accounting Review.				
Source: Editorial Review (2010); Chenhall and Smith (2011)				

4.3.2 Research Approach Selected for the Current Study

The management of healthcare expenditure needs to become more efficient. Otherwise healthcare demands will undermine public finances. The recent economic crisis and its impact on fiscal budgets have heightened pressure and made the issue more urgent (Section 3.1.1). With this in mind, the research objective of the study was to explore the operation of management control practices in a healthcare context during an economic and fiscal crisis. To achieve this, the Irish hospital sector was selected as an appropriate setting (Section 1.3).

As little was known about management control practices in an Irish hospital context, a preliminary phase of investigation was conducted. Utilising Ferreira and Otley's (2009) Performance Management Control framework, the preliminary phase of the study aimed to develop an understanding of the type of management control practices that were operational in the research context being studied and to acquire a broad understanding of the factors influencing the operation of these practices. These objectives were achieved by exploring the perceptions, thoughts and encounters of four individuals at distinct hierarchical levels in a large, acute, public teaching hospital (Sections 4.3.4 and 4.3.5). The preliminary phase provided valuable insights into the operation of management control practices in the Irish hospital sector and a number of issues that could be further explored were highlighted (Section 5.1).

Following the preliminary investigation, consideration was provided to each of the research approaches applied in the management control research. Particular attention was given to the merits of conducting a cross-sectional quantitative survey. However, following careful reflection and analysis of the preliminary findings, the decision was made that the most appropriate means of conducting further investigation was to use a qualitative case- study based research approach. A number of factors informed this decision. Firstly, the preliminary phase highlighted particular issues that could not be further explained through quantitative investigation, as the issues lacked adequate understanding and definition. Secondly, it was believed that undertaking an in-depth qualitative enquiry would provide a better understanding of the key issues that had emerged from the preliminary phase of the research, as well as allowing new issues to emerge. Finally, most management accounting research that has investigated the operation of management control practices has used cross-sectional survey research methods. Hartmann (2000, p. 478) argues that, while the cross-sectional research method is well documented in the methodological literature, its use in research seeking to explore attitudes and responses associated with the operation of management control practices 'often does not seem the outcome of a deliberate choice, but rather a result of mere conservatism'. Moreover, as discussed earlier in Section 4.3, the existing management accounting studies in healthcare have, in the main, employed quantitative survey-based research methods and it has been suggested that there is, therefore, a need to use additional qualitative evidence to explore the operation of management control practices in a healthcare context (Abernethy and Stoelwinder, 1990; Abernethy *et al*, 2006). For these reasons, the researcher was convinced that the case-based research approach was both sufficiently powerful and flexible to allow the researcher to make a significant contribution. While it was certainly accepted that there was a place for other research approaches, on

balance it was believed that a case based research approach would best address the research objective of the study. Furthermore, it was concluded that the concerns associated with this approach could be minimised by developing a robust research design.

4.3.3 Merits of Case Study Research

Case studies, as a key pillar of research design, offer a number of benefits that have relevance to this study. Firstly, this approach has the potential to provide a holistic perspective on the phenomenon under investigation, thus enabling the development of a rich description of events and leading to a greater understanding of them (Otley and Berry, 1994). Secondly, it facilitates the gathering of data from a number of different sources within the same case organisation, thus allowing the researcher to analyse corroboratory and contradictory evidence as it is presented (Yin, 2009). Thirdly, it offers the opportunity to step backward and forward, for example, refining the research objectives(s) and/or collecting additional evidence (Ryan *et al*, 2002). Fourthly, case studies have the potential to lend themselves to early, exploratory investigations where the variables are still unknown and the phenomenon is not fully understood (Cooper and Morgan, 2008). Finally, case studies allow much more meaningful research questions to be posed concerning 'how' and 'why', rather than just 'what' and 'how', which may be answered based on a fuller understanding of the nature and complexity of the complete phenomenon (Merchant and Van der Stede, 2006).

4.3.4 Challenges of Case Study Research

Despite their usefulness, case studies have often been criticised. For example, they have been challenged on the specific bases of lack of scientific rigour, poor implementation, the scope for bias and limited scope for generalisation and, more generally, the approach has been condemned as a time-consuming activity that produces voluminous, illegible documents (Bryman, 2004; Yin, 2009). Scapens (1990) suggests three common problem areas of case research: 1) the challenge of mapping the perimeter of the case in terms of the number of cases, or in a longitudinal sense; 2) the potential for bias through the presence of the researcher; and 3) the principles of the researcher, for example, confidentiality issues inside and outside the research setting. In this study, it was, therefore, considered important to minimise these potential drawbacks through the development of a robust research design.

4.3.5 Summary

This section described the process of selecting an appropriate research approach. Consideration was given to the research approaches applied in the management control research as well as the research objective of this study prior to a case-based approach being selected.

4.4 Research Design

4.4.0 Introduction

'A research design is the logic that links the data to be collected and the conclusions to be drawn to the initial objective of a study' (Yin, 2009, p. 18). The purpose of this section is to elucidate and justify the research design employed. Consideration is given to the merits and inherent limitations associated with the various research methods employed. In addition, related issues such as site selection and access are discussed. Finally, this section highlights the most important data collection and analysis issues of the study.

4.4.1 Case Study Design

A key aim when undertaking case-study research is the matching of the research objective and the study design. Marshall and Rossman (1999) outline four possible research purposes for a given study (i.e. exploratory, explanatory, predictive and descriptive) and suggest the most appropriate research design for each type. As little was known about the operation of management control practices in a healthcare context, the researcher decided that the research objective would be best addressed by conducting an exploratory case study.

A further fundamental decision, in terms of case-study research design, is whether to adopt a single or multiple-case based approach. The decision was made after careful deliberation. Eisenhardt (1989, p. 545) advocates that multiple case sites are required and that, where fewer than four case sites are used, both the theory emerging and the empirical findings may be 'unconvincing'. In contrast, Dyer and Wilkins (1991, p. 614) argue that 'it is the careful study of a single case that leads researchers to seek new theoretical relationships and question old ones'. An alternative perspective is proposed by Yin (2009, p. 42), who suggests that there are five circumstances in which the adoption of a single case study could be considered a robust research design. These are presented in Table 4.2 below.

Table 4.2: Rationale for Single-Case Design	
Critical case	Where the single case represents a critical case within which to test a well-formulated theory and to confirm that this theory is either correct or can be the subject of alternative explanations.
Extreme case	Where the single case is either a unique or extreme case and hence no patterns are able to be established.
Representative case	Where the case is a representative or typical case and where the aim is to capture the conditions of a situation and hence to be informed about the experiences of the average organisation or individuals within it.
Revelatory case	Where the case is a revelatory case in that the phenomenon has been previously inaccessible to study.
Longitudinal case	Where the case is worthy of longitudinal study through examination at two or more different stages/points in time.
Source: Yin (2009, p. 42)	

In relation to this study, the justification for the adoption of a single-case research design was that the case organisation would be revelatory in that the phenomenon has not been previously studied. Prior studies of the Irish hospital setting were conducted prior to the implementation of the Health Service Reform Programme (2003) and the establishment of the HSE. Consequently, the study was considered exploratory and revelatory in nature.

A final decision in defining the design for the case study is to determine the level of analysis. Yin (2009, p. 14) distinguishes between holistic and embedded cases; a holistic case investigates the phenomena from a global perspective, while an embedded case investigates multiple units of analysis. Of particular importance to this study is an argument by Ryan *et al*, (2002) that, if management accounting researchers want to exploit the full potential of case-study methods to understand the nature of accounting, they must be prepared to study accounting practices at various levels within the organisation and the relationships between various groups of managers. The implication of this argument for management accounting research is that case studies should explore the day-to-day accounting practices of real people and attempt to study the context in which they work. As this study sought to examine the operation of management control practices at various organisational levels, it is argued that this case has an embedded nature, with multiple levels of analysis. Therefore, the case-study research design can be characterised as an exploratory, revelatory, single-case study with embedded units of analysis.

4.4.2 Case Site Selection

Hospital services in Ireland are delivered in both public and private hospitals. There are 48 public hospitals in Ireland, 34 of which are owned and operated by the HSE, with the remainder being voluntary hospitals providing hospital services to the HSE under service-

level agreements (Section 3.1.3.3). Given the researcher's aim of examining the operation of the management control practices in public hospitals, the potential sample was, therefore, 34. However, it was anticipated that a sample comprising only the larger, multifaceted hospitals, which deliver a diverse range of hospital services, would best address the study's research objective. Accordingly, a potential sample of eight hospitals was complied. The selection was based upon the HSE's classification of 'Teaching' (eight hospitals), 'Non-Teaching' (21 hospitals), 'Paediatric' (two hospitals) and Maternity (three hospitals) (Section 3.3.3.4). On this basis, it was concluded that each or all of the eight teaching hospitals had the potential to inform the empirical investigation. However, as set out in Section 4.3, a single-case based study was determined to be the most appropriate research approach.

By its very nature, case-study research cannot be effectively conducted without adequate organisational co-operation. Ferreira and Merchant (1992, p. 19) suggest that, with an effective 'sales pitch' and the use of as many contacts as possible that can facilitate access, case-study researchers can expect a success rate of 50 per cent. This means that a researcher needs to contact two organisations to have the expectation of securing the co-operation of one. On this recommendation, the researcher selected two of the eight teaching hospitals. Chua (1996, p. 221) suggests that researchers should seek approval 'as high up the organisational hierarchy as possible' to minimise future access restrictions, while being mindful that the researcher is not viewed as an undercover detective hence undermining trust. In the first hospital, a document outlining its organisational structure was obtained from a general administrator within it by means of a phone call. In view of Chua's (1996) guidance, and based on an examination of this document, an email was then sent to the Finance Manager outlining the overall scope of the research and requesting an opportunity to have an informal discussion in respect of it. Subsequently, a follow-up phone call was also made and a meeting was arranged with both the Finance Manager and his superior, the Financial Controller. Both individuals were supportive of the research study, providing valuable insights that contributed to the researcher's understanding of the healthcare context. However, the interviewees did not have the authority to grant approval of the study and so referred the researcher to the Hospital's Managing Director who, unfortunately, was leaving his current role to move to a HSE role and the researcher was unsuccessful in her attempts to gain access to the incoming Managing Director.

With regard to the second hospital, the organisational structure was once more assessed to select an appropriate initial contact. A phone call was also made to a personal contact to establish who in the organisation may be predisposed to engage with the research study. The

same email used previously was sent to the organisation's Deputy General Manager and, in a follow-up phone call, arrangements were made for an informal meeting, during which the researcher outlined the overall scope of the research and explained its requirements. The Deputy General Manager then granted approval for the study to be conducted. In the following weeks, this was confirmed formally by a written letter. The Deputy General Manager consequently became a 'gatekeeper' of the research process, described by Burgress (2002, p. 48) as 'those individuals who control and have power to grant access within the research context'. The study's research design was also approved by the Dublin City University Research Ethics Committee.

4.4.3 Case Organisation

The case organisation, Woodford, is a large, acute, publicly-funded, teaching hospital in Ireland. Woodford is pseudonym used for confidentiality reasons. The Hospital serves the local population but also acts as a regional centre for a range of medical and surgical specialisations. The population served by Woodford has increased dramatically over the past two decades with the latest census data showing it to have grown by 31 per cent during the period 1981 to 2011. Furthermore, the number of people over the age of 65 in the region has increased by 43 per cent (Central Statistics Office, 2014). Accordingly, the intensity of demand for hospital services within the region has increased in recent years. Woodford has 760 beds, of which 685 are inpatient beds and 75 are day-beds. The Hospital currently employs 3,660 staff of which 68 per cent are employed in its clinical services and 32 per cent work in support services. In relation to the latter, 41 per cent of support-service staff work in management and administrative roles. Woodford is also affiliated with a medical school in Ireland as a teaching hospital and is part of the national medical rotation training scheme.

The need for a robust strategic planning process that results in the formulation of a clear organisational mission was articulated as an important prerequisite for the successful operation of management control practices in Section 2.1.3. Woodford's mission statement, delineated in its Service Plan (2011), was stated as follows: 'to provide high quality care for those we service with a focus on clinical excellence, patient safety and continuous improvement through clinical education and research'. This mission was reinforced by a vision statement, which articulated the following four organisational goals:

- Woodford Hospital will strive to value its expertise in the provision of quality acute healthcare services and to have a positive impact on the lives of those it encounters.
- We aim to build a work environment where each person is valued and respected.

- We aim to continue our focus on education through building on the formal affiliations with educational institutions, facilitating learning and continuous performance improvement within the organisation.
- We will promote active participation in research and innovation, leading to improved health outcomes for patients.

Woodford Service Plan (2011, p. 6)

Significantly, the vision statement focuses on issues of enhancing healthcare delivery, the work environment and the development of the Hospital's teaching and research programmes. In contrast with the HSE's vision statement (discussed in Section 3.1.3.1), reference is not made to issues of equality, accountability or the co-ordination of services.

An examination of the organisational arrangement revealed that the Hospital has three core management levels: 'Woodford Management' (WM), 'Senior Management' (SM) and 'Clinician Management' (CM). There are three members of WM at the Hospital: a CEO, a Director of Nursing and a Clinician Director. At the next level down in the organisational structure, there are seven members of SM including an Operations Manager, a Director of Midwifery, a Business Manager Representative, an Information Technology Manager, a Human Resource Manager, a Medical Manpower Manager and a Finance Manager. The purpose of SM is to report to WM on matters of finance, service delivery, human resources, information technology and hospital quality programmes.SM is supported by a Service Management Group (SMG) and a Support Service Board (SSB). The SMG consists of managers of support and clinical services and provides a forum for review of issues relating to clinical practice or hospital management that are of common concern. The SSB comprises managers from a range of support services, which provide care and support to patients. The main function of the SSB is to provide a forum for members to share information and seek input or advice from other disciplines or functions in relation to developments in their own disciplines and to co-ordinate inputs from individual units into the annual service plan. CM in the organisation is categorised into 15 CM divisions. The divisions are based on grouping specialisations with their related service and resource requirements. Each CM division is comprised of three members: a Division Chair (DC), a Business Manager (BM) and a Nurse Service Manager (NSM). The DC is appointed by the CEO for a term of two years. Nominations for appointment as DC are made from within the divisions. The DC is accountable to WM.

An important adjustment was made to the organisational arrangements during the study period. A Cost Containment Board (CCB) was established to monitor and track budget control in 2012. The CCB had five members: the CEO, the Director of Nursing, a Clinical Director, the Finance Manager and the Operations Manager. In order to facilitate the discussion of the interview findings, in subsequent chapters, Woodford Management (acronym 'WM') will be used to describe the five members of the CCB. The circumstances and outcomes associated with the establishment of the CCB will be discussed in Section 6.1.1.

4.4.4 Conducting the Interviews

Interviews generally fall into one of three established categories: structured, semi-structured and unstructured (Yin, 2009). Structured interviews require that similar questions are asked of different people and that comparable information is obtained. In contrast, the semi-structured interview allows the researcher flexibility to pursue new themes as they arise and thereby explore emerging lines of enquiry. Furthermore, in the semi-structured interview, the researcher has a broad framework on which to base the questions asked, meaning that similar issues are discussed with a number of different people but there remains sufficient flexibility to explore the issues in depth and to ask follow-up questions tailored to the responses given by particular interviewees. Finally, unstructured interviews are informal and are used to conduct a deep exploration of an area of interest. Semi-structured interviews were considered the most appropriate form of interview for this study because they allowed the researcher to probe the meaning attached by interviewees to control issues and to explore how these issues influenced the operation of management control practices. This supported the study's overall research aim of exploring how management control practices operate in a healthcare context during an economic and fiscal crisis.

Patton (2002) outlines a number of benefits associated with the interview research method. He suggests that interviews allow issues to be examined in depth without predetermining categories of responses. This method also allows the interviewer to develop a rapport with the interviewee and can encourage them to describe and reflect on personal experiences. Furthermore, Patton (2002) suggests that interviews allow complex topics to be addressed and greater control over the presentation of questions, thereby providing more opportunities for in-depth probing of issues while facilitating the observation of the interviewee and his or her emotional reactions. A further benefit of the interview method is that it allows the interviewer to seek clarification on, and engage more deeply with, issues that arise during the discourse. However, in selecting the interview as an appropriate research method, the

researcher was also cognisant of its limitations. Becker and Geer (1957) identify three limitations associated with the interview as a research method. Essentially, these aspects arise from the fact that the interviewee gives an account of actions that occurred elsewhere in time and space. In this context, the first issue is that the interviewer may not fully understand the language that is specific to the particular field under examination. This factor was particular relevant in the current study as the connotations of certain healthcare terms were not immediately apparent to the researcher. Secondly, for a variety of reasons the interviewee may omit important details. This may be due to a difficulty in expressing certain issues or because they appear to the interviewee to be impolite, insensitive or inappropriate. Thirdly, an interviewee may have a distorted perception of a situation and, hence, provide an account that is misleading yet is not open to checking or verification. With these limitations in mind and maintaining an awareness of the potential problems that could arise, the researcher made every effort to mitigate the effects of these factors when conducting the interviews.

As delineated earlier, the Irish hospital sector was selected as an appropriate setting in which to explore the operation of management control practices during an economic and fiscal crisis. As little was known about management control in an Irish hospital context, a preliminary phase of investigation was conducted. Utilising Ferreira and Otley's (2009) Performance Management Control framework, the preliminary phase of the study aimed to develop an understanding of the type of management control practices that were operational in the research context being studied and to acquire a broad understanding of the factors influencing the operation of these practices. An interview guide informed by the Performance Management and Control framework of Ferreira and Otley (2009) was created in advance of conducting the preliminary interviews. The primary areas covered in the interview guide used in the preliminary phase are set out below:

- Background information: e.g. job title, responsibilities and organisational position.
- Management control practices in general: what management control practices are used and how these practices are generated, adapted and communicated.
- Design attributes of goals to achieve: e.g. vision and mission, key success factors, key performance indicators and target setting.
- Design attributes of means used: e.g. organisational structure, strategies and plans and performance evaluation and reward systems.
- Factors influencing the use of management control practices: identifying the strengths, changes or adaptations that should be made to the management control practices.

- Consequences of management control practices: the rewards (financial or non-financial) for achieving or penalties for failing to achieve performance targets.
- Flow of management control information: information flow up and down the organisation.
- External influences on management control practices: exploration of changes to management control practices as a result of any external factors or influences.
- Management control practice linkages: discussion of how strong and coherent the links are between the different management control practices.

A copy of the full interview guide used in the preliminary phase is included in Appendix B.

These preliminary interviews proved to be a critical phase of the study. From a research design perspective, careful analysis of and reflection on the preliminary findings, combined with a critical review of the empirical literature helped to shape the design of the main phase of empirical work. With respect to conducting the interviews in the main phase, the questions posed emerged primarily from the analysis of data gathered in the preliminary phase of the study, as well as from existing research. Consequently, the researcher returned to the case site with an interview guide designed with due consideration of both the prior literature and the context of the study itself. The major areas covered in the interview guide used in the main phase of the empirical investigation included:

- Background information: e.g. Length of time working in the Irish hospital sector, length of time working in Woodford Hospital, length of time in current position and brief description of training and educational background.
- Individual involvement: e.g. Nature of involvement with management control practices, job activities requiring involvement with management control practices and extent and purpose of involvement with management control practices.
- Individual factors affecting involvement: e.g. professional orientation, personality, participation, training and education and other individual issues having an impact on involvement.
- Organisational factors affecting involvement: e.g. the HSE, communication processes and other organisational issues influencing involvement.
- External factors: political interference, environmental uncertainty and other external issues affecting involvement.
- Management control factors: e.g. target setting, task uncertainty, performance evaluation and other issues associated with the control practices that have an impact on involvement.

- Improve involvement: measures that could be implemented to improve involvement with management control practices.
- Decision making: changes in the decision-making process associated with the operation of management control practices.
- Behaviour: changes in behaviour associated with the operation of management control practices.

A copy of the full interview guide used in the main phase is included in Appendix C.

It is important to note that the interview guides employed in both phases of the empirical investigation were adapted to meet the needs of each individual interviewee's areas of responsibility. Furthermore, the interview guides were used in a flexible manner in order to allow emerging issues to be explored and illustrations to be provided. The researcher's approach to the interviews was naturalistic in orientation and efforts were made to ensure interviewees felt comfortable and free to discuss the issues openly. In this regard, at the beginning of each interview the researcher briefly explained her background and outlined the research objectives of the study. The interviewees were also reassured that, while the case organisation was facilitating the study, it was an independent research project. The researcher was particularly careful to help participants to feel comfortable when discussing their concerns about the operation of management control practices. The researcher also brought a copy of the Hospital's Service Plan and a HealthStat Report to each interview as a reference aid in the main phase of the study.

In terms of obtaining consent from individuals, the researcher contacted both Woodford and Senior Management on an individual basis via email and a follow-up phone call if necessary. For Clinician Management, the researcher contacted and interviewed the Business Managers of the respective Clinician Divisions initially and sought their assistance in gaining access to the selected clinicians in their division. The preliminary-phase interviews took place between February and May 2011. The main-phase interviews took place between mid-July and mid-October 2012. Each interview, on average, lasted between 50 and 60 minutes. The location of the interviews varied but the majority took place at the offices of the participants. The interview with the Senior Consultant in the Emergency Division took place in a patient waiting area and that with the Chair of Cardiac Division was conducted in the corridor outside of an operating theatre. In the latter case, the individual's daily schedule was running late and the interview was conducted while a patient was being prepared for surgery. Permission was granted for the recording of all interviews. During each interview, additional

notes were taken to record aspects such as setting, body language and the rapport existing between the interviewer and interviewee. Immediately after each interview, the quality of the data collected was reviewed. Each audio file was checked to ensure that the interview has been properly recorded. In addition, notes taken during the interview were reviewed to ensure that they would be fully comprehensible to the researcher at a later point in the research process. A research diary was also kept to reflect the researcher's thoughts and feelings about the organisation and issues raised during each visit.

4.4.5 Selection of Interviewees

The objective of the interviews was to enrich understanding with regard to the operation of management control practices in a healthcare context during an economic and fiscal crisis. Consequently, a purposive sampling approach was adopted. Patton (2005, p. 91) defines purposive sampling as 'the process of identifying a population of interest and developing a systematic way of selecting individuals that is not based on advanced knowledge of how the outcomes would appear'. This approach was considered appropriate as the purpose of the interviews was to gain a sense of how the management control practices had evolved into their current form and no attempt will be made to generalise the findings of these interviews. In addition, the selection of participants interviewed was informed by Ferreira and Otley's (2009) suggestion that the full use of their Performance Management and Control framework requires participants at various hierarchical levels to be interviewed. They argue that, to gain a full understanding of the overall effects of a management control system, it is necessary to gather evidence about the patterns of usage and behaviour at each level so as to understand the overall effects of the management control system. Furthermore, the researcher believed that exploring the operation of management control practices at various hierarchal levels would make a valuable contribution to the existing literature, which has tended to adopt a narrow focus, whereby the management control literature concentrates on top-management usage, while the management accounting in healthcare literature has directed its attention towards clinician management.

As highlighted in Section 4.3.3, Woodford has three core management levels: 'WM', 'SM 'Woodford Management', 'Senior Management and 'Clinician Management'. At the Woodford Management level, interviews were conducted with five individuals: the CEO, the Director of Nursing, the Clinical Director, the Finance Manager and the Operations Manager. At the Senior Management level, interviews were conducted with five individuals: the Services Manager, the Support Services Manager, the Deputy General Manager, the Bed Manager and the Business Manager to the Clinical Director. One individual at the Service

Manager Group level (the Bed Manager) was highlighted as being of specific relevance to this study. At the Clinician Management level, the 15 clinical divisions were examined, from which the three selected were: Cardiac Services, Emergency Services and Oncology. The researcher felt that the selection of three clinical divisions would balance the need for an in-depth enquiry into each clinical division with the need for meaningful comparative analysis, while also being mindful of resource constraints. Within each of the clinical divisions, four roles were targeted: (i) Chair; (ii) Business Manager; (iii) Nurse Service Manager; and (iv) Senior Consultant. Consequently, in terms of sample size, the researcher conducted 24 interviews across three management groups. Table 4.3 sets out the details of the individuals interviewed in the study.

In order to facilitate the discussion of the interviews in subsequent chapters, a lettering system will be used. For Woodford Management, the acronym 'WM' is used. For Senior Management, the acronym 'SM' is used. Finally, as three Clinician Divisions were involved, a double lettering system is also used to differentiate between them. The first letter indicates in which of the three Clinician Divisions the interviewee is located (e.g. 'E' for the Emergency Division, 'O' for the Oncology Division and 'C' for the Cardiac Division. Secondly, an acronym is used to allow the findings to differentiate between the four roles in each of the three Clinician Divisions: 'BM' indicates the interviewee is a Business Manager; 'Consul' denotes a Consultant; 'NSM' denotes a Nurse Service Manager and 'Chair' indicates the interviewee is the Chair of the Clinician Division. Thus, for example, 'CNSM' is a Nurse Service Manager in the Cardiac Clinician Division.

4.4.6 Organisational Documentation

Documentary evidence is a common component of qualitative enquiry and provides a rich source of insight into the interactions and communications occurring between individuals and groups at all levels in an organisation (Bryman and Bell, 2015). One of the most important functions of documentary evidence is to corroborate and strengthen other data sources (Yin, 2009). In this study, organisational documentation was used in both the preliminary and main phases of the study in order to gain an understanding of how management control practices had been designed and implemented in the case organisation. Furthermore, organisational documents were used to build up a description of the organisation and its history (Bryman and Bell, 2015). Finally, organisational documentation was used in order to elicit greater detail and depth during the interviews and when probing interviewee responses.

Table 4.3: Interview Sample Details		
	Date	**Ref**
Woodford Management		
Chief Executive Officer *	02/02/2011	WM1
Director of Nursing	01/10/2012	WM2
Clinical Director	03/10/2012	WM3
Finance Manager	10/07/2012	WM4
Operations Manager	20/07/2012	WM5
Senior Management		
Deputy General Manager *	21/04/2011	SM1
Services Manager	11/07/2012	SM2
IT Manager	17/07/2012	SM3
Support Services Manger	21/07/2012	SM4
Business Manager to Clinical Director	10/08/2012	SM5
Service Management Group		
Bed Manager *	14/05/2011	SMG1
Clinician Management - Oncology Division		
Chair of Oncology Unit	28/08/2012	OChair
Nurse Service Manager in Oncology Unit	18/09/2012	ONSM
Business Manager in Oncology Unit	26/08/2012	OBM
Senior Consultant in Oncology Unit	12/10/2012	OConsul
Clinician Management - Cardiac Division		
Chair of Cardiac Unit	02/09/2012	CChair
Nurse Service Manager in Cardiac Unit **	21/05/2011 05/09/2012	CNSM
Business Manager in Cardiac Unit	28/08/2012	CBM
Senior Consultant in Cardiac Unit	20/08/2012	CConsul
Clinician Management - Emergency Division		
Chair of Emergency Unit	05/10/2012	EChair
Nurse Service Manager in Emergency Unit	21/08/2012	ENSM
Business Manager in Emergency Unit	15/07/2012	EBM
Senior Consultant in Emergency Unit	05/10/2012	EConsul
* Individuals who participated in the preliminary phase ** Individual who participated in the preliminary and main phase		

4.4.7 Archival Data

Archival data was also used to develop a complete understanding of the case context. Moers (2007, p. 400) defines archival data as 'data for which the original purpose for gathering it was not academic research'. According to Hageman (2008), archival records perform an important function in enhancing a research study through the triangulation of evidence collected within the overall research context. It should be noted that Hageman (2008) cautions that the use of archival records alone limits a researcher's understanding of a phenomenon but that triangulating this method using other qualitative research methods leads to a more profound and nuanced insight into the topic of study. In this study, triangulation was achieved by using archival records in conjunction with organisational documentation and interviews. Yin (2009) recommends the use of a case study database. The researcher maintained a database of all case study documentation. The content of the case study database, is detailed in Appendix D.

4.4.8 Data Analysis

The analysis of evidence has been identified as the most complex element of case-study research (Miles and Huberman, 1994) both because of the significant amount of data generated at the collection stage and as a result of its descriptive, narrative-based nature. Miles and Huberman (1994, p. 26) describe qualitative data as an 'attractive nuisance' because of the appeal of its richness but the simultaneous difficulty of finding clear analytic paths to interpret it. The objective of the analysis was the same in both phases of the study and sought to interpret and gain insight, creating a coherent, credible narrative. The transcripts of the recordings were typed and then read and re-read, with initial notes made in a wide right-hand margin on the transcript. The interviews were also listened to repeatedly and interview notes and summaries were continuously consulted and judgments noted.

The process of data reduction commenced after initial reflections had been made and involved data coding. Coding required reducing the data by assigning signposts and flags to extracts of text that could be used to illuminate aspects of interest in terms of the research objectives and which could also be used to illustrate themes when presenting the research findings. Miles and Huberman (1994, p. 56) define a code as 'tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study. Codes are usually attached to [chunks] of varying size - words, phrases, sentences or whole paragraphs'. The coding process used in this study was guided by the Template Analysis approach. This approach to data analysis emerged in America in the 1990s and gained

credibility in the UK through the work of King (2012) in the health and sociology fields. King (2012) argues that, although Template Analysis makes use of codes, it is not as unfastened as Grounded Theory or as prescriptive as Content Analysis. In Content Analysis, codes are pre-determined prior to data analysis, whereas there is no consideration of codes before the data is reviewed in Grounded Theory. King (2012) suggests that Template Analysis lies between these two extreme positions. In addition, he proposes that Template Analysis can be used within a range of epistemological positions and thus can be useful to a large number of researchers. Thus, based on the management control and healthcare literature, the researcher was cognisant of possible themes or codes that may apply to the context but was also open to new themes and codes emerging from the interviews. The data from the preliminary phase was coded manually and extracted for presentation in a tabular format in a Word document. In contrast, after completing the initial analysis of the transcripts in the main phase, these transcripts were imported into Nvivo10® for coding purposes. The lists of codes developed during this stage of the data analysis are presented in Appendix D.

4.4.9 Reliability and Validity

It is essential to ensure that the findings from an empirical investigation are deemed credible and rigorous. Silverman (2013) states that important concepts relevant to the credibility of research findings are reliability and validity. Validity addresses whether the research explains that which the researcher set out to explain or understand (Punch, 2005); it is often categorised as internal or external validity. Internal validity relates to the establishment of causal relationships in the research findings between events and conditions and looks at the degree to which those findings accurately map the phenomenon in question. External validity, on the other hand, relates to the extent to which the study's findings are generalisable. The concepts of reliability and validity have their roots in the positivistic perspective, which underpins the quantitative approach in the natural sciences. Many qualitative researchers have, however, preferred to use different terminology to distance themselves from this perspective.

One such researcher, Golafshani (2003, p. 397 - 444), contends that it is inappropriate to evaluate the research process and findings of qualitative studies using conventional measures employed within the quantitative approach. Instead, he argues that the credibility of qualitative studies should be reviewed by considering the issues of 'credibility, transferability, dependability and conformability'. Credibility may be achieved by 'member checking', which involves the researcher presenting the findings to the interviewees for

verification purposes. Transferability may be achieved through capturing the richness in describing the contextual situation or circumstances in order to permit transferability judgements to be made by others who may wish to apply the study to their own context. Dependability involves ensuring that the qualitative process and the judgments made during it are amenable to audit by external reviewers. Conformability is attained through ensuring that 'data can be tracked to their sources and that the logic used to assemble the interpretations into structurally coherent and corroborating wholes is both explicit and implicit in the narrative of the case study'. It is imperative that these issues are considered when designing, conducting, analysing and communicating the findings of qualitative research studies. Therefore, as the researcher was cognisant of the challenges inherent in establishing the reliability and validity of an empirical study, the following measures were employed in this study:

- Tactics to ensure honesty of interviewees: It was ensured that interviewees participating in the study understood its objectives and purpose. They were also encouraged to be frank from the outset and the researcher established a rapport in the opening moments by indicating that there were no right answers to the questions posed. In addition, the independent status of the researcher was emphasised.

- Triangulation: Supporting data were obtained from documents, where possible, to provide a background to and help explain the attitudes and perceptions of the individuals in question, as well as to verify details that interviewees had supplied. Furthermore, the individual viewpoints and experiences shared were discussed with other individuals in order to construct a more holistic understanding of the context.

- Debriefing sessions: Frequent debriefing sessions between the researcher and the study's supervisors ensured that the vision of the researcher was broadened. Furthermore, these provided a sounding board for the researcher to test developing ideas and interpretations.

- Reflective commentary: Maintaining a research journal allowed the researcher to reflect on the effectiveness of the techniques employed. This was also used to record the researcher's initial impressions of each data collection session, the patterns appearing to emerge in the data collected and the theories generated.

- Data checks: The recording of all interviews, as permitted by interviewees, ensured that the expression of views was accurately captured.

4.4.10 Summary

Ferreira and Merchant (1992, p. 21) contend that 'a common issue in case-based management control research is an excessive focus on the conclusions, which causes a failure to adequately describe the research method used or the data on which the conclusions are based'. They argue that such descriptions are necessary to provide the reader with a basis on which to assess whether the researcher understood the territory being studied and whether he or she studied the case site in sufficient depth. The purpose of this section was, therefore, to outline the research design employed in this study.

4.5 Conclusion

This chapter set out each of the study's objectives and the philosophical assumptions that underpin the study as a whole. In addition, the research approach and methods selected were discussed. Finally, it presented an overview of the study's research design. In this way, the chapter demonstrated that, in the objectives and overall design of this study, a rigorous approach has been adopted that responds to calls made in the management control and management accounting in healthcare literature. The next chapter presents the findings from the preliminary phase of the empirical study.

CHAPTER 5: THE PRELIMINARY PHASE OF THE EMPIRICAL STUDY

5.0 Introduction

The purpose of Chapter 5 is to provide a brief synopsis of the key issues that emerged in the preliminary phase of the study and shaped the design and focus of the main phase of the empirical work, which will be presented in the following chapter.

5.1 The Management Control Context

5.1.0 Introduction

The preliminary phase of the empirical study aimed to develop an understanding of the type of management control practices that were operational in the healthcare context being studied and to acquire a broad understanding of the factors influencing the operation of these practices.

5.1.1 The Management Control Practices

In order to gain an understanding of the management control practices in operation in the research context, organisational and archival records were utilised. As highlighted in Section 3.1.3.2, the National Service Plan (NSP), an annual agreement between the HSE and the DoH for the type and volume of services to be delivered in return for the funds provided by Government, was a crucial element in the HSE's annual planning and control process. In order to monitor and report on the progression of an individual organisation's (in this case Woodford's) performance towards the NSP, three management control practices were found to be operational: (i) budget control, (ii) activity control and (iii) operational control. The following subsections provide a description of each management control practice.

5.1.1.1 Budget Control Practice

As set out in Section 3.1.3.4, the HSE prepares an annual budget document known as the Statement of Revenue Requirements. Following this process, each public hospital receives an annual budget grant allocation. The preliminary findings confirmed that the bulk of Woodford's budget is determined on a historic basis, with modifications made for items such as public pay adjustments or other new developments. The findings also confirmed that the Casemix budget allocation practice, discussed in Section 3.1.3.4, had been operational at Woodford since January 2007. However, only a small proportion of Woodford's budget (approximately 10 per cent) was allocated using the Casemix allocation process.

Although the hospital's budget increased significantly over the previous decade, in 2010 and 2011 Woodford's budget was cut by 12 per cent (36 million) and seven per cent (18 million)

respectively. This was a direct consequence of the economic and fiscal crisis, which caused annual expenditure in the Irish healthcare system to contract by over €1.85 billion (approx. 12 per cent) in 2013 relative to 2007 (discussed in Section 3.1.3). In 2011, approximately 70 per cent of the budget assigned was allocated to pay and 30 per cent to non-pay expenditure. Table 5.1 provides details of how Woodford's budget was formulated in 2011.

Table 5.1: Budget Control Practice	
Headings:	**Total: €'000**
2010 Budget	
Less 2010 Adjusted Once - Offs	xxx
Add 2010 Reinstated Once - Offs	xxx
Casemix Adjustment	xxx
Recruitment Moratorium	xxx
Drugs Cut	xxx
Agency Reduction	xxx
Procurement National Savings	xxx
Internal HSE Adjustments	xxx
Strategic Priorities	xxx
2011 Budget	**xxx**
Source: Annual Service Plan (2011)	

5.1.1.2 Activity Control Practice

Under the Health Act (2004), the HSE is required to prepare a strategic plan every three years, referred to as the Corporate Plan (discussed in Section 3.1.3.2). In addition, each year, a NSP is prepared which translates the Corporate Plan into a set of Key Result Areas (KRAs). Simultaneously, Regional Service Plans (RSPs) are prepared by each of the four Regional Directors of Operations (RDOs). It was found that, during the formulation of the RSP, negotiations take place between Woodford and the RDO, taking into account the planning parameters set out in the NSP. Based on these discussions, Woodford prepares a Local Service Plan (LSP) that is aligned with the NSP. For example, the NSP 2011 set a national target of a 2 per cent reduction in inpatient activity, which was to be offset by a 3 per cent increase in day cases. Table 5.2 outlines how this NSP target was translated into deliverable actions at Woodford Hospital. Activity control information was provided to the researcher but, for confidentiality reasons, is not provided in this thesis.

Table 5.2: Activity Control Practice						
	Inpatients		Day cases		Out Patient Days (OPDs)	
	2010 Activity	2011 Target	2010 Activity	2011 Target	2010 Activity	2011 Target
Woodford Hospital	xxx	xxx	xxx	xxx	xxx	xxx
Cardiology	xxx	xxx	xxx	xxx	xxx	xxx
Oncology	xxx	xxx	xxx	xxx	xxx	xxx
Emergency	xxx	xxx	xxx	xxx	xxx	xxx

5.1.1.3 Operational Control Practice

A Balanced Scorecard control practice, referred to as 'HealthStat', was implemented by the HSE in 2009. From its inception, metrics were organised around three perspectives: (i) access, which sought to evaluate waiting times for healthcare services; (ii) integration, which sought to assess if service delivery was patient-centred; and (iii) resources, which sought to determine how resources were being used. Performance measures and targets were developed for each of these perspectives and are set out in Appendix E.

Three types of performance targets were established. Where international targets were available, these were used in the first instance. If international targets were not available or were unrealistic, then national targets based on government policy were used. Where neither international nor national targets were available, a 'best in class' process was adopted. This was calculated by using the average figure derived from the top three performing hospitals for the performance measure. Performance was displayed by means of a 'dashboard', which was a collection of graphics illustrating the extent to which a hospital has met its targets. A system of 'traffic lights' was used as shorthand for presenting performance and these were assigned according to closeness to target. In this way, a green traffic light indicated that the performance measured was within target, an amber traffic light indicated that it was outside its target, and therefore of concern, and a red traffic light showed that it was significantly outside its target and, hence, of serious concern. These were used to generate a traffic light for each of the three perspectives (access, integration and resources) and, finally, for overall performance. The management control information acquired for HealthStat was discussed at a quarterly meeting referred to as the 'HealthStat Forum'. At the Forum, the HSE was represented by the CEO, the Performance Management Advisor and the National Directors

of Finance and HR. The Hospital was represented by the Regional Director of Operations, the Integrated Services Director and Woodford Management.

Accordingly, the preliminary findings established that budget, activity and operational control practices had been implemented in order to monitor and report on the progression of an individual organisation's (in this case, Woodford's) performance. As discussed in Section 2.2.1, an appropriate degree of integration is an important characteristic influencing the operation of such practices. In this way, the activity control practice ought to provide a link between activity and expenditure and, in so doing, it should be possible to link budget and activity control targets by adapting the budget according to targeted / actual activity levels. Moreover, it should be possible to evaluate budget and operational performance ex-post, taking actual activity levels into account. The degree of integration among the management control practices will be explored in the empirical investigation.

5.1.2 The Complexities of Woodford Hospital

The management accounting literature relates specific features of management control practices to the particular contexts in which they are found (Sections 2.3.1 and 2.3.2). In this section, a brief summary of the contextual factors emerging from the preliminary interviews is provided.

The significant role played by the HSE in the strategic management of Woodford emerged as an important issue. While Woodford had its own mission, vision and goals, the findings illustrated that Woodford Management did not determine the specific objectives and targets for a period; instead, these were imposed by the HSE and Woodford Management was charged with achieving them, as Senior Manager 1 (SM1) explained:

> *'We take our lead from the HSE. We report to the Integrated Service Area Manager who reports to the Regional Director of Operations. We have certain budget, service and operational targets to meet.'* *(SM1)*

The SM1 expressed the view that the HSE's role in strategy formation resulted in improved performance and asserted that '*the links are much stronger under the new system than the old system as we all have a better understanding of where we are going and how we are going to get there*'. In particular, she suggested that the ISD role helped to ensure better cooperation and coordination between the hospital and primary care services.

A second issue addressed in the preliminary interviews related to the difficulties of preparing accurate management control information due to the many complex operating processes involved in the provision of healthcare services and their many mutually influential interconnected elements. The Service Group Manager 1 (SGM1) explained that providing healthcare relies on the collaboration of a variety of different service providers. For example, she explained that the performance of Woodford was dependent on its affiliation with primary care service providers in the locality. She argued that operating management control practices in such circumstances was cumbersome as these practices encouraged service providers to pursue their own performance criteria at the expense of joint outcomes. She commented:

> *'We are being traded off against each other. There is a bottleneck. We need to get them out but there are no home-help hours available because there is no budget for it. If they stay here, then we have someone on a trolley that needs that bed. Community targets are fine. Alternatively, I'm forcing them out because I'm way over budget. Home-help hours are taken off someone else who ends up back in hospital. It's a vicious circle'.* *(SGM1)*

Furthermore, she stressed the importance of recognising that healthcare is not a standardised commodity as the production process is distinct in terms of degree of routine, task variety and the lack of a clear relationship between means and ends. She articulated this fundamental difference in the following way:

> *'We are not making cars or running banks, we are treating patients. The difference in healthcare is your supplier is your patient, your inputs are the patient, the processes are the patient, your output is the patient and your patient is still your consumer'.* *(SGM1)*

The high task uncertainty associated with delivery of hospital services was also perceived as problematic. The SM1 explained that Woodford was a Level One Trauma Centre, meaning that '70 *per cent of the services provided are demand led. It is very difficult to say you can't take the person with the next MI [Myocardial Infraction] because we have treated our ten patients for the day'.*

The professional orientation of clinicians also emerged as an important issue in seeking to gain an understanding of the research context under investigation. Woodford Manager 1

(WM1) recognised this issue, remarking that clinicians were primarily oriented towards the effective clinical care of individual patients, while Woodford Management were oriented towards the effective use of resources for all patients. The WM1 described the significance of professional orientation in the following manner:

> *'There is a discernible difference between what is of interest to us and what is of interest to clinicians. What is of interest to us is often to do with metrics which have to do with organisational performance. What is of interest to clinicians is much closer to what an individual patient needs or what an individual patient might need'.* *(WM1)*

The WM1's perception was that clinicians tended not to have '*trust*' in how management control information was compiled. He observed, '*the first thing they will say to you is that the data is inaccurate even though it is their own data…they disown Casemix data even though it is their own data'.* In relation to this issue, the SM1 commented that clinician managers often saw '*themselves as being more patient focused and more compassionate'*. She further noted that clinicians frequently articulated that *'the patient is the centre. I keep saying it is for all of us. However, I suppose we don't get as passionate about the patient'.* The age profile of clinicians was linked to their professional orientation. The SM1 noted that younger clinicians who had experience of working abroad were more predisposed to managerial roles. She attributed this willingness to the experience these clinicians had gained while working in other countries.

A further feature perceived to pose a challenge for the operation of management control practice manifested in the multiple and often conflicting goal sets imposed on the organisation by external stakeholders. For example, political interference was noted in terms of decisions being made based on political considerations. The WM1 reflected on his own personal knowledge of the healthcare system in Germany where, he explained, the number of hospitals had been reduced substantially and activity had been consolidated. He drew a comparison with the Irish healthcare system and, in particular, the reconfiguration of cancer services, remarking:

> *'If you contrast that with the nonsense that goes on in this country, you have people out parading the streets and politicians on the back of lorries and disagreeing about this and that. If decisions are based on data it is very difficult for politics to interfere to the extent that it can change a decision, whereas if it is*

just based on where the constituency of that minister is it has to stay there, which is historically what has happened'. *(WM1)*

The influence of media scrutiny was also recognised. For example, the SM1 was frustrated by the media's continued focus on 'bad' news stories and their refusal to accept possible explanations. With regard to emergency department waiting times, she commented:

'No matter how many times you get a media query and you say "we have had so many admissions in the last three days. Of those three quarters needed to be admitted. They couldn't go anywhere else." They don't want to hear the explanation. It doesn't sell the story. It's frustrating'. *(SM1)*

Furthermore, the WM1 was exasperated by the impact media attention had on how he was perceived by the general public. He commented, *'I can go down to the pub and the fellas in the pub are able to tell me from the paper we are in the red. It's crazy'.*

The SM1 also suggested that public perception of the Hospital was an important consideration. With regard to the operation of the HealthStat control practice, which was publicised, she expressed the following opinion*:*

'People are saying the dashboard is like a soccer table or league table. Someone said to me - it is like the premiership and you are in the bottom division. I'm not going to be treated there.' *(SM1)*

A final important issue to emerge from the preliminary findings was the individual and organisational reward mechanism in situ. The lack of a formal individual performance evaluation system was viewed as a problem. The SM1 explained that there were no control practices in place that set individual performance targets and, as a result, there was no system for rewarding good performance or for punishing bad performance. The SGM1 also suggested that the vague job descriptions given to front-line staff and ambiguous lines of accountability hampered the operation of management control practices. The reward mechanisms at an organisational level were also perceived as problematic. The view articulated was that the achievement of a control target simply resulted in the setting of a more challenging target. In contrast, failure to achieve a control target would result in the provision of additional resources to support its achievement. In relation to budget control targets, the SM1 commented:

'Even though you come in on target we are further penalised, whereas we felt other institutions, that didn't come in under target, they are seen to be in dire straits, and in need of further support. You manage and you perform but you don't get any credit for it. You are never rewarded. But you're looking at someone who didn't and their budget isn't cut as much as ours is.' (SM1)

The WM1 also mentioned performance evaluation in the context of the management control practice and he provided evidence to suggest that management style was an important factor influencing superior-subordinate relationships and, hence, the operation of management control practices. The WM1 differentiated between the managerial styles of two HSE managers with regard to the HealthStat management control practice. He explained that, in the past, the management control practice had been used in an inflexible manner but a recent change in HSE management had resulted in a more flexible use of performance information. The WM1 suggested that a previous CEO of the HSE had used performance information in a rigid way and reasonable explanations of failures to meet targets were unlikely to be accepted. In contrast, the new CEO, while still considering it an important indicator of good performance, adopted a more flexible approach to the use of this information. Evidence to support this assertion was provided by the SM1 who remarked:

'We would have found previously with the former HSE manager that he looked at it and used it in a very dictatorial manner. You went down through it 1, 2, 3, 4, 5. You were told you haven't, you haven't, you haven't / you didn't, you didn't, you didn't, you're red, you're red. Whereas with this new HSE manager he might say - Yes you're amber. Where are your problem areas? What can be done to bring you up?' (SM1)

The preliminary findings provided evidence that the rigid use of HealthStat information was perceived as associated with causing resistance and low motivation. In contrast, a more flexible use of such information was perceived to foster participation and a sense of honesty between Woodford and HSE management.

In this way, the findings pointed to a range of contextual issues influencing the operation of the management control practices under investigation. These included: the role of the HSE, the complexity of the core operating process, the professional orientation of clinicians, the multiple and often conflicting goal sets and the performance evaluation processes in situ.

5.1.3 The Role of Management Control Practices

Management control practices are designed to help an organisation to adapt to the environment in which it is set and to deliver the key results desired by its stakeholder groups (Section 2.1.1). The purpose of this section is to review the preliminary findings to explore the role of management control practices in ensuring organisational objectives were achieved at Woodford.

The preliminary evidence suggested that management control information affected the SM1's decision-making processes. She explained that an essential control target for the HSE was the '*colonoscopy waiting times'*. She was very conscious of this control target and would personally monitor the waiting list to ensure that individual patients did not exceed the waiting-time target of three months. The SM1 also expressed the belief that management control information could be used by the Hospital to influence HSE decision making. She explained that, in the context of the HealthStat control practice and discussions between Woodford and HSE management, management control information could be used to highlight a problem area (i.e. where targets were not being achieved) in order to secure additional resources. The SM1 remarked:

> *'We might say we can do a waiting-list incentive but we will need some additional resources to put on the incentive because we are going to have to ask staff to come in on their off-duty to put on an extra theatre. He might say "ok, there is your 4 grand but you are going to be green on this the next time you come up.'* *(SM1)*

In contrast, the evidence suggested that management control information had little impact on the decision making of the Cardiac Nurse Service Manager (CNSM). Although the CNSM did recognise that the increased need to be more resource conscious had permeated her decision making, she believed that this was attributable to the fiscal problems affecting the public sector in Ireland, rather than the operation of management control practices. She remarked:

> *'You would have, in the past, had a culture of "well that is not my responsibility and that is their responsibility over in finance department". I think that is slowly changing and that is being driven on by the economic situation over the last three years. Now everyone knows we have to, we are being paid by Germany. People are frightened because of that'.* *(CNSM)*

The CNSM mentioned a meeting she was scheduled to have later in the day with the CEO to discuss a key budget control target: nursing agency costs. She explained that the HSE had put in place a target of a 30 per cent reduction in annual agency costs; however, to date, the Hospital had already spent almost 70 per cent of the previous year's budget. The perception of the CNSM was that the control target established was '*completely unrealistic'*. Furthermore, it was her opinion that the HSE did not understand the operational ramifications of setting such targets, which would ultimately result in the closure of services. She also asserted that clinician responsibility was the dominating premise for decision making and appeared to rely on professional guidelines of care as a defence against management control practices, noting '*we are under pressure to produce a standard of care, with professional guidelines and recommendations on the ratio of staff to patients. Thank God they are there, because if they weren't'.* The following comment from the CNSM member summarised her attitude towards the operation of management control and revealed her view on how these practices affected the day-to-day functioning of the Hospital:

> *'I think the HSE is a very good organisation for ticking boxes. How we translate that on a day-to-day basis is very different. We have all the business words, like vision, mission and KPI's, [Key Performance Measures] etc. However, I think if you went out to any clinician or staff nurse on a ward they wouldn't know anything about them, because they are struggling to look after patients'.* *(CNSM)*

With regard to improved organisational planning and control, the WM1 believed that the operation of management control practices had resulted in the organisation becoming more data driven and thus more able to utilise this data to improve organisational control. He remarked: *'It is fair to say that, as an organisation, we have become much more data driven and much more focused on epidemiology and on the analysis of trends in terms of presentations to the Hospital'.* He illustrated this assertion by providing an example of how a recent study of emergency activity at Woodford had revealed that the division's busiest period was contrary to expectations. He explained:

> *'For example there are a lot of anecdotes about the winter time is the busiest time of the year in A&E and that weekends are the busiest time of the week. In fact, we did a big study and we found that that the summer time is the busiest with accidents on farms and sports etc. While Monday was actually the busiest*

day of the week because patients go to their GPs on a Monday and their GPs send them in here. So the use of data is incredible important.' *(WM1)*

It was also suggested by the SM1 that management control information provided an impetus for closer cooperation with other hospitals and primary healthcare providers. She pointed out that, recently, the Hospital had received a '*red*' indicator for paediatric waiting times. An investigation of this target had revealed that Woodford had a significant number of child patients who had been waiting over three years for a particular straightforward procedure related to a urology issue that required patients to be circumcised. The SM1 explained that this procedure should normally be performed in a public hospital but that this waiting list had increased dramatically because of the need for paediatric anaesthetists. However, based on research conducted by Woodford in collaboration with the National Treatment Patient Fund, it had managed to make arrangements for these procedures to be completed in the private hospital. The SM1 concluded: '*performance measures are therefore useful; they highlight the issue and help make the argument.'*

In contrast, the SGM1 and CNSM believed that management control practices had failed to improve organisational planning control. The SGM1 supported her view by referring to the HSE's strategy of reconfiguring acute hospital services, which had resulted in Woodford admitting 20 per cent more patients each year. The SGM1 was frustrated, as she considered that the Hospital's budget allocation had not been adjusted in accordance with this strategy. The reconfiguration of acute hospital services was also discussed by the CNSM who argued that, although the strategy itself is founded on good principles, there was a lack of planning around how these would be implemented. It was the CNSM's opinion that, although Woodford had received a significant number of new consultant appointments in recent years, there had been a failure to sufficiently plan how these positions would work. The CNSM remarked, '*in the last few years, we have had 35 to 45 new consultant appointments. We don't have operating theatres, we don't have outpatient rooms, and we don't have offices. We have people but nowhere to put them. On top of that when you bring in new appointments, you also bring in new procedures. Then there are additional costs. It's a lack of planning.'*

The management control targets established by the HSE were also viewed as being difficult to achieve given the complex operating processes prevalent in the organisation. In particular, the CNSM asked 'what *is the point in setting targets that are completely unrealistic?'* The perception of the CNSM was that the HSE's role was ineffective. A similar view was

expressed by the SGM1 who indicated her belief that '*the HSE is developing targets centrally at a national level with no input from the ground'.* The SGM1 suggested that the target-setting process would benefit from greater participation of clinicians. She illustrated her view with the following example:

> *'I sit on the National Group for measures for the A&E department. For the first time they have set up a group that involves the clinicians. The HSE are beginning to recognise that the people on the ground know the answers, we are the experts and we have to be involved in the setting of performance targets'.* *(SGM1)*

5.1.4 Summary

Utilising Ferreira and Otley's (2009) framework to frame the preliminary phase allowed an overview and appreciation of the management control practices that were operational in the research context to be achieved. In addition, it enabled a broad understanding of the key issues influencing these practices to be acquired, to be achieved which helped to inform both the scope and design of the main phase of empirical investigation.

5.2 Analysis of the Preliminary Findings

The findings from this preliminary phase provided valuable insights. In particular, the preliminary findings established that three management control practices were operational in Woodford: (i) budget control, (ii) activity control and (iii) operational control. The preliminary findings also revealed that the operation of these management control practices had mixed implications. Although the perceptions of each interviewee were fundamentally consistent regarding the complex nature of the Irish hospital context, the findings suggested that attitudes and responses towards the operation of management control practices differed. The WM1 and SM1 were primarily concerned with the overall performance of Woodford and viewed management control information as an important means of evaluation. In contrast, the findings suggested that the SGM1 and the CNSM did not regard management control information as important in decision making. Instead, clinical responsibility was perceived to be the dominating basis for these individuals and their focus was on patient care and meeting clinical standards.

Empirical research examining how hospital management responds to the operation of budget control practices suggests that organisational performance is enhanced if these practices are used interactively (Abernethy and Brownell, 1999; King *et al*, 2010; Naranjo and Hartmann, 2007). While the preliminary findings provided support for this assertion, it should be noted

that the attitudes and responses of hospital management to the operation of management control practices are important issues that have not, as yet, received much empirical attention. The management control literature demonstrates that any management control practice is an imperfect tool and, therefore, must be used in a way that takes account of its limitations and is appropriate to the particular circumstances (Merchant and Van der Stede, 2011). Consequently, the preliminary findings depicted a much less precarious situation than might have been anticipated given the complexities associated with the hospital context, and it would be beneficial to explore these issues further with a broader sample of hospital managers in the main phase of the empirical investigation.

In the ongoing debate around the attitudes and responses of clinicians, overall, it has been found that they are antagonistic towards the operation of management control practices. These practices have been perceived as a fundamental threat to the values of the medical profession and, consequently, have been resisted (Jacobs, 2005; Jones and Dewing, 1997; Nyland and Pettersen, 2004). However, studies have also reported clinicians to be accepting of the need for management control (Kurunmaki, 2004; Llewellyn, 2001). This research demonstrates a certain willingness amongst clinicians to accept greater responsibility and to become centrally involved with management control issues. Therefore, while the management accounting in healthcare literature provides some insights into the attitudes and responses of clinicians, the evidence is mixed and somewhat *ad hoc* in its approach. Further research is warranted.

A further important avenue for further consideration is the relationship between hospital management and clinicians. It has been suggested that the operation of management control practices has increased the awareness of management regarding medical practices and thus enabled them to exercise greater control over healthcare activities (Broadbent *et al*, 2001; Kurunmaki, 1999), resulting in conflict and poor working relationships between management and clinicians. The preliminary evidence pointed to this being an important issue at Woodford. While existing studies have identified this issue as a factor impeding clinicians from engaging with management control practices, studies have failed to fully explore the implications of the relationship between management and clinicians.

Finally, the preliminary findings provided support for the merits of the framework as ‘a tool which researchers can employ to describe the structure and use of the ‘package’ of controls deployed by management’ (Ferreira and Otley, 2009, p. 278). However, in the context of this study, where organisational objectives, strategies, key success factors, performance measures

and targets were formulated by an external stakeholder, the relevance and validity of Questions 1 to 5 of the framework were found to be marginal. Consequently, it is suggested that, where management control practices are implemented in order to monitor and report on the progress of an individual subunit's performance, it may be advantageous to reduce the emphasis on questions related to the formulation of objectives (e.g. vision, mission, key success factors, key performance measures, strategies and plans and target setting) and prioritise questions relating to the means by which these goals should be achieved (e.g. performance evaluation, reward systems, usage and information flows). This issue is highlighted as providing a potential contribution to management control theory in Section 8.2.

Consequently, a number of key issues emerged from the preliminary phase of the study which informed both the scope and design of the main phase of empirical investigation. With respect to the scope of the main phase, following careful analysis of the preliminary findings and a critical review of the empirical literature, it was decided that the study's research objective could be best achieved by exploring how contextual factors associated with a hospital context were perceived to influence the perceptions, attitudes and responses of individuals towards the operation of the management control practices in place. In terms of the design of the main phase, the key issues deriving from the preliminary phase were as follows:

- The preliminary findings demonstrated that three management control practices were operating at Woodford: (i) budget control, (ii) activity control and (iii) operational control. The researcher decided to examine the operation of all three management control practices in the main phase of the empirical investigation. It was considered that this would address deficiencies in previous studies that have tended to focus on the operation of individual management control practices.

- The management control in healthcare literature has primarily focused on clinicians and it was, therefore, deemed important to gain an understanding of management attitudes and responses to the operation of management control practices through their inclusion. It was also believed that incorporating both management and clinicians would allow the development of an understanding of how the relationship between these cohorts influences the operation of management control practices.

- It was believed that exploring the operation of management control practices at various hierarchal levels would provide an important contribution to the existing literature, which has tended to adopt a narrow focus, with the management control literature concentrating on top-management usage and the healthcare literature directing its attention towards clinician management.

- A number of key issues that influenced perceptions and responses to the operation of management control practices were identified. The main phase aimed to achieve a deeper understanding of these issues; however, it was anticipated that supplementary issues would also emerge and it was, therefore, important that the main phase of the investigation was designed to facilitate their exploration. Consequently, the researcher decided that an in-depth, qualitative, case-based investigation would be the most appropriate research approach (see Section 4.3.2 for further discussion). The researcher's decision was also informed by Woodford's willingness to participate and co-operate with the study.

5.3 Conclusion

This chapter has described and analysed the findings from the preliminary phase of this study. The findings from the preliminary phase informed the design of the main phase of the study, which conducted a deeper investigation of the topic. Specifically, the main phase of the study, presented in Chapter 6, drew on the understandings gained from the preliminary phase to examine more thoroughly how management control practices operate in a healthcare context during an economic and fiscal crisis.

CHAPTER 6: THE MAIN PHASE OF THE EMPIRICAL STUDY

6.0 Introduction

The preliminary phase of the empirical investigation was exploratory and was conducted in order to develop an understanding of the type of management control practice that were in operation and to acquire a broad understanding of the factors influencing the operation of these practices. The findings, reported in Chapter 5, demonstrate that the research context being investigated is complex and a number of issues that required further investigation were uncovered. The purpose of Chapter 6 is to present the findings from the main phase of the empirical investigation, which sought to extend understanding about the operation of management control practices in a healthcare context during an economic and fiscal crisis.

6.1 The Management Control Context

6.1.0 Introduction

The purpose of this section is to examine the organisational context during the main phase of the empirical study. The section commences by highlighting key issues affecting the organisational context. The section goes on to provide a description of how each of the management control practices operated during the main phase of the empirical study, with modifications occurring since the preliminary phase emphasised. These contextual details were obtained from interviews conducted in the main phase of the study, in combination with a review of relevant HSE reports, service plans, external reports and other internal organisational documentation.

6.1.1 The Organisational Context

In the discussion of the Irish healthcare context (Section 3.1.1), it was explained that the Irish economy collapsed in 2007/2008 when the international financial crisis and the resulting restriction of credit exposed the insolvency of Irish banks and the unsustainable levels of public spending. In November 2010 due to collapsed revenues and an inability to finance bank recapitalisation and day-to-day spending, the Irish government negotiated an €85 billion loan from the European Union (EU), the European Central Bank (ECB) and the International Monetary Fund (IMF), together known as the Troika. This resulted in a loss of economic sovereignty and further accelerated a programme of austerity measures that had been initiated in 2008, in order to ensure that the targets set by the Troika in respect of the government deficit would be achieved.

The Troika identified the public sector and, in particular, the healthcare sector as having considerable potential to achieve savings for government and, therefore, advised extensions

of initiatives already in place. A moratorium on recruitment was implemented and salaries were cut both directly and through the introduction of a pension levy. A new government department of Public Expenditure and Reform was established, which set out a range of commitments in its Public Sector Reform Plan that included initiatives aimed at improving customer care, reducing costs through the introduction of shared services for HR, payroll, salaries, procurement services, reform of organisational structures and new ways of working (Department of Public Expenditure and Reform, 2011). Throughout 2012, the government emphasised that the scale of consolidation required could only be achieved through further contributions from all the major components of expenditure. A figure of €8.5 billion emerged as the saving that needed to be made from the budget over the three-year period 2013 - 2016 if annual deficit targets were to be achieved (Department of Finance, 2012). The healthcare sector, as the second largest consumer of public funds, was again identified as a key area where savings could be achieved.

Consequently, Irish public hospitals, including Woodford, continued to work within unprecedented budget constraints in 2012. The HSE's budget provision for the delivery of healthcare services in 2012 was €12,237 million. This represented a total quantifiable cost reduction target of €750 million. This budget reduction followed two years, unparalleled in the history of healthcare, in which the total budget reduction amounted to €1.85 billion. Moreover, the National Service Plan (NSP) was published on the 13th of January 2012. At its publication, the HSE CEO, Mr Cathal Magee, noted:

> *'2012 will be a very challenging year for the health services. In the last two years, reductions in health expenditure have been achieved largely through a combination of procurement efficiencies, successive drug price reductions and staff costs. A key driver of cost reductions for 2012 will be the exit of a further 3,000 staff from the health services. Together with a budget reduction of €750m, the challenge will be to accelerate the implementation of the National Clinical Programmes and the new models of care and continue to drive efficiencies in order to offset the impacts on frontline services'.*
>
> *HSE CEO, Mr Cathal Magee*

The NSP estimated that, on average, hospital budgets would drop by 4.4 per cent of the previous year's allocation. Significantly, hospitals were also expected to address any underlying deficits from 2011. It was estimated that this would require an expenditure reduction of 7.8 per cent across the hospital sector. In order to ensure that this challenge was

achieved, each of the four HSE Regions formulated a Cost Containment Plan (CCP) that identified cost containment actions required to deliver their service plan targets within the allocated budgets. Subsequently, CCPs were prepared for individual subunits. Individual hospitals (including Woodford) designed a CCP, outlining how it would bridge the gap between its 2011 and 2012 budgets. Further details of Woodford's CCP are provided in Section 6.2.2.1.

However, uncertainty surrounded the effectiveness of the CCPs. In May 2012, the Department of Health (DoH) commissioned a confidential review to investigate the probability of the budget target being achieved. The review, led by Mark Ogden, was conducted in June 2012 and highlighted a wide range of problems associated with all aspects of the budget control practice. It was reported in the Irish Independent (June 2012) that on the basis of the expenditure figures in April 2012, the projected deficit would be in excess of €500 million by the end of the year. This projected deficit was viewed as having far-reaching and significant consequences for the Irish economy, as the Troika identified the exchequer deficit as a significant issue influencing Ireland's ability to exit from the bailout programme.

Furthermore, uncertainty also existed regarding the future management and delivery of healthcare services. In July 2012, the DoH published the Governance Bill, which outlined a major restructuring of the HSE, and set out milestones to achieve a single-tier health service supported by Universal Health Insurance (UHI) by 2016. Under the proposed changes, it was planned that the HSE would initially be reorganised into six new directorates to manage different areas, including separate directorates for mental health and primary care for the first time. Furthermore, it was envisaged in the Governance Bill that the HSE would eventually be abolished and replaced with new structures but it was unclear as to what would replace it under these plans. In the week following the publication of the Governance Bill, the HSE's CEO, Cathal Magee, resigned. Media reports suggested that there were considerable tensions between the DoH and the HSE over the current management of the organisation and that the DoH was arguing that savings could be achieved through greater efficiencies in the delivery of healthcare services so that applying bed reductions as a cutback measure was unnecessary. The HSE, for its part, argued that many of the required savings, for example in overtime allowances, staff rostering, generic drug prescribing and increasing private income insurance, required action at Government level. Irrespective of the validity of these media claims of tension and conflict, the further uncertainty existing with respect to the governance and organisational arrangements created further inconsistency in the Irish hospital sector.

This section set out the economic and political background to the study in order to illuminate the findings from the main phase interviews. While other external changes occurred during 2011 - 2012, the two main changes highlighted in this section, the budget position and the Governance Bill were among the key changes that influenced the context under examination.

6.1.2 The Management Control Practices

The preliminary phase of the study established that three management control practices were operational in Woodford: (i) budget control, (ii) activity control and (iii) operational control. Section 5.2 provided a brief description of how each of these control practices operated. The purpose of this section is to build upon this work by describing how each of these management control practices functioned during the main phase of the empirical study.

6.1.2.1 Budget Control Practice

Woodford's budget is determined on a historic basis. Comparisons between the 2011 and 2012 budgets are problematic as a number of funding streams had been reorganised. However, additional funding of approximately 5 percent of the total annual budget had been provided to the Hospital. The majority of this additional funding was associated with transfer of cardiology services to Woodford and, in addition, it was provided to facilitate the targeted recruitment of individuals in priority areas. The Hospital also received a minor funding efficiency award as a result of the Casemix funding model. However, deductions of 11 percent of the total annual budget were imposed on the Hospital. The non-replacement of staff accounted for 22% of this deduction, while improvements in efficiency accounted for 18%. Moreover, it was explained that patient income from private healthcare insurance companies was estimated to increase by 10 percent. When the budget is adjusted for these figures, the budget reduction for Woodford in 2012 amounted to 4.7%. In addition, the underlying deficit from 2011 also needed to be addressed. Therefore, Woodford's total resource challenge for 2012 was a budget reduction of 5.5%.

Within Woodford, the Finance Department was responsible for the operation of the budget control. The Finance Manager presents a budget report to senior management on a monthly basis. The format of this report remains constant and essentially involves monitoring each cost object every month in order to facilitate comparisons of actual performance with the budget for the current month and a cumulative year-to-date comparison is also made.

A copy of the June 2012 report was provided to the researcher but, for confidentiality reasons, is not provided in this thesis. However, examination of the report revealed that on a

monthly basis, three main budget categories are monitored: (i) pay, (ii) non-pay and (iii) income. These three budget categories are subdivided and performance is tracked in order to compare actual performance with the budget set for the current period and on a cumulative year-to-date basis. These subcategories and their relative percentages are presented below:

- Pay accounts for 70% of the gross budget and was sub-divided into six areas: medical (31%), nursing (36%), paramedical (14%), housekeeping (5%), catering (2%), portering (2.7%) and administration (9.3%).
- Non-Pay accounts for 30% of the gross budget and was subdivided into 21 cost objects: medicines (19%), medical and surgical devices (29%), blood (10%), medical gases (0.4%), medical equipment (2.4%) , radiology (4%), catering (0.3,%), cleaning and waste (0.4%), laundry (1.97%), energy (4%), bedding/clothing (0.6%), furniture (0.16%), pathology (12.4%), maintenance (0.65%), transport/ staff travel (1.6%), office expenses (1.8%), telecommunications (0.5%), computer (1%), administrative expenses (3.6%) and staff recruitment and training (0.7%).
- Income is subdivided into five categories: patient income (85%), sales (2%), recoups and refunds (1%), income from car park (8%) and superannuation (4%).

It is notable from the report that the most significant unfavourable variances in the pay category were nursing and paramedical costs. In the non-pay budget category, these were medicines and medical and surgical equipment. In the income category, patient income was performing favourably, with a positive variance reported. A limited number of key performance indicators are also contained in the report: bed occupancy percentages and the number of and value of consultant claims.

The Finance Department is also responsible for monitoring the performance of the Hospital's CCP. Essentially, the CCP outlined the actions needed in order to ensure that the required saving of €18,977 million was achieved. Woodford's CCP contained 19 initiatives, categorised according to pay, non-pay and income. The CCP pay category accounted for 41% of the total saving required, with initiatives such as the non-replacement of clinical staff and reduction in medical and nursing agency costs being the most significant. The CCP non-pay category accounted for 33% of the total saving required, with initiatives focusing on improving efficiencies in radiology and pathology being the most significant. However, many of the other non-pay initiatives were vague in nature e.g. time-related savings and non-pay reductions. The CCP income category accounted for 26% of the total shortfall required. Initiatives included increasing patient income by increasing charges for private beds and ensuring that all private bed charges were processed. For each initiative, a cost

scenario plan was established that set out the following: (i) initiative summary; (ii) background and rationale for proposal; (iii) implications for clients and services; (v) implications for staff; and (vi) costing associated with the initiative. A Cost Containment Board (CCB) was established to track and monitor the progress of the CCP. The CCB has five members: the CEO, the Finance Manager, the Clinical Director, the Director of Nursing and the Operations Manager. The CCB is accountable to the Regional Director of Operations. The CCB meets with the RDO and senior members of the HSE management team on a monthly basis to order to discuss the progress of the CCP. At an organisational level, the CCB meets on a weekly basis to discuss the CCP. Consequently, the volume and detail of budget control information intensified and greater attention was being directed towards the budget control practice.

6.1.2.2 Activity Control Practice

As highlighted in Sections 3.1.1 and 6.1.1, the Irish healthcare sector has been under considerable budget pressure since 2008. However, despite reductions in funding and staffing levels, Irish hospital activity levels increased. According to HIPE (Hospital-in-Patient Enquiry) statistics published in 2013, 1,554,290 discharges were reported by acute public hospitals, representing a mean annual increase of 2.5 percent over the period 2009-2013 and an increase of less than 1 percent over the period 2012-2013. The number of inpatients has increased from 590,160 in 2009 to 622,217 in 2013, a mean annual increase of 1.4 percent, with a decrease of less than 1 percent between 2012 and 2013. With respect to patient profile, the 65 years and over age groups accounted for the largest proportion of total discharges in 2013 (34.1 percent), this represented a mean annual increase of 4.1 percent for this age group between 2009 and 2013. Table 6.1 provides details of activity levels at Woodford during the study period.

Table 6.1: Activity Levels 2008 -2013

	2008	**2009**	**2010**	**2011**	**2012**	**2013**
Inpatient Discharges	25,720	26,520	26,636	29,546	32,445	33,514
Day case Discharges	69,282	73,505	81,033	78,163	77,619	80,740
Emergency Attendances	52,751	51,941	51,803	52,296	60,632	63,122
Outpatient	128,594	132,105	136,067	158,638	159,749	162,478

Source: McNamara (2015)

6.1.2.3 Operational Control Practice

The operational control practice, 'HealthStat', continued to operate from January to May 2012, with its performance reports published on the HSE website. However, the HealthStat forums ceased in May 2012 in advance of the establishment of a new operational control practice: 'CompStat'. CompStat was described as a web-enabled operational control practice based on similar principles to HealthStat. CompStat results were to be discussed at monthly CompStat Forum meetings, chaired by the RDO, and were to be published on the HSE website in 2013. However, inspection of the website revealed that this publication never occurred. The researcher was unable to gain access to a CompStat Report but was informed that CompStat measures were the same as the KPIs set out in the NSP 2014. Significantly, it was explained that operational control results were no longer discussed at a national level as had occurred during the preliminary phase (Section 5.2.2.3). The prominence attached to the operational control practice was perceived to have declined, which was attributed to the increased attention paid to the budget control practice.

6.1.3 Summary

The purpose of this section was to describe how each of these management control practices functioned during the main phase of the empirical study.

6.2 Contextual Factors Influencing Attitudes and Responses

6.2.0 Introduction

This section presents the interview findings from the main phase of the empirical investigation. It focuses on the contextual factors perceived to influence attitudes and perceptions relating to the operation of management control practices. The contextual factors are grouped into four classifications: organisational factors; factors external to the organisation; management control factors; and individual factors.

6.2.1 Organisational Factors

Organisational factors refer to the contextual factors that exist within the organisation (in this case Woodford). The findings relating to organisational factors are presented within the following themes: (i) organisational structure, (ii) accountability arrangements, and (iii) authority structures.

6.2.1.1 Organisational Structure

The structure of the organisation was perceived to influence responses to the operation of management control practices. An important adjustment was made to the organisational arrangements during the study period. A Cost Containment Board (CCB) was established to monitor and track budget control in early 2012. The CCB had five members: the CEO, the Director of Nursing, a Clinical Director, the Finance Manager and the Operations Managers. In order to facilitate the discussion of the interview findings, Woodford Management (acronym 'WM') will be used to describe the five members of the CCB. These organisational arrangements were perceived as an influence in determining the responses of individuals to activities associated with the operation of management control practices. The findings suggested that each member of WM felt a sense of obligation towards the management control practices and were motivated to work together to achieve control targets; as noted by the WM5, '*everything we do is in some way related to control'.* In addition, the finding suggested that WM had become increasing involved with budget control information as a result of the fiscal crisis. The effect of the fiscal crisis is discussed further in Section 6.3.2.1. However, it was evident that WM were experiencing stress and work related tension as a result of their increased engagement with management control practices. The WM2 commented:

> *'Every one of us [Woodford Management] is stressed at the moment. Last week was the first time that I could actually feel it was really getting to me'. (WM2)*

The WM4 also suggested that increased involvement with budget control information was causing increasing job-related tension. He remarked:

> *I think the levels of stress are through the roof. People say to me; I don't know how you do your job. I wonder myself at times. I don't go over to the canteen anymore. Because people will me and say "Now that I have you, I need to replace X or Y". Whereas, if they don't see you, they may forget'. (WM4)*

In contrast, the findings suggested that the Senior Management (SM) were demotivated by the organisational arrangements. The findings indicate that SM did not engage with activities associated with the operation of management control practices. The WM4 explained that SM meet on a monthly basis. During this meeting, the WM4 presents a report on the Hospital's finances. However, the WM4 felt that the SM gave this little attention, preferring to concentrate on their own areas of interest. The WM4 remarked:

'I make a finance presentation and we provide a pack, it's about 30 pages. I find by the time you get to the third or fourth page, you are losing their interest. We try to highlight the important things. Because you get 10, 15 minutes on this and you have lost them. There are other things on the agenda ….and they are looking ahead, where are my particular areas and when are they going to come up. There's not a huge level of engagement'. *(WM4)*

The evidence provided by the SMs supported the views of WM4. For example, when the SM2 was asked about budget control, her response was:

'I am sure the finance people will definitely fill you in on that. That wouldn't be up for me to enlighten you. There are good presentations delivered on a regular basis from the Finance Manager. However, my areas of responsibility would be different. There isn't much overlap between all of us'. *(SM2)*

Moreover, SM3 believed that the implications of management control were not broadly understood by senior managers. SM3 commented:

'It's very hard to determine what the key issues are. Even if you could understand what the key issues were, it is difficult to know what it means in terms of the service changes that I need to make on the ground. That's the piece that's missing. I am not saying the information is wrong or that it's badly presented. I just think that there is a lack of understanding'. *(SM3)*

With regard to Clinician Management (CM), the interviewees explained that the clinician divisional structure had been established in 1999, following the CIM initiative (discussed in Section 3.1.3.2). The general opinion among interviewees was that the clinical division structure had been beneficial and had improved organisational performance. However, it was felt that, following the DoH's endorsement of a Clinical Directorate structure in 2009, there had been considerable uncertainty with respect to the operation of the clinician divisional structure. The OChair remarked:

'The problem with the current divisional structure is that there's a limbo about it. We are supposed to have moved into directorships. That hasn't happened. As a

result, the divisional structure has slid, because people were expecting the changeover. I think that has affected behaviour'. *(OChair)*

The above comment suggests that the anticipated establishment of a directorate structure had resulted in the divisional structure failing to operate effectively. However, the WM5 believed that the uncertainty surrounding the divisional structure was employed as an excuse. The WM5 suggested that the reason clinician divisions were not functioning was as a result of changes made to their autonomy arrangements. The WM5 remarked:

'While I think the directorate model is a very good model it also gives people an excuse and an opportunity. I know that divisions have not been operating as divisions in the true sense of the word. Maybe because of the directorate model, but also because any degree of autonomy they had has been taken place centrally in recent years'. *(WM5)*

The issue of autonomy is discussed further in Section 6.2.1.3. Irrespective of the reason underlying it, the general opinion was that Clinician Divisions were not functioning in the manner envisaged and that this was perceived as influencing responses to the operation of management control practices. During an interview, the OChair printed out and presented a document detailing the responsibilities of Clinical Chairs and Clinician Divisions. Samples of the identified responsibilities outlined in this document are set in Appendix F.

This shows that many of the activities and responsibilities set out are associated with the operation of management control practices. However, numerous examples were also provided to demonstrate that the responsibilities contained in this document were not being carried out as prescribed. For example, responsibility (iv) involved organising and chairing a divisional meeting. The OChair described the divisional meeting as:

'A process - I attend the meeting because I am chairing, but attendance wouldn't be great. Often the meetings are a moaning and groaning session…just moan, moan, moan, groan, groan, groan'. *(OChair)*

The OChair also felt that the role of Divisional Chair was ineffective. The OChair remarked:

'I think it's an ineffective role. We have a meeting. I Chair the meeting. If there are jobs to be done, such as writing letters, I will do that. For example, we need a

dietitian, so I have written a few letters about that. I would see it [Divisional Chair] as being a fairly powerless sort of letter-writing role'. *(OChair)*

Responsibility (v) for the development of a bi-monthly report was also discussed. While sceptical of the outcomes from this reporting process, the OChair felt that it was beneficial, commenting *'it's a nice thing to do in that you do that certain things have happened and the major problems are highlighted. However, there's also a real sense that there's a process going on and that nothing happens at the end of it'.* Significantly, it was explained that this reporting process had not taken place since 2009.

The EChair explained that divisional meetings were convened on a weekly basis in the past but '*might now take place every couple of weeks'*. The EChair also debated the significance of these meetings, given the lack of autonomy held by the Business Manager. The EChair commented:

'We found we were meeting every week and we were discussing the same old stuff. There are two big sections to our divisional meeting. One is the operational issues such as, letting home a patient that we shouldn't have let home, or there's a complaint…that kind of thing. But, the Business Manager and the Nurse Service Manager coming down formally…we probably only do that every couple of weeks maybe. We did have it billed for every week. And more often than not we were rehashing the same conversation. There's no money. Do you know the CEO is looking at every invoice over €500 now?' *(EChair)*

The above comment suggested that divisional business managers no longer had the autonomy to make budget decisions, which was perceived to have had an impact on the attitudes and responses of clinicians. This issue is further discussed in Section 6.3.1.3.

In this way, the evidence presented demonstrated that Woodford's structural arrangements were perceived to influence the operation of management control practices. The general opinion was that the Clinician Divisional structure was not functioning effectively since 2009, which was perceived to have had a negative impact on attitudes towards the operation of management control practices. Moreover, it was maintained that only a small cohort of individuals (i.e. WM) were engaged with activities associated with the operation of management control practices. These managers with responsibility were engaged in and felt a sense of obligation to management control practices. However, the remaining individuals

concentrated on their own areas of interest with little or no reference to these practices. The implications associated with the organisational arrangements are discussed further in Section 7.3.1.

6.2.1.2 Accountability Structures

A strong emphasis was placed on accountability as a factor influencing attitudes towards the operation of management control practices. The findings indicated that WM were held accountable for organisational performance. The WM2 believed that the obligation to answer questions regarding the financial, activity and operational performance of Woodford remained with this cohort of individuals. The WM2 remarked:

> *'At the moment, the only accountability is at the top. It has to come down. We have a no blame culture. I don't want to go around blaming everyone, but if someone makes a mistake they need to learn. At the end of the day someone has to be held accountable'.* *(WM2)*

The comments of WM2 suggested that she believed that a lack of accountability influenced responses to the operation of management control practices. Some interviewees suggested that a lack of financial accountability among clinicians was a particularly pertinent issue. The CBM maintained that clinicians were not obliged to answer questions regarding their decisions and/ or actions that had resulted in their disregard of management control issues. The CBM commented: '*consultants need to be more accountable'. We only spoke about this issue at a meeting yesterday'.*

The OChair also discussed the issue of clinician accountability. It was her contention that failure to hold clinicians financially accountable hampered the organisation's ability to control activities. Furthermore, she felt that clinicians exploited the lack of accountability in order to prioritise their own professional objectives. The OChair commented:

> *'There is a lack of accountability here. Clinicians can say in 'my clinical judgement this person needs to be treated as an emergency'. But it not an emergency and the patient is being treated at top dollar. Also, maybe someone should have treated a patient on a Friday, but because the person was not efficient enough, it gets pushed until the weekend. That person then gets paid overtime at the weekend. I think that happens a lot too'.* *(OChair)*

The effects of clinician professional orientation are discussed further in Section 6.3.4.1.

The absence of divisional budgets and the inability to hold divisions financially accountable were also perceived to be important factors influencing attitudes and perceptions. As explained by WM5:

> *'On a monthly basis we get a report as to how each expense category is performing. But no individual manager has a budget for his or her department that includes the pay for the staff, the overtime, the non-pay. What happens is the management team [WM] get the report. We see what's going up, what's going down. So we don't devolve …. they are not held accountable per se for spending in their area'.* *(WM5)*

As delineated in Section 6.2.2, expenditure was monitored according to two main categories: (i) Pay and (ii) Non-Pay. Therefore, the budget control practice did not facilitate Clinician Divisions being held accountable for their expenditure because it did not monitor expenditure at a divisional level. The appropriateness of management control information is discussed in further detail in Section 6.3.3.1.

Many interviewees believed that the budgets needed to be devolved so that Clinician Divisions would be held accountable. In the absence of this step, they felt that activity planning was meaningless. The SM3 felt that, coupled with the need to make individuals more financially accountable, was the need to ensure that they had the authority to make decisions. She remarked:

> *'The HSE is a business. People talk about healthcare being a service. However, when you are spending €13 billion a year, you need to run it on a more commercial basis. You need to get people more accountable. The problem I would have found is that you can hold people accountable but you also need to give them some level of authority as well, where they can exercise that accountability'.*
>
> *(SM3)*

The issue of autonomy is discussed further in Section 6.3.2.3. However, the participants' views discussed in this section suggest that a lack of accountability was resulting in a growing apathy towards the operation of management control practices. The implications associated with this issue are discussed further in Sections 7.2.2, 7.2.3 and 7.3.1.

6.2.1.3 Authority Arrangements

The authority or freedom to make decisions was considered to be an important factor influencing responses to the operation of management control practices. Many interviewees believe that only a select cohort of individuals (i.e. WM) had the autonomy to make management control decisions. The WM5 explained that, in the past, Business Managers in the Clinician Divisions had the authority to approve non-pay expenditure items but that, following the fiscal crisis, this authority had been removed. Instead, all non-routine expenditure was referred to the CCB (WM) for authorisation. The WM5 explained:

> *'We vet every request on a weekly basis from a clinical and administrative perspective. We say yes or no to that request. In the last year, because of the financial situation, the answer has been mostly no'.* *(WM5)*

The implications of this decision were exemplified by the EConsul who explained that the replacement of a light bulb in a teaching room had been refused so many times that one clinician out of sheer frustration had personally purchased the light bulb.

The WM5 did not believe the removal of autonomy was an appropriate course of action but was the only option available in the circumstances. He commented:

> *'It has affected things within the Hospital in the most brutal way. We just took back authority from division managers and centralised back. This was the wrong way. Devolving is the way to go. But when you are firefighting in the current financial crisis, you don't have time for hand holding and doing things the right way'.* *(WM5)*

This style of usage by WM was, however, not reported to be customary and the variation was attributed to the economic and fiscal crisis. The implications associated with this style of usage are examined in Section 7.3.3.

The lack of autonomy to make management control decisions at a clinician level was viewed by most interviewees as a significant issue. For example, the WM2 felt that if clinician divisions were granted the authority to make budget decisions, attitudes would change rapidly. Her opinion was founded on her experience in the UK where budget autonomy had been implemented in the 1980s. She noted:

'In the UK, we had devolved budgeting in the 1980s. It changed the organisation in an 18-month period - Because I knew exactly what my budget was. If somebody asked me what my budget was in this Hospital, I would have to say I don't have one. How can you manage a budget you don't have? Whereas, when I was in the UK I knew what my budget was. If stuff arrived on the ward, if it wasn't ordered, it went straight back and I made sure it was refunded back into my account. If staff went out sick, I only replaced three hours instead of 12 hours. You just did things differently'. *(WM2)*

There were repeated demands from clinicians for budget control to be '*devolved*' to the divisional level. The following comment is indicative of attitudes expressed:

'The biggest change would be to devolve budgets. We need to have budgetary control. There needs to be some real effort put into devolving - budgets primarily - but we need to have the autonomy in other issues as well. We need to be able to make decisions within the division'. *(OChair)*

The WM4 recognised that individuals were frustrated by the lack of authority to make decisions; however, it was also felt that many of those demanding authority did not understand that with authority came accountability. The WM4 commented:

'Clinicians and other people love the whole thought of having the authority to make decisions, especially in the current climate. But they need to take accountability with that. At the moment, there is nothing which can be done to hold them accountable, except maybe a rap on the knuckles or a letter. It is my opinion that they wouldn't sit down every week to make those decisions.' *(WM4)*

While most clinicians were exasperated by the lack of authority to manage their divisional budgets, some clinicians maintained that, often, they were allowed too much autonomy. In the view of the OChair, clinicians were allowed to authorise expensive procedures and tests without providing any justification for their actions. The OChair remarked:

'I am surprised at times, that people can say I want to do X, which is going to cost a fortune. I think there is too much autonomy to be honest. I would prefer it to be tighter - you can only authorise that test in the following circumstances'.

(OChair)

The WM2 also addressed this issue, commenting:

> *'From a clinician perspective this is a great place to work. They get everything they want. They have free choice to order whatever tests they want; whatever devices they wish to use. They love working here. They openly admit that. Whereas in the UK, they get the generic and that's it'.* *(WM2)*

However, the WM2 acknowledged that removing this autonomy was problematic. It was believed that, in the UK where clinician autonomy had been reduced, many clinicians were unwilling to provide additional services. The WM2 added '*in the UK, many clinicians are not willing to do the extra bit. They worked their 35 hours, full stop'.* In contrast, she felt that the majority of clinicians in Woodford worked '*far in excess of their contracted work hours. They work above and beyond the call of duty'.*

It was recognised that, while the WM had the authority to grant/ refuse non-routine-pay expenditure items, this was in fact of minor significance in respect of the total budget. Instead, the perception was that it was HSE management, directed by the DoH that had the real authority to make significant decisions. The WM3 maintained that, while a select cohort of managers (including him) was responsible for the performance of the Hospital, they did not have the authority to make many significant decisions influencing its performance. The WM3 commented, '*I have the responsibility but not the authority. I am not even talking about just me. I am talking about the CEO of the Hospital'*. The evidence presented suggested that the DoH, via the HSE, had the authority to make those decisions that were of significance. This opinion was vividly expressed by the WM5 in the following remark:

> *'I am the Operations Manager. However, I am no more a manager. I am what I would call an 'implemenistrator'. I coined that phase myself. I implement the decisions made by others. Management in the current climate, where you have got a national top-down structure, you have no authority to spend money, because there's none there. You have no authority to hire because of the moratorium. Where's the management in that? Instead, you manage a change programme. We become impleministrators and counsellors - someone for people to vent their frustrations at'.* *(WM5)*

The SM4 believed that the centralisation of decision making at a HSE level was the principal issue influencing attitudes. She commented:

'The HSE has become a centralised organisation, with a lot of decision-making being taken centrally without reference to the people at the coalface. Decision-making is too centralised and, because of that, the people that are making decisions are divorced from the service delivery component and people who are in charge of the service delivery component cannot make decisions. Therefore you have decision-makers who have no responsibility for service delivery and people who have responsibility for service delivery but can't make decisions' *(SM4)*

The SM4 illustrated her opinion by reference to the recruitment process. She explained that following the establishment of the HSE, the recruitment process had been centralised nationally and, while it was acknowledged that this change could enhance efficiency in terms of administrative costs, it she also felt that it failed to recognise the importance of personal and social issues. She remarked:

So now they recruit nationally, but I don't want somebody working in here that I have never met, I have no idea whether they will fit in with my team or not. You don't want somebody coming in who is going to rock the whole place and that I spend my time having issues with, and that my colleagues are coming to me saying, in the name of the Lord, where did you go wrong with this. It's out of my hands. It has an impact. *(SM4)*

The implications associated with these issues are further discussed in Sections 7.1.4.

It seems then that the perception among interviewees was that a small cohort of individuals (i.e. WM) had the authority to make decisions. However, the findings also indicated that HSE management retained a significant amount of the authority. In reality, Woodford Management felt that they were responsible for implementing the decisions taken by HSE management. The reduction of divisional autonomy, in terms of the ability of Business Managers to authorise expenditure, was suggested to have generated feelings of resentment, which had a detrimental effect on attitudes to the operation of management control practices. However, a closer analysis of the issue suggests that, while having an important impact on individual attitudes and responses, the removal of autonomy may have had only a minor effect on organisational control. For example, clinicians continue to have considerable autonomy in terms of medicine, test and device usage. The implications associated with these issues are further discussed in Sections 7.2.3 and 7.3.1.

6.2.1.4 Structural Issues

The findings showed that structural differences between the Clinician Divisions influenced responses to the operation of management control practices. This issue was of specific relevance to the Emergency Division. The EChair explained that many general practitioners were directing their patients to their department too hastily and this had a sequential impact on the division's ability to meet management control targets, as it was very difficult for these patients to be discharged. The EChair remarked:

> *'A factor which has had a big impact has been that the GPs have completely changed practice. Sorry, that's not true. Some GPs are outstanding…and genuinely manage patients very well, do the best they can to keep them out of hospital. Some other GPs, a minority, they just don't understand what a big step it is to send somebody in…when really they know …in their gut feeling it's not necessary. But once they get into the system it's very difficult for us to discharge them'.* *(EChair)*

Interviewees also maintained that the ability to achieve management control targets was dependant on the cooperation of other Clinician Divisions. However, it was felt that the management control practices did not provide any incentive to encourage collaboration but, rather, caused divisions to impede the effective delivery of healthcare services. This issue was again found to be of specific relevance to the Emergency Division. The EConsul explained:

> *'If I happen to be an in-patient team, I will come down here [Emergency Division] and if I admit a patient, I have avoided any risk. I have done the easy thing of admitting the patient. I have left them in the corridor …in other words me, the Emergency Division… The emergency department consultants, the nursing staff, and portering is expected to come in, run around, and take care of them, in the space that isn't there. We are discharging 90 per cent of the patients we see. Whereas in-patient teams admit 90 per cent of the patients. They have a vested interest in them admitting them, and thereby clogging up the whole system. Because they get paid. And more importantly, it's not just the money…it really isn't the money. It's the fact that they have avoided risk'.* *(EConsul)*

Further evidence that the difficulties associated with forecasting the demand for healthcare services was an important factor influencing responses to the operation of management control practices was also provided by the SM3 who remarked:

> *'I think in-patient activity was supposed to be 33,000 for the year, but I think after six months they were 20 per cent ahead. It's a demand-led service. You can't control it. If you were doing a service plan properly, you would come to the middle of October and you would close the door and say, we have done our procedures for the year. That doesn't happen. It can give you a rough prediction. But things change. For example, we had the bird flu a couple of years ago and everything got skewed. Or you could get a serious influenza'.* *(SM3)*

The SM1 also maintained that Woodford Hospital's position, as the only Level One trauma centre in the region, affected its ability to control activity. Unlike many voluntary hospitals in the region, it could not 'close its doors'. The SM4 also addressed this issue. She maintained that the organisation could not select the type of healthcare services it wished to provide; rather, the Hospital had to accept 'whatever comes in the door'. The SM4 observed:

> *'Most of our admissions are emergency trauma admissions. If you get someone who needs ten consultants to manage their condition, you have to treat the patient. We can't pick and choose and say, "You are very expensive this week, and we don't have the money to keep you this week, so go away please. This patient could be having a myocardial infraction," It is simply not possible to rationalise'. (SM4)*

The repercussions of not providing healthcare services were particularly significant in the Oncology Division. This view was vividly expressed by the OConsul in the following remark:

> *'If someone pitches up with leukaemia on a Friday, they have to come in for treatment, regardless of resources or activity or whatever. They will be dead by Monday otherwise. We simply have no choice. We are constantly being asked to pull back on activity. But it's not that we are doing elective surgeries, where you can have a waiting list. People would be dead on Monday if we didn't treat them'*
>
> *(OConsul)*

The implications of these issues are explored in more detail in Section 7.3.1.

6.2.2 External Factors

The main phase findings indicated that there were a number of external factors that influenced responses to the operation of management control practices. The interview data relating to external factors was categorised into environmental developments, public scrutiny and political interference.

6.2.2.1 Environmental Developments

The majority of interviewees noted that external environmental factors such as economic conditions and technological advancements affected attitudes to the operation of management control practices. In particular, the interviewees emphasised the fiscal problems affecting the public sector in Ireland as having an impact. The WM3 maintained that fiscal issues had increased the significance of management control practices. He commented:

> *'The reality is that the control practices have really grown in the last three to five years. They weren't a big part of healthcare management prior to that. What fascinates me is that they weren't there originally, when I came back in 2001/2002 I was fascinated at how little management knew about what was happening in terms of our inputs and outputs'.* *(WM3)*

This observation suggested that WM were more cognisant of management control practices as a result of the budget position. This view was supported by the WM4 who remarked:

> *'I find the CEO has a lot more grasp of the finances than he had a few years ago. He would be far more clued in to those figures than he would have been a few years ago. But yet again we didn't have problems back then. But we have such a serious problem here now and that he has to be more interested and more on top of it. The other members [WM] would be same'.* *(WM4)*

WM were also required to formulate CCPs that identified cost containment initiatives to ensure that activity control targets were achieved within the newly allocated budgets (Section 6.1.1). Furthermore, it was suggested that the importance of budget control information in the evaluation of organisational performance was amplified. The WM5 remarked:

'We have the boys [HSE Management] watching us morning, noon and night and holding us accountable all of the time. But at the same time we are sensible, pragmatic, committed people who put people first. And at the end of the day it's all very well for the boys in Dublin to be saying, do it this way and do it that way and do the other, they are not here at the coal face watching what's coming in and out' *(WM5)*

WM also perceived that explanations for budget variances were unlikely to be accepted. The WM2 commented:

'I suppose it's been made very clear to us from the people that we report to that this is the budget you have to work with and…it's to try and stretch it as far as possible. This year we are finding it almost impossible. We are really struggling this year. We thought last year was bad at the time. But this year it's a lot worse. However, HSE Management don't want to listen to excuses. *(WM2)*

The WM4 also explained that meetings were being arranged with HSE Management meeting on a daily basis to discussed budget control issues. The WM5 maintained that, while the Hospital's budget had been reduced each year for the last four years, it was the budget reduction in 2012 that was going to have the biggest impact in terms of influencing attitudes. He commented:

'The low-hanging fruit is gone. The juice is all squeezed. All the proverbs and analogies you want to use. It's really going to start hitting us this year. And yet this year is the biggest cut we have got over the last four years. We have never discharged so many patients in 2011 in the history of 32 years as a hospital. We have never seen so many out-patients. And we have never seen so many people in A&E with €80m less. What price or consequence is that coming at? So Christ, we were very comfortable up to then'. *(WM5)*

The WM2 believed that anxiety had increased as a result of the fiscal problems:

'The way the Troika are operating at the moment, we don't know what's going to come down the track for staff….or you know the cuts and the salary freezes and all that. The financial implications for all of us going home at the end of the week you know, do you have a job and all that…you know. That has influenced

behaviour, probably in a positive way in relation to control issues though'. (WM2)

The following example was provided by the WM2 to describe how the fiscal uncertainty had influenced her own attitudes.

> *'It's out there in black and white that the country is in such dire straits, you know….I suppose everybody has a part to play. And signing off on that overtime sheet I am not going to do so quickly anymore. (WM2)*

However, the findings suggest that there was a limit to the extent to which increased budget emphasis would lead to improved performance. The implications of this issue will be discussed further in Sections 7.1.1 and 7.1.2.

The SM3 felt the impact of the economic crisis on individuals would differ depending on the age profile of the individual. It was believed that older individuals who had worked in healthcare during the 1980s would react more positively. The SM3 commented:

> *'It depends how long you have been in the service. I'm in the service quite a long time so I remember the late 1980's when the old adage was you couldn't buy a pack of paper clips if you wanted to. Then we moved on from that and it changed and we moved on to the good times. Money was spent on ridiculous things. The people that were there in the 1980s understand what this new reality is.' (SM3)*

Thus, the findings suggested that the fiscal problems affecting the public sector in Ireland were causing management in Woodford to be increasingly cognisant of the activities associated with the operation of budget control practices. The implications of this issue will be discussed further in Sections 7.1.1 and 7.1.2.

It was also noted in a small number of interviews that the increasing demand for hospital services and continued advancements in medical treatments and philosophies had influenced the operation of budget control practices. The EChair explained this in the context of stroke treatment:

> *'Technology is increasing. Twenty years ago if you had a stroke that was tough. Whereas now, we can do all sorts of things. That's the joy of the job. But the budget doesn't necessarily reflect these changes'. (EChair)*

This comment suggests that management control practices must reflect changes in the delivery of healthcare services if individuals are to respond favourably to their operation.

6.2.2.2 Public Scrutiny

The use made of management control information by the local and national media was perceived as having a significant impact on responses to the operation of the related practices. Many interviewees, across the different management groups, were frustrated by the media's continued focus on 'bad' news stories and the HSE's failure to defend its employees. The EConsul commented:

> *'Somebody to fire half of RTE would be very nice, because they give such biased reports. They just forever give negative stories. Nobody takes the media to task. That would make a big difference, straight away'.* *(EConsul)*

The SM5 also addressed this issue. She felt that the HSE needed to be more proactive in communicating positive developments.

> *'The HSE should be more proactive in terms of their communications about what actually has been done and accomplished, you will always hear about the negative.* *(SM5)*

Although the WM4 did not believe that media scrutiny directly influenced his own attitude, he found it discouraging that media pressure could result in the political system altering a stated intention. He remarked:

> *'The frustration…. say somebody goes to the media with an issue and suddenly a solution is found. That's very frustrating. You are there trying to hold the line saying, this is the budget we have got and we have to live within it. And then an external pressure comes on, a politician or media or somebody… and you are made to look fairly foolish. You are completely undermined. It's very difficult to come back the next week.'* *(WM4)*

The issue of increased public scrutiny as a result of the fiscal pressure the country was experiencing was also found to affect attitudes. The general opinion was that the public had lost confidence in the hospital sector's ability to manage its operation. An example of how this issue had influenced the public responses was provided by the ONSM, who explained:

'And you know they are the patients, they are the people that come through the service. So everybody is vigilant. And they are watching… they are on the radio every day and they are saying, well you know now there was three people at that reception desk, I didn't see them doing anything….what are they doing'. (ONSM)

Media scrutiny and public expectations were suggested to have a positive effect on attitudes to management control practices in terms of determining the extent of attention paid to management control practices. While interviewees were critical of the HSE's inability to communicate positive developments, it was noted that media attention was unlikely to improve individual attitudes. Furthermore, it was suggested that the public expectations of greater accountability and efficiency were likely to have a positive impact on responses to the operation of management control practices.

6.2.2.3 Political Interference

Political interference was perceived as an influence in terms of decisions being made based on political considerations rather than management control information. The general opinion was that the advancement of political agendas rather than hospital objectives generated feelings of frustration, which resulted in individuals becoming uninterested in the operation of management control practices. For example, the CConsul explained that DoH had sanctioned a treatment, of dubious merit, that would take approximately €5 million from the healthcare budget. He viewed this decision as absurd in the context of his mandate to reduce activity. Furthermore, several interviewees believed that the DoH were often critical of the HSE and also that the DoH restricted the HSE's authority. For example WM3 maintained that the DoH needed to assume one role and not both and, if it wanted to retain the authority to make decisions, it needed to accept the responsibility. Alternatively, it could delegate the authority to the HSE and hold it accountable. The WM3 asserted:

'I think there is far too much interplay of the political system with healthcare management. I don't have an issue with that as long as we stand up and say that's the case. But I have a real issue with the fact that the politicians can complain about the HSE. But on the other level they can influence it on the basis that we can't make decisions unless it's agreed right through to the top'. (WM3)

Overall, the interviews suggested that political interference was having a detrimental effect on attitudes to management control practices and that it generated a sense of infuriation, which resulted in both clinicians and managers becoming apathetic to activities associated with the operation of management control practices. The implications of this issue are discussed in Section 7.1.5

6.2.3 Management Control Factors

The preliminary findings indicated that the HSE was responsible for the design of management control practices. Furthermore, they showed that features of the management control practices, including the appropriateness of management control information, and performance evaluation processes, were perceived to influence attitudes to the operation of these practices. The main phase interviews sought to further explore this issue by examining how the appropriateness of the management control information was perceived to have affected attitudes and responses.

6.2.3.1 Appropriateness of Management Control Information

The preliminary findings pointed to the difficulties associated with providing appropriate management control information. With respect to budget control, it was delineated in Section 6.1.1 that the Finance Department is responsible for providing budget control information. The three main budget categories reported were: (i) pay, (ii) non-pay and (iii) income. This method of monitoring expenditure and income was perceived by many interviewees as inadequate. The WM3 remarked:

> *'When the Hospital talks about a budget, it talks about what we spend. It doesn't really talk about budgeting. It talks about income and expenditure estimates. It doesn't talk about budgeting or planning for the next period'.* *(WM3)*

It was believed among interviewees that prevailing budget information did not facilitate divisional accountability and autonomy (Section 6.2.1.2 and 6.2.1.3) and they, therefore, suggested that departmental budget information was required. The EConsul remarked:

> *'You cannot run a department if you don't know what the budget is. You need the information. You need a coherent budget. While I was Chair of this division, which was over a ten-year period, I never once saw a departmental budget. That is*

simply ridiculous. How can you control something, if you don't have the information?' *(EConsul)*

The WM5 explained that WM would closely monitor budget control information in order to prevent and, correct unfavourable deviations from the budget. He explained:

'On a monthly basis we get a report as to how each expense category is performing. But no individual manager has a budget for his department. What happens is that WM get the report. We note what's going up, what's going down. We go after a particular division or department line manager…. *(WM5)*

In addition, it was argued that the provision of activity-based budget control information would be more appropriate, given the complexity of the core operating process. The following example was provided by the WM3 to illustrate how activity-based budget control information could be utilised.

'If I go to a consultant and say, we only have this much of a budget, therefore you can perform X number of these procedures this year. You can choose which ones you do. If I can do that, then the reality is, they will be unhappy, but at least they will know. They don't want to be told in September, you can only do ten more before the end of the year. *(WM3)*

However, the WM3 believed that the Irish hospital system was *'light years away from being able to provide that type of information'*. The provision of individual cost information was also suggested to be deficient. The WM3 said that, on returning to work in the Irish system in 2001, he was fascinated by the limited individual cost information that could be provided. This issue was also addressed by other interviewees who believed that the provision of budget information was restricted by the Finance Department. For example, the SM4 remarked:

'Even if you consider some basic examples, if you had a range of dressings on the ward, if you put the price up next to each dressing then somebody could say, "I didn't realise that. I can use A instead of B." At the moment, you are not able to do that. However, if you give them the information, at least they can make an informed decision'. *(SM3)*

The implications of this issue are further highlighted in Sections 7.2.2 and 7.3.3.

The appropriateness of operational control information was also discussed and a number of different issues were addressed. Firstly, it was thought that most operational control information was generated in order to meet the reporting requirements of the HSE. The EChair remarked:

> *'Yes we have more information now. I get a weekly report to tell me how many people have come through, what their triage categories were, how long they waited. But that's all because it's being asked for centrally. More is necessary. I would like a data control purpose of my own, so I could know what's happening on a day-to-day basis as opposed to being told about it a month later.* *(EChair)*

Secondly, interviewees believed that there was a lack of appropriate operational control information provided that was relevant to Woodford was an important issue. In this regard, it was suggested that achieving management control was cumbersome because the information required was not available. The following example was provided by the WM2 to illustrate the issue:

> *'If I wanted to look at what Professor X has done in surgery, I have no way of getting that information other than going down to the theatre book and manually working my way back through it'.* *(WM3)*

The WM3 also provided an example of where the provision of operational control information had improved organisation control. Recently, the Hospital had implemented a system of reporting '*average length of stay'* information. It was explained that, in the past, it was difficult to assess the performance of an individual clinician's '*average length of stay'* rates as the control information was not available. Although clinicians were initially concerned about the provision of this information, following its publication, the majority were pleased with the development.

Lastly, the provision of appropriate operational control information relevant to clinical decisions was not available. Interviewees in Emergency Division were particularly vexed by this issue, with the EConsul asserting:

'You can't run a department without data. And you can't run it, except for going around and visually seeing things, which is great…which is management on the shop floor. But I can't improve anything. *(EConsul)*

The EConsul maintained that the lack of operational control information available was as a consequence of the '*HSE's bad attitude to data'*. He also suggested that it was a consequence of having '*no carrot and no stick'*, referring to a lack of reasons for inputting management control information and consequences of not doing so.

In contrast, interviewees from Cardiac Division were more positive in their perceptions regarding the appropriateness of the operational control information. While acknowledging that the provision of appropriate control information was a '*huge elephant in the healthcare system in Ireland'*, the CChair indicated that his division was '*fortunate to have robust information'*. He remarked:

'We have fantastic data on our length of stay, per condition, etc. It feeds back to the entire team what we are doing well on, and what we have to work on. So I think information is critically important to be properly informed'. *(CChair)*

Finally, the appropriateness of activity control information was addressed. The general opinion was that the provision of activity control information should, in theory, be useful. However, the demand-led nature of providing services meant that activity planning information was of little benefit. The following is an example of a typical interviewee comment:

'Academically…or in any business management book, activity planning is reported as a good idea. However, to be honest because of the practicalities of running a hospital and managing a hospital and working in a hospital, it doesn't get the attention sometimes you would think it should get. There are no weekly or monthly plans per se…. and decisions made as a consequence of being…. or seeing too many patients this month.' *(WM2)*

Therefore, the findings highlighted the inability of the activity control practice to manage the complexity of the core operating processes as influencing attitudes and perceptions. This issue is further discussed in Section 7.3.3.

6.2.3.2 Performance Evaluation

The preliminary phase pointed to performance evaluation being an important issue. The general opinion was that there were no consequences, favourable or adverse, associated with the operation of management control practices. The main phase interviews sought to investigate this issue further. The findings suggested that performance evaluation was having an impact on individual, group and organisational responses. At an individual level, the ONSM explained that many individuals (e.g. nurse managers and consultants) had the authority to sanction additional work hours. It was her view that, if an audit was conducted, it would be found that very little verification of the work being completed was being carried out.

> *'There should be repercussions. I can sign off on anything right now. It's down to myself and my own integrity. It's down to the individual taking it seriously. In the private sector you would be fired'.* *(ONSM)*

This comment by the ONSM provides further support for the suggestion made in Section 6.2.1.2 that a lack of accountability was perceived to be an important issue influencing responses to the operation of management control practices. The ONSM believed that a lack of consequences resulted in apathetic behaviour. She maintained that, until penalties for inappropriate behaviour were introduced, it was going to be difficult to ensure that individuals behaved in a manner consistent with the objectives of management control practices.

The WM2 cited '*security of tenure'* as another important factor influencing responses to the operation of these practices. It was the WM2's opinion that, when an individual was performing below the level of the 'status quo' [level of performance expected], it would be decided to move him or her to a different section of the organisation, rather than dealing with the poor performance. The WM3 reported that failure to meet performance targets had no repercussions for individuals at any level in the Hospital. This was contrasted with other healthcare sectors, where failure to achieve such targets could result in job losses. However, the WM2 remarked, '*it's no secret that our jobs were threatened last year if we didn't sort our budget',* which would suggest a number of individuals had been advised that failure to meet control targets would have individual consequences.

The SM3 suggested that a lack of repercussions for an individual under-performing could influence both the response of the individual in question and also the responses of others.

The SM3 commented, '*if you get people who are underperforming and somebody works very hard next to them, they end up with the same salary, the same benefits and that can disincentivise people'.* In this way, the findings suggested that a lack of repercussions influenced individual responses to the operation of management control practices. While acknowledging that, unlike the private sector, it was not possible to give extrinsic rewards, some interviewees suggested that the Hospital could do more to intrinsically reward individuals. The CBM commented:

> *'I think a lot can be achieved by closing the loop and acknowledging people. Sharing and celebrating success is also important. Give people just a little leeway, be compassionate. I say thank you all of the time, that's all I can do, but I am acknowledged here for saying it'.* *(CBM)*

However, the EChair did not agree that fostering a positive working environment would result in individuals engaging with activities associated with the operation of management control practices. Rather, he maintained that tangible benefits that appealed to the vocational aspirations of individuals were of far greater motivational importance. The EChair commented:

> *'Staff should be rewarded when they do well. Not financial rewarded. Staffs aren't looking be to financially rewarded. They are not even looking for a box of chocolates at the end of the month. And it's not a thank you, because that's all derogatory ****.'* *(EChair)*

The implications of this issue are further examined in Section 7.2.3.

At an organisational level, the findings suggested that there were no incentives in place to encourage Clinician Divisions to engage with management control practices. For example, the OChair noted that there was no impetus for divisions to reduce expenditure because any saving achieved could not be reinvested in the division. The OChair remarked:

> *'We might try to save money in one area, if you thought you could invest in another area. You could do that in the UK. Here you don't control the budget.'* *(OChair)*

Interviewees mentioned a reward process that had operated from 2009 to 2011. The WM2 explained that, in order to increase the amount of private income generated, the Finance Department had implemented an evaluation process, which would reward divisions that maximised their private income. The EM1 explained that, where income increased, 2 per cent of the extra income was given to the Nurse Service Managers. The WM2 explained how the money had been used: '*they would use it for buying equipment, or buying new curtains or getting some painting done. They would really use it to brighten up their wards or do something for their patients'.* The WM2 recalled how difficult it was to award the funding in 2011:

> *'At this time last year it was difficult. We were overrun on the budget. We had managers saying "you said you would give us the money". I said "we have to give them the money. We will lose kudos." Christ we were struggling to save money left, right and centre. But we made a promise earlier in the year that if you increase income we would reward. (WM2)*

Significantly, the decision was made in 2012 not to allocate the funding. In reference to this decision, the WM2 remarked:

> *'Every ward I go into; I get "why should we be bothered". You go right back on your word. Now it's gone into the pot of money. If we are seen to spend a penny more than what we are meant to be spending, we will be murdered. I think it was the wrong decision'. (WM2)*

The WM2's comment suggested that failure to follow through with the performance process had generated a feeling of disillusionment, which was likely to have a negative impact upon responses to the operation of management control practices. Furthermore, it was perceived that the reason for not rewarding performance was the fear that HSE management would disapprove. The implications of this issue are further discussed in Section 7.1.4.

HSE evaluation processes were found to have an impact. As cited in the preliminary findings, the view articulated by interviewees was that the achievement of a control target resulted in a more challenging target being set. In contrast, if a control target was not achieved; additional resources would be provided to support its attainment. The implications of this issue were articulated by the SM3, who suggested:

'Historically the view from a budget perspective was the organisation who over-spent the budget got more the next year and the organisation who under-spent their budget got almost penalised. So there is no incentive not to spend money. Whereas it should work the other way around. The organisation that makes real efforts to reduce costs should get some tangible benefit'. *(SM3)*

This failure to put in place penalties for not meeting management control targets was suggested to have resulted in individuals losing respect for the budgeting process. The WM4 noted:

'One of the problems is that last year, we did go over budget. But there was money found somewhere. Probably this year is the first year, when there might be a penalty. At least that what's being said. But the problem is when I ask if more money will be found. I haven't got a categorical "no, there's no more money." That's a problem for local managers. If we cut and then there's money found we will look like complete idiots'. *(WM4)*

The WM4 also explained that in an effort to strengthen discussions with HSE management and to relieve tensions associated with the inflexible approach adopted, the Director of Nursing (WM2) and the Clinical Director (WM3) of Woodford had begun to attend performance evaluation meetings.

'We find it very good for Director of Nursing and Clinical Director to come with us to these meetings. Because they can talk from the coal face… HSE management are only administrators and they can't argue with a Clinical Director. We could be talking forever about this, but they pay attention to a Director of Nursing'. *(WM4)*

The findings suggested that this approach had been advantageous as it facilitated a better understanding of the operational repercussions of budget targets and was, therefore, more likely to be accepted by HSE management. The implications of the organisational reward processes are further examined in Section 7.1.3.

6.2.3.3 Communication of Management Control Information

Overall, the communication of management control information was perceived as an important issue influencing responses to the operation of management control practices. The

WM2 discussed the communication of management control information between the HSE and Woodford Management. He made reference to the HSE's organogram (presented in Appendix B) and gave his view that, in theory, the communication of control information between HSE and Woodford Management was candid but, in reality, at the various hierarchical levels, individual managers were not concerned with telling their superior managers their real issues, preferring instead to tell them '*what they want to hear, rather than what the truth is'*. He suggested that this skewed communication of control information had an injurious impact upon responses to the operation of management control practices. He commented:

> *'I think if you look at the organogram of the HSE, it looks like it should work very effectively. I think one of the problems is that, there is a lack of honesty in communication. I think, very often, local managers are concerned about telling HSE managers what their real concerns or issues are. The same goes on up to the national managers and on up into the political system. People get told what they want to hear, rather than what the truth is'.* *(WM2)*

The WM2 also provided the following example to illustrate the significance of this issue.

> *'In August the whole thing about hospitals being €250m over budget and they are going to be €500m over by the end of the year. Suddenly we are told we have to fix it. So you get into a process of planning what you are going to do to achieve that. So you put together a plan. But there's a discomfort with that plan because it's going to affect services more than we really want them to be affected. And maybe that's going to be difficult to communicate publicly. So we spend quite a bit of time being told, no, that's not agreed yet '.* *(WM2)*

Evidence was also provided to suggest that WM did not know what would happen in the final months of 2012. While, on the one hand, they hoped that additional resources would be provided in order to ensure that services could be delivered, the findings also suggest that they would be frustrated if this had occurred, as they had consistently been asserting the need for financial austerity to be implemented within the Hospital. The WM3 commented:

> *'One of the problems that we had last year is that we really did go over budget. But there was money found somewhere in the system. The problem is that, for us as managers we are in that grey area that we don't know…like we really feel we*

need to really cut out this and cut out this. But if we cut them out, and then there's money found we will look like complete idiots'. *(WM3)*

Notably, the phase '*complete idiots'* was also used by WM4, suggesting that this issue may have already being discussed amongst Woodford Management. The implications of this issue are further examined in Section 7.1.3.

The communication of management control information within Woodford was also suggested to influence responses to the operation of management control practices. Many interviewees felt that management control information was not effectively communicated. The SM2 explained that organisational arrangements had been established in order to ensure that managers at each level in the organisation received management control information; however, he believed that if an audit of the control information were to be conducted, it would find that very little management control information was being disseminated. The following comment by the WM2 suggested that the concerns of the SM3 were correct:

'If people knew costs, if people knew the implications, it would make a huge difference. People don't. They haven't a clue. We are probably at fault for that one'. *(WM2)*

The perception among interviewees was that the communication of management control information within Woodford was poor. Management control information was only available to individuals at the apex of the organisation. Reasons suggested for explaining this problem included the prioritisation of patient care and an overreliance on email. The SM1 explained that, as a result of budget constraints, clinician managers were increasingly prioritising the delivery of healthcare services, which had an impact on attendance at meetings where management control information was discussed.

Many interviewees suggested that the Hospital had become over-reliant on email as a form of communication. It was maintained that email was an ineffective form of communication and there was a need to increase face-to-face communication across the entire organisation.

Ultimately, it was indicated that the inability to communicate pertinent management control information was a problem. The SM2 remarked:

'Now people will say that the people on the ground have no interest. But I think that people have an interest, everybody talks about, being €250m over budget at the end of July. That's a very notional figure… you need to get down to an individual level, otherwise it just flows off people's tongues…and people don't know whether they are talking about millions or billions '. (SM2)

In this way, the interview data suggest that individuals need to be more aware of what the management control measures are, why they have been chosen and how they are calculated. The greater the transparency in the communication of management control information, the greater the satisfaction levels of individuals, which will have a direct effect on their attitudes and responses. The implications of this issue are further examined in Sections 7.1.5 and 7.3.4.

6.2.3.4 Establishment of Performance Measures and Targets

The selection of performance measures was perceived to be an important factor influencing responses to the operation of management control practices. The SM4 felt that an excess of performance measures were being captured and that there was a discrepancy in the measurement processes. The WM3 also addressed this aspect, maintaining that the excessive number of performance measures was causing individuals to lose focus. The WM3 remarked:

'There are too many measures at the moment, which don't necessarily align. There needs to be some rationalising of the performance measures because the amount of work that goes into collecting this information is significant. Also, people lose focus when there are too many different measures'. (WM3)

The WM4 suggested that the collection of management control information was also an important issue, highlighting that the majority of information was collated by HSE management. The WM4 commented:

'We would very much rely on the HSE Region for our reports. Everything comes from them. So they actually see it before we do. Whereas in other industries, I have worked in, you could look at the information during a period and see how things are going. I can't do that at present. You don't get it until the end of the month. So the systems are very limited'. (WM4)

The implications of this issue will be discussed in Sections 7.1.5.

The performance measures selected were perceived by some interviewees as uncontrollable. For example, the WM5 explained that it was difficult to hold individuals accountable for them, as often they did not have control over them. The following example was provided by the WM5:

> *'We hold pathologists accountable for re-agent spend. However, when I discuss it with them, they will argue, we don't ask for the test, the consultants do. Why am I responsible for the re-agent spend of €6 million? I buy it, I use it, but Jesus I am not drinking it. I am using it because someone else asked for it. Therefore, I do think it is difficult to hold them accountable for something they have no control over'.* *(WM5)*

This issue of controllability was also related to the high task uncertainty associated with the healthcare context (discussed in Section 6.3.2.4). Many interviewees felt that the demand-led nature of the healthcare services influenced the Hospital's ability to meet management control targets. The OBM remarked:

> *'And there's very little of that that we can control. We have to treat emergencies, which is 80 per cent of what's coming through the door. You have to treat cancer, cardiac. Thus there is very little we can control'.* *(OBM)*

A final issue influencing the appropriateness of performance measures was the Hospital's inability to adjust a weighty portion of its total budget. The WM3 maintained 'the *biggest problem with the health budget is that realistically 70 per cent of it we can't touch because it's salaries. Therefore, we have been making the big savings in areas such as non-pay and eventually that starts to impact on patient care'.*

Thus, many of the performance measures selected were perceived as uncontrollable, given the complexity associated with the core operating process. Perceptions of uncontrollability were suggested to generate feelings of unfairness, which have a detrimental effect on responses to the operation of management control practices. The implications of this issue are further discussed in Section 7.3.3.

6.2.4 Individual Factors

The findings indicated that there were a number of individual factors influencing the operation of management control practices. The findings regarding individual factors broadly focused on understanding how the relationship between clinician and management influenced responses to the operation of management control practices. These results are discussed under four headings: (i) professional orientation, (ii) participation, (iii) personality and (iv) working relationships.

6.2.4.1 Professional Orientation

The majority of interviewees believed that an individual's professional orientation influenced their responses to the operation of management control practices. The data suggested that the goals of the management control practices, which were to improve efficiency, were often in conflict with the professional objectives of clinicians. The WM3 felt that clinician reluctance to accept management control practices was related to their inability to identify with efficiency-related goals. The WM3 commented:

> *'It goes back to the clinician wanting to treat his/her patients and control practices trying to manage the available budget to treat all patients. And if the expectation of the clinician is that they can treat what walks through the door, without concern for budget or otherwise, then that's their expectation. If we have to put controls in place then that's inevitably a hamper on what they want to achieve. So there's an automatic conflict there.* *(WM3)*

In this regard, the WM3's perception was that these conflicts of interest between clinicians and management control practices were spontaneous and based on the professional objectives of clinicians, in that clinicians were focused on the needs of individual patients, while management control practices focused on organisational objectives. Nevertheless, it was suggested that improved communication was essential in order to ensure that dysfunctional outcomes did not occur. The WM3 added, '*it was only in recent years, due to the recession, that this was becoming an important issue'*.

The OConsul maintained that the primary role of a clinician was to be a patient advocate. She summarised her position on clinician involvement with management control practices as follows:

'We are there for the patients. That is first and foremost. We have had incidents whereby we have had to fight really hard to get drugs for people. We would never accept being told, sorry, there's no money for drug x…., you keep going …. until you get it. I didn't go into medicine to limit the service'. *(OConsul)*

The OConsul went on to acknowledge that, on many occasions, she used *the* line*, 'in my clinical judgement'*. However, it was felt that this argument was becoming increasing difficult to win. The OConsul noted, '*now they want proof'.* When asked how she had dealt with the request for evidence, she responded:

'Occasionally we have had to push at kind of national level if we feel that… something is worth prescribing and it's very expensive. We have always got it'. *(OConsul)*

The OConsul's remark provides further support for the importance of political interference in decision-making (discussed in Section 6.2.2.3). Moreover, it suggested that clinicians had achieved their objectives every time. The OConsul also believed that that not all clinicians wanted to be involved in the management of healthcare resources. She suggested that clinicians should be given the option to become involved or not. She indicated that those who did not wish to have a managerial role were either opposed to it because they did not want to cut back on their clinical practice or because they feel they would be unsuited to the role. She expressed the following view:

'The problem is that most people go into medicine to be doctors. If you gave me a choice I would do more clinical work and far less administrative work. I think most of the clinicians would be like that. I think you are being pulled into healthcare management ….. I think you should be given maybe a choice. Also some clinicians don't have the skills necessary to undertake these roles'.

(*OConsul)*

The issue of clinicians having the necessary skills and attributes required to effectively engage with management control practices was discussed with the WM3. He identified the four most important attributes that will influence a clinician's ability to engage with management control practices as follows:

'First, they have to have an interest in actually managing healthcare. Two, that they are not afraid to challenge their colleagues. Three, an understanding of the limited resources with which we work. Finally, you need a broad understanding of medicine'. *(WM3)*

Some interviewees suggested that the sensitivity of clinicians to the goals of efficiency were changing. The WM2 attributed this change to the reduction in autonomy. She observed:

'In the last number of months, I have seen a huge change in them, they [clinicians] are becoming more reasonable and they understand now. Whereas they were very aloof, they didn't come to the meetings. We do have them more engaged now.' *(WM2)*

Other interviewees did not agree with this view, but rather suggested that clinicians continued to remain reluctant to accept efficiency-related goals. The OBM suggested that clinicians relied upon their professional knowledge and freedom to guard against the operation of management control practices. He commented:

'I have sat in meetings …. where I said "look our capacity to treat here is limited." We are running at dangerously high levels. There are ways that we can reduce our activity by using different treatment modalities but then the three words can be mentioned. My clinical judgement. That's it…. once those three words come out…I am done. My authority has been wiped out…with three words'. (OBM)

The WM4 also considered that his ability to challenge the decisions of clinicians was restricted. He explained that when clinicians are asked to change the medical device used, they will often refuse, arguing that the device suggested would not produce the same results, and he felt that he did not have the medical expertise to challenge this point.

This perception of clinicians exploiting their professional expertise was also addressed by the OChair. It was her belief that clinicians regularly put forward an argument based on medical expertise that was fallacious. The OChair commented:

'People can say "in my clinical judgement this person needs to be treated as an emergency." It happens all the time here. And it's not an emergency. I have seen people argue things that I know are not true'. *(OChair)*

Therefore, the findings suggest variation in perceptions between interviewees with regard to whether or not clinician reluctance is weakening. The WM3 suggested that there was an increasing need for management to be supported by clinicians when implementing management control practices. In Woodford Hospital, the Clinical Director and the Director of Nursing were viewed as instrumental in enabling clinician control to be achieved. Similarly, the WM2 provided an example of where she was able to utilise her clinical knowledge to help clinicians understand the consequences of their apathetic responses to the operation of management control practices. She commented:

I am able to argue it, because I have clinical knowledge. I would say, hang on now a second, you know, this is the situation, this is the patient, this is what's happened. *(WM2)*

The CBM suggested that there were '*methods'* which could be used to ensure that clinicians cooperated with management control practices. She explained that, in order to ensure that clinicians in her department engaged with management control practices, she would '*negotiate with them'*. She commented:

'A big bug bear at the moment is the non-compliance with the private health insurance claims. There are about €5 million of unprocessed claims at the moment. So if they want anything, they are told, your claims aren't cleared. There has to be give and take'. *(CBM)*

Clinicians also suggested that they were highly competitive by nature and argued that, if management control practices could exploit these characteristics, this would lead to greater clinician involvement. The OConsul remarked:

'I think if you put a little bit of competition into most things it gives people a bit more focus. Because…you know you mightn't be best in class but nobody wants to be bottom of the pile, I think it does drive performance …. A little bit of pride comes into it'. *(OConsul)*

Some interviewees suggested that the influence of professional orientation differed depending on the background and experience of the individual clinician. It was maintained that younger clinicians who had experience of working in other healthcare systems were much more likely to respond favourably to the operation of management control practices.

Therefore, the evidence points to the professional orientation of individuals constituting an important factor influencing responses to the operation of management control practices. In particular, it was found that the professional goals of clinicians can often be in conflict with the objectives of management control practices. The implications of the issues addressed in this section are further examined in Sections 7.3.1 and 7.3.2.

6.2.4.2 Participation and Education

Many clinicians were sceptical about the commitment of management to involving clinicians. Examples were provided of decisions being taken by WM without any attempt to obtain clinician views and opinions. For example, the EChair explained that the WM had recently decided to stop ordering a particularly expensive drug used to prevent chemotherapy patients from vomiting. While recognising that this may have been a good decision, as a cheaper alternative was available, he also stressed that, in this context, it should be recognised that the '*law of unintended consequences was huge'*. He explained that the drug was also used to treat children who were suffering from gastroenteritis and, if the drug was given to such children, they could be monitored for a couple of hours and then discharged. However, the EChair had noticed a large number of children being admitted; when he questioned why, he discovered that the children were being admitted because the drug was no longer available. The EChair remarked:

> *'So I have had to go and make the case. Which when I explain it, will make sense. But it will take me a week or two to fix it. But that decision was taken remotely. And I understand it. It's nothing personal. You know it wasn't "let's screw that department". But it's the unwieldy centralised nature of things that I find very frustrating'.* *(EChair)*

This example given by the EChair provides further support for the suggestion made in Sections 6.2.1.1 and 6.2.3.3 that the structural arrangements prevalent in Woodford are not fostering effective communication between management and clinicians. The implications of these issues will be discussed further in Section 7.3.4.

In addition, several clinicians referred to the frustration they felt due to the sense of being distant from the decisions-makers in the Hospital. Their perception was that most decisions were taken by WM and that there was a real need for greater participation at a clinician divisional level. The OConsul commented, *'if they even said, "we are under enormous pressure, please help!! Please engage." Instead we have a cloak and dagger approach. They are very distant from people on the ground'.* It thus emerged that clinicians seemed to value visibility and dialogue and to feel that they should have more contact with Woodford Management. Furthermore, the EConsul believed that WM only interacted with clinicians when there was a specific issue or problem that needed to be resolved. The EConsul remarked:

> *'I think the level of engagement has been poor – up to the point where the hospital is starting to struggle from a financial point of view. You are never really made aware of the bigger picture. You are made aware of it when it's a problem or when you go looking for something, you know, they will say there's no money for that'.* *(EConsul)*

An example of how WM could foster greater participation from Clinician Management was also given by the WM2, who reflected:

> *'Why do all the meetings have to be to suit the manager? Why can't the meetings be in their (clinician) area? You would get a lot more involvement and a lot more participation if you actually move down to meet them.* *(WM2)*

The WM2 also believed that greater participation could be fostered by investing time in getting to know individuals and their role in the organisation. She commented:

> *'Participation is a huge thing and working with the team. You know, knowing who the team is…. I know it's a big time waster sometimes, but at the end of the day you won't go very far if nobody is buying in, you know'.* *(WM2)*

Some clinicians recognised that an attempt had been made to foster greater participation from clinicians. The WM4 explained that, in the past year, a monthly '*forum*' had been established whereby the Clinical Director (a member of Woodford Management) would meet with clinicians to discuss '*management related issues'.*

However, many interviewees felt that clinicians were reluctant to participate with management control practices because of the absence of effective communication channels to provide updates and feedback on progress. The OChair reflected:

> *'I think also people have got quite cheesed off with certain things. Like one of my colleagues, he got into the reconfiguration for the region. He worked very hard on, you know, how oncology could fit into reconfiguration. He wrote a letter saying, you know, could he have some feedback. He still hasn't heard anything. I think he was fairly cheesed off after all his efforts'* *(OChair)*

Thus, it was suggested that the more clinicians were allowed to participate in the operation of management control practices, the more likely it was that they would respond favourably. This issue of clinician participation will be explored in further detail in Section 7.3.4. Interviewees also suggested that clinicians were slow to participate because of their pre-existing ineffective working relationships with Woodford Management. This issue will be discussed in detail in Section 6.3.4.4.

The issue of training and education was also discussed. Some interviewees suggested that clinician training and education encouraged them to work as individuals. They argued that, through their training, clinicians had learnt to be independent and competitive; therefore, engaging with management control practices that expect individuals to share responsibility with others was difficult. The CChair also recognised that clinicians needed to increasingly work as '*teams*'. However, he believed that this did not occur naturally and that management control practices and structural arrangements needed to encourage this to take place.

With regard to the provision of training and education, the opinions expressed were mixed. The WM2 believed that the managerial training provided was more than adequate but that the ability of an individual to apply their training within the organisation was an issue. She commented:

> *'Managers were trained…but it was a case of learning. I would say we have spent a huge amount on education. I am not popular for saying it. And I will say it at any meeting, we haven't got the payback for the amount of money we have spent on education and training.'* *(WM2)*

The ONSM believed that it was difficult to get clinicians to participate in managerial training. Reflecting on the provision of training on management control practices, he commented:

> *'Training and education, there is nothing. Plus you will find this with clinicians - I have just been through a project with some of the clinicians - they don't have the time for training. Now if it can be done in an hour they will say to you, "grand "but most training cannot be done in an hour'. (ONSM)*

Furthermore, it was also suggested that clinicians gained valuable experience working with management control practices in other countries but that, upon returning to Ireland, they found their experience was not utilised. Therefore, it was suggested that, in order to overcome the difficulties associated with professional orientation, it was important that clinicians were educated about the need for management control practices. This issue is examined further in Section 7.3.2.

6.2.4.3 Personality

The personality of individual managers was also suggested to influence responses to the operation of management control practices. The WM2 highlighted this issue by means of an example. She explained that there were two diabetic clinicians working at the hospital, one of whom she characterised as '*dynamic and forward thinking*', the other as '*worlds apart'* in contrast. The WM2 suggested that the differing personalities caused '*the waiting list for one is huge while the other one is flying through his waiting lists'*. She concluded that the first clinician had implemented a range of procedures and policies that changed the delivery of services but, while she attempted to encourage the other clinician to partake, progress was slow.

The SM4 also referred to the issue of personality, suggesting that the personality types of individual managers influenced the responses of subordinates working in their departments. She remarked:

> *'Some clinicians become managers and don't do the jobs that come with being a manager. As a result, some departments don't have a culture of engagement, don't have a culture of open communication, of teamwork and team building. Whereas I don't do a lot of clinical work anymore, because that's just not my job anymore'. (SM4)*

The ability of managers to be effective leaders was also suggested to influence responses to the operation of management control practices. As the SM2 noted:

> *'If you have a very good leader in a group then everything rises. If you have a poor leader in a group that will filter across. If you get somebody who is energised and positive, respects their staff, gets them on board, acknowledges their good work, then you create a positive attitude and that ripples out'.* *(SM2)*

6.2.4.4 Working Relationships

The findings suggested that the working relationship between WM and clinicians influenced responses to the operation of management control practices. WM were perceived by the majority of clinicians to be inaccessible. As highlighted in Section 6.3.4.2, clinicians emphasised their difficulties in obtaining responses to their queries from WM. The OConsul commented:

> *'There is a complete lack of feedback from management. Sometimes it is an accomplishment to get a 'No' response. Too often you don't get any response or worse you get "we'll see how things go".'* *OConsul)*

Other interviewees expressed concern that they did not know the direction WM was taking with regard to organisational issues. They believed that Woodford Management were unaware of their workloads and the pressurised pace of their work. In particular, it was mentioned that WM did not adopt a long-term perspective. The WM3 recognised that clinicians were frustrated by the inability of Woodford Management to make decisions. The WM3 provided the following example:

> *'One great example is dealing with varicose vein treatment. We currently do a lot of it in theatre. We could take it out of theatre and instead of having three nurses, an anaesthetist and everybody else doing it; you have one nurse specialist, the consultant and an administrator who will just check the patient in, check the patient out. What we need for it is an appropriate room and the problem is we don't have that kind of space. We don't have the capital funding to actually build or change an area. That creates frustration'.* *(WM3)*

Several consultants noted that the history of the relationship between WM and clinicians has not been a good one. In this context, they identified a lack of trust and were sceptical about management's ability to overcome the issues involved. The OConsul commented:

> *'Management don't have the tools or the abilities to be able to reconcile the tensions that are within the system. Clinicians invariably if they have been here long enough to develop extraordinary levels of frustration and ultimately acute allergy to managers within the Irish healthcare system'.* *(OConsul)*

The OConsul also believed that WM did not do enough to ensure that Hospital achieved sufficient resources. The OConsul commented:

> *'Maybe it is that they [Woodford Management] don't have the power to execute change, I suspect that they are capped. But I would argue equally that it is their job to go out and fight for it. You will see Dublin hospitals and they seem to be very good at putting themselves out there, asking for things. I always felt here that we have a very small voice'. (OConsul)*

The EConsul debated if management had the appropriate training and education to overcome the issues that Woodford needed to confront.

> *'Very few managers have worked outside of the HSE. They have been promoted because they are here the longest - it is expected you will be promoted from grade 5 to grade 6 or whatever. 'To get appointed to my consultant role I had to work very hard, completing post-qualification courses and have a strong research record. Management get appointed to senior roles based on their length of service'* *(EConsul)*

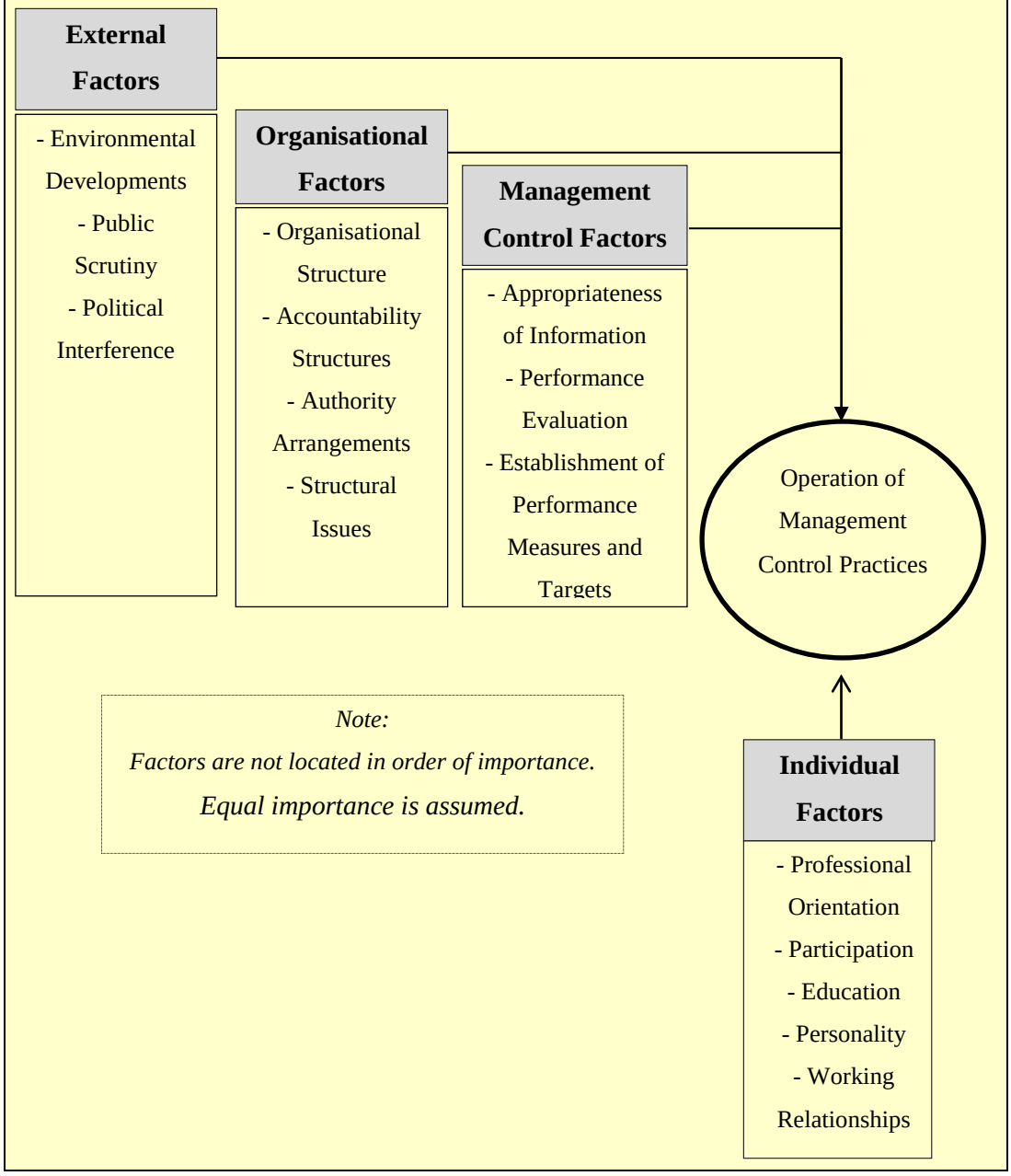
Thus, the evidence presented suggested that clinicians had a pervading sense of distrust regarding the ability of Woodford and HSE management to manage the organisation. The implications of this issue are further examined in Section 7.3.4.

6.2.5 Summary

In this section, a description of the contextual factors perceived to influence attitudes and responses to the operation of management control practices was provided. The discussion focused on four main areas: the organisational context in which the management control

practices operate; the nature of the external environment; the appropriateness of the management control practices themselves; and the attributes and features of the individuals themselves. The findings of this research reveal attitudes and responses of individuals to the operation of management control practices are part of a complex and contextually dependant process. Furthermore, the findings indicate that each of the themes identified cannot be considered in isolation as they are all highly interrelated. The main themes and the subcategories identified are presented in Figure 6.1.

Figure 6.1: Summary of Key Findings



6.3 Conclusion

The existing literature and the preliminary findings suggested that the healthcare context was multidimensional and complex. Understanding how this complexity influences the operation of management control practices is important given the potential for harmful side-effects to occur when these practices are designed and used inappropriately. The findings from this study contributed to the attainment of an improved understanding of the topic. Chapter 7 draws together the findings from both phases of the empirical work to examine how management control practices operate in the research context being considered.

CHAPTER 7: DISCUSSION OF FINDINGS

7.0 Introduction

The objective of the study was to explore the operation of management control practices in a healthcare context during an economic and fiscal crisis. To achieve this, an in-depth case study of a large, acute, public hospital in Ireland was conducted. The purpose of Chapter 7 is to draw together the study's findings. The chapter is structured around three key themes. Although each theme is presented separately for discussion purposes, it is important to recognise that, in reality, the research context is complex and multifaceted. As a result, there are important linkages between each of the three themes, which will be made explicit during the course of the discussion. The primary issues associated with the structure of the Irish hospital sector will be addressed in Section 7.1. The purpose of this section is to discuss how national management and organisational issues were perceived to influence the operation of management control practices in the study setting. Section 7.2 provides a discussion of the organisational arrangements within Woodford. The emphasis in this section is on examining how interrelated issues of organisational structure, accountability and authority influenced the operation of management control practices. Section 7.3 explores the fundamental issue of how conflicts of interest between clinicians and control objectives influenced the operation of management control practices. The purpose of this section is to discuss the key factors perceived to influence the attitudes and responses of clinicians to the operation of management control practices at Woodford. Section 7.4 draws conclusions from the chapter's discussions.

7.1 The National Healthcare Structure - External Control & Scrutiny

7.1.0 Introduction

A key factor perceived in this study to influence the operation of management control practices emerged in the organisational and management structures implemented by Government to manage the delivery of healthcare services. As set out in Section 3.1.3.2, the Irish healthcare system maintained a relatively stable structure for more than 30 years until 2004 when a major reorganisation was instigated, resulting in the abolition of the former Health Boards and the creation of a single national body: the HSE. This was a transformational change in the structure of the Irish healthcare system and was introduced following publication of a number of high-profile reports calling for healthcare services to be managed as a national system. While the DoH retained overall responsibility for the development of healthcare policy, the HSE took full operational and budgetary responsibility for the management and delivery of healthcare services.

As highlighted in the examination of accountability arrangements between the DoH and the HSE in Section 3.1.3.2, the National Service Plan (NSP), an annual agreement between the HSE and the DoH for the type and volume of services to be delivered in return for the funds provided by Government, was a crucial element in the HSE's annual management planning and control process. In relation to monitoring and reporting on the progression of an individual organisation's (in this case Woodford's) performance towards the NSP, three management control practices were found to be in operation: (i) budget control, (ii) activity control and (iii) operational control. It is recognised that 'performance' is itself an ambiguous term in that it does not indicate to whom such 'performance' is directed. In this study, an organisational perspective was adopted and it was assumed that an organisation that is performing well is one that is successfully attaining HSE objectives; that is, it is effectively achieving the strategies established by national HSE management. The purpose of this section is to explore how national management and organisational factors were perceived to influence the operation of management control practices during the economic and fiscal crisis.

7.1.1 Economic and Fiscal Difficulties

The findings revealed that national management and organisational arrangements did influence the operation of management control practices during the economic and fiscal crisis. The establishment of the HSE occurred during a period of unprecedented economic and fiscal prosperity in Ireland, with healthcare expenditure increasing by 62 per cent between 2002 and 2007 (Section 1.3). During this period, the relationship between Woodford and HSE management was perceived as amiable and cordial as noted by the SM3: '*during the boom times, we were told spend, spend, spend, everything and everyone was awash with money. It was all great'.* However, the economic and fiscal landscape fundamentally changed in November 2010 when the Government agreed to a Programme of Financial Support from the EU and the International Monetary Fund (collectively known as the Troika) with a total value of €85 billion. The drawing down of funds was subject to compliance with certain conditions set out in the Programme Documents, which included a commitment to achieve a deficit of 7.5 per cent of GDP in 2013 and a 3 per cent deficit by 2016. Amongst other fiscal reforms, the control and reduction of healthcare expenditure was cited by Government as being of critical importance to the attainment of these GDP deficit requirements. As a result, the Irish healthcare sector and public hospital organisations, in particular, were compelled to operate within unprecedented budgetary constraints.

These extraordinary economic and fiscal developments were perceived to influence the operation of management control at a national (HSE) level and, ultimately, the operation of management control practices at Woodford. In particular, the operation of the budget control practice was regarded as having been altered to facilitate achieving the required budget reductions. Cost Containment Boards (CCBs) were established and were required to formulate Cost Containment Plans (CCPs) that identified cost containment initiatives to ensure that activity control targets were achieved within the newly allocated budgets (Section 6.2.1). Furthermore, the importance of budget control information in the evaluation of organisational performance was amplified. As described in Section 6.3.2.1, additional meetings were arranged by HSE management to discuss Woodford's CCP and budget reduction targets, with the frequency of these meetings progressively increasing to the point that, by June 2012, they were being arranged on a daily basis. In this way, the findings demonstrated that the volume, detail and frequency of budget control information being produced increased during the economic and fiscal crisis.

In the study period, the prominence attached to the operational control practice was perceived to have declined, which was attributed to the increased attention paid to the budget control practice. For example, HSE management no longer met on a quarterly basis with Woodford Management to discuss operational control information as had previously occurred: '*at the moment every discussion is about the budget, everything else is secondary'* (WM2).

The findings also revealed that the focus of the activity control practice was perceived to have changed. The view was expressed that, prior to the fiscal difficulties, the focus of the activity control practice had been to ensure that the incremental funding made available each year was utilised to increase activity levels in keeping with the DoH's healthcare policy (Section 5.2.2.2). Therefore, before the fiscal crisis, the focus of the activity control practice had been to establish the number of additional in-patient and day-case procedures to be performed based on the additional funding provided in a given year. However, subsequent to the fiscal crisis, the focus of this control practice was regarded as being to establish the appropriate in-patient, outpatient and day procedures to be performed in order to ensure that the budget reduction targets required could be achieved. Overall, the study's findings showed that little attention was given to the activity control practice, as its merits were considered to be negligible given the increasing and largely uncontrollable demand for services. As highlighted in Sections 6.1.2.1 and 6.1.2.2, despite reductions in funding and staffing levels, Woodford's activity levels had increased. The number of inpatients increased

from 25,720 in 2008 to 33,514 in 2013, representing a mean annual increase of 5 per cent. With respect to the number of outpatients, this number increased from 128,594 in 2008 to 162,478 in 2013, a mean annual increase of 4.3 per cent. The reported number of emergency attendances in 2013 was 63,122, representing a mean annual increase of 3.2 per cent. The issue of integration between the budget and activity control practices is further examined in Section 7.3.3.

As discussed above, the study's findings demonstrated that the operation of the management control practices at a national level were perceived to have been influenced by the economic and fiscal crisis, with three principal effects highlighted in this regard. Firstly, the volume, detail and frequency of budget control information being produced were considered to have intensified. Secondly, the focus of the activity control practice was seen as having changed to become a mechanism by which to reduce, retain or modify organisational activity levels. Thirdly, the significance of the operational control practice was perceived to have declined as increased attention was given to budget control practices. These findings provide useful insights into the impact of the economic and fiscal crisis on the operation of management control practices, an aspect highlighted by Arnold (2009), Hartmann (2000), Hopwood (2009) and Van der Stede (2011; 2015) as important but under-researched. The results from this study suggest that poor economic conditions may lead to the increased frequency of budget control communication, a finding previously reported by Argyris (1952). Furthermore, this study's findings are consistent with Hopwood's (2009) discussion of an unpublished study by Olofsson and Svalander in 1975, which examined the response of a Swedish organisation to an economic downturn and noted that the crisis resulted in an intensification of budget information flows within the organisation. The economic and fiscal crisis was also considered to have altered the use made of management control information by HSE management, which is the focus of the following subsection.

7.1.2 The Use of Management Control Information by HSE Management

Since Hopwood's (1972) seminal paper, the management control literature has demonstrated a great interest in understanding the use made of management control practices (Section 2.3.2). In this study, HSE management was perceived to have begun placing a high emphasis on achieving budget reduction targets and to be using budget control information in an inflexible manner such that failure to achieve budget reduction targets resulted in poor evaluations, regardless of the reasons for that failure. One interviewee gave the following description regarding HSE management's use of budget control information.

'You get a right rollicking basically. They will say this is your Cost Containment Plan. You said you would reduce costs by X in this area. The report is saying Y. Why is that not happening? No, that's wrong actually - they don't say why. They just tell you it's not happening. Why would be seen as an excuse. We would be told, we should have mitigated against the risk of that happening. We would be told, you had to achieve a reduction of €1 million this month, you said you were going to achieve it in five ways, if ways four and five aren't working; you should have used replacements six and seven. We wouldn't be used to that strong handed approach in the public sector'. *(WM5)*

This style of usage by HSE management was, however, not reported to be customary and the variation was attributed to the economic and fiscal crisis. A number of implications associated with this style were identified by the study. For example, Woodford Management considered that they had become more involved with budget control information as a result. Furthermore, Woodford Management believed that they worked together to achieve budget reduction targets and working relationships amongst these individuals were regarded as having improved. However, the use made of management control information by HSE management was also perceived to have negative implications. Woodford Management reported that they experienced considerable job-related stress and working relationships with their superiors (in this case HSE management) were perceived to have deteriorated.

Previous findings in the literature would suggest that Woodford Management would have engaged in harmful behaviour, such as data manipulation, in order to relieve the tensions associated with the use made of management control information by HSE management. However, evidence of data manipulation was not reported, although it is plausible that such a response was not feasible since the majority of the budget control information was collated by HSE management, thus restricting the ability of Woodford Management to engage in data manipulation (Section 6.3.3.4). Nevertheless, the findings of this study show that, in an effort to strengthen their discussions and to relieve tensions associated with the style of usage adopted, the Director of Nursing and the Clinical Director of Woodford had begun to attend budget-related performance evaluation meetings. It was argued that HSE management would not be able to dismiss the explanations and concerns of Woodford Management as easily in the presence of these individuals, as they could use their clinical knowledge and expertise to communicate the difficulties encountered within Woodford. This approach was suggested to have been advantageous as it had facilitated a better understanding of the repercussions of

budget reduction targets and was, therefore, more likely to be accepted by HSE management (Section 6.3.3.2).

The implications associated with the use made of budget control information by HSE management in relation to budget-related performance (i.e. the ability to achieve budget reduction targets) at Woodford were also considered. Woodford successfully achieved the budget reduction targets imposed in 2008, 2009 and 2010 and, at the same time, had managed to increase activity levels (Section 6.1.1). Consequently, the study's findings suggested that the use made of budget control information by HSE management had improved the management of healthcare expenditure in these years. Woodford did not, however, achieve its budget control targets in 2011 and was unlikely to do so in 2012 (Section 6.3.3.2). In this regard, it emerged that the cumulative effect of the budget reduction targets was viewed as being too challenging and that, irrespective of the use made of budget control information by HSE management, achieving the more recently imposed budget reduction target had become unmanageable. The findings demonstrated that, in order to continue the delivery of services in the final quarter of 2011, additional money had been provided by HSE management. In this way, the findings supported Otley's (1972) contention that using budget control information in an inflexible manner so that reasonable explanations of failure to meet budget targets are unlikely to be accepted will lead to improved budget-related performance. However, as indicated by Emmanuel *et al*, (1990) in describing the relationship between budget difficulty and budget-related performance as an inverted U-shape, the findings suggest that this style of usage will improve budget-related performance up to the highest point in this graph, a point related to budget difficulty, but that, beyond that point, this style of usage will no longer lead to improvements in budget-related performance. However, it must be acknowledged that activity levels continued to rise during 2011 and 2012, thereby making it difficult to appropriately assess budget-related performance. In addition, this finding has been developed from a case study of a single organisation and, consequently, there is a need for future research to examine the relationship between the use made of budget control information, target difficulty and budget-related performance. This is highlighted as a potential area for future research in Section 8.4. Woodford's budget-related performance during the economic and fiscal will be further discussed in Section 7.2.1.

7.1.3 Ambiguity associated with Budget Allocations

The findings from this study show that HSE management had a custom of allocating additional budget resources in the final quarter of the financial year. Interviewees explained

that this process reflected a cultural history whereby additional budget resources had generally been found in the final quarter of the year when the HSE had auxiliary resources available. Woodford Management explained that, initially following the establishment of the HSE, they had received instructions from HSE management to spend a specified additional amount by year-end and, as a result, were under pressure to ensure that this was done. While this process led to the accumulation of organisational resources that were valuable immediately after the fiscal crisis began, it was also perceived to have destabilised the operation of management control practices. The findings showed that the budget reductions imposed by the HSE were achieved in 2008, 2009 and 2010 and, consequently, additional funds were not provided to Woodford (Section 5.2.3). However, it was believed that other hospitals that had not achieved their budget reduction targets had received an injection of money in the final months of those years. In other words, the findings suggested that HSE management had provided additional resources to some hospitals in order to ensure that they could continue to deliver services during those months. In contrast, there was a perception amongst interviewees that hospitals such as Woodford that had achieved their budget reduction targets were penalised by the imposition of more challenging budget reduction targets in 2010 and 2011.

Further analysis of the budget control process in 2012 provided a deeper understanding of the complexity of this issue. Woodford had not fully achieved its budget reduction target in 2011 and it was explained by interviewees that additional funding had been provided in order to deliver services in the final quarter of that year. However, the evidence suggested that, in July 2012, Woodford Management had grave concerns about how matters would evolve later that year when existing funds had been consumed. While their past experience implied that additional funding would be allocated in the final quarter, the hospital sector was now largely being funded by the Troika, a situation not previously experienced (Section 7.1.1.) The evidence suggested that Woodford Management did not know what would happen in the final months of 2012. While, on the one hand, they hoped that additional funding would be provided in order to ensure that services could be delivered, the findings also suggested that they would have been frustrated if this had occurred, as they had consistently been asserting the need for budget reductions to be implemented. It was felt that the allocation of additional funding would have undermined their position, as noted by WM3: '*if we make cuts and then there's money found, we look like complete idiots. It's a difficult situation to be in'*. The custom of providing 'bail-out' money at year-end was thus undermining Woodford Management and had the potential to diminish their motivation and morale (Section 6.3.3.2).

Furthermore, the findings suggested that this 'bail-out' custom had the potential to encourage a perverse form of gaming behaviour. In the management control literature, gaming typically refers to behaviours where subordinates use job-related actions to deliver a desired message to their superiors (Argyris, 1992). In that context, the superior sets the rules of the game (i.e. the budget level) and the subordinate chooses his or her actions on the basis of maximising payoffs. More precisely, gaming of management control information is deemed to exist when subordinates knowingly select courses of action on the basis of achieving a more favourable evaluation, rather than in order to reach a more desirable level of performance consistent with the goal of their superior. Observations from this study in Woodford suggest that a different kind of gaming behaviour could be linked to budget control practice: namely, the selection of actions on the basis of achieving an *un*favourable evaluation at the expense of selecting an alternative course of action that would result in a more desirable level of performance in terms of the goal of HSE management. Hence, despite a commitment to the contrary, it is plausible that Woodford Management may have chosen not to fully implement initiatives aimed at achieving budget reduction targets in order to ensure that the organisation received an *un*favourable evaluation and, therefore, benefited from a greater leniency later in the financial year. Finally, as an unfavourable performance evaluation was considered a means of avoiding the imposition of a more challenging budget reduction control target in the following year, it also encouraged an irregular form of budgetary slack to take place. In the management control literature, budgetary slack occurs where slack is created by setting budget targets to render them easier to achieve (Dunk and Nouri, 1998). Consequently, if Woodford received an unfavourable evaluation, this helped to ensure that a less onerous budget reduction target was established in the subsequent period. In this way, Woodford Management may have deliberately failed to work towards meeting these objectives to avoid imposition of a more demanding target in future years. Notably, Woodford Management did not admit to engaging in such behaviours themselves, but they alluded to other hospitals as doing so.

The findings from this study add to our understanding of the potential outcomes associated with an organisation's budget allocation process thereby making a contribution to literature (Merchant, 1990; Van der Stede, 2000). The findings indicate that ambiguities associated with the evaluation of budget-related performance were undermining Woodford Management and had the potential to diminish their motivation and morale to perform. Furthermore, they had the potential to encourage harmful side effects such as gaming and budgetary slack.

7.1.4 Devolvement of Accountability without Autonomy

Following the enactment of the Health Act (2004), the HSE was mandated to manage and deliver health and personal social services. At a national level, eight directors were responsible for leading the planning, monitoring and evaluation of services, as well as developing standards and best practice. At a regional level, a RDO and an ISA manager were responsible for monitoring and reporting on the performance of individual organisations (Section 3.1.3.2). The findings from this study revealed that the accountability and autonomy structures connected to these organisational arrangements were important issues influencing the operation of management control practices at Woodford. At a strategic level, the findings showed that no autonomy had been delegated to Woodford Management. Woodford's goals, objectives, key success factors, performance measures and targets were all formulated by HSE management (Section 5.2.3.) The literature would suggest that managers who lack authority have little reason to positively embrace management control practices (Abernethy and Lillis, 2000; Chenhall and Morris, 1986; Merchant, 1986); yet the findings from this study indicated that a lack of strategic autonomy did not have any negative implications in this regard. On the contrary, the evidence from the interviews with Woodford Management indicated that they were reasonably content to act in accordance with the HSE's strategic direction. It is notable, however, that the HSE's strategic plan centred on creating a centre of excellence at Woodford (Section 6.1.1). It is feasible, therefore, that, had the HSE's strategic direction involved de-prioritising the Hospital's position, Woodford Management may not have been so happy to comply with the HSE's approach.

Woodford Management were, however, frustrated by their inability to make operational decisions. The establishment of the HSE was stated by several interviewees to have resulted in excessive centralisation and to have created a separation between those responsible for making decisions and those responsible for service delivery. In other words, Woodford Management argued that they were held accountable for operational performance despite the fact that the authority to make operational decisions had not been delegated to them. This issue is best illustrated in Section 6.3.3.2, which describes the reward initiative devised by Woodford Management to incentivise clinicians to maximise the organisation's private income. Interviewees explained that this initiative had been terminated and indicated that this may have been caused by the use made of budget control information by HSE management (Section 7.1.2): 'I *don't agree with the decision - I think it was the wrong decision, but if we are seen to spend a penny more than we should we will be murdered'* (WM3). A further case in point was presented in Section 6.3.1.3 where it was explained that, following the

establishment of the HSE, the recruitment process had been centralised nationally and, while it was acknowledged by interviewees that this change could have enhanced efficiency in terms of administrative costs, they also felt that it failed to recognise the importance of personnel and social controls. Interviewees stated that it was imperative that the relevant management from within Woodford were involved in the recruitment process in order to ensure that all staff recruited had the personality and social characteristics necessary to successfully partake in organisational activities.

Managing the competing demands of autonomy and accountability has long been recognised as important by the research literature (Solomons 1965; Lawrence and Lorsch 1967). However, few studies have sought to gather empirical evidence to support the assumption that authority structures are an important factor influencing the operation of management control practices (Merchant, 1984; Gordon and Narayanan, 1984; Abernethy & Lillis, 1995; 2001). The findings from this study provide empirical support for this view: Woodford Management were not frustrated by their inability to make decisions about the strategic direction of the organisation because they were not held accountable for strategic performance; rather, it was their lack of authority to determine how the desired results could be achieved that had important implications in terms of morale. Woodford Management were frustrated because, although their performance was evaluated based on the achievement of budget and operational targets, they did not have the authority to make changes, such as devising reward incentives or hiring appropriate staff. The frustration resulting from this lack of authority affected job satisfaction with regard to the attitude of Woodford Management towards their role and towards the operation of management control practices. It also was reported by several interviewees to have had an impact on working relationships with clinicians (Section 6.3.4.4). The findings showed that many clinicians, while recognising that the authority of Woodford Management was restricted, had become jaded from listening, with growing scepticism, to their repeated assertions that HSE management were at fault. The implication of this issue for the working relationship between clinicians and Woodford Management is discussed in Section 7.3.4.

7.1.5 Information Flows between HSE and Woodford Management

The HSE's organisational arrangements were implemented to ensure that management control information flowed effectively between the HSE and Woodford (Section 3.1.3.2). However, Woodford Management reported that they were hesitant in their communications with HSE management, using adjectives such as '*poor*' (EM1), and '*guarded*' (WM2) to describe the flow of management control information. Furthermore, this restraint was

believed to have been continually perpetuated up the organisational hierarchy, leading to the communication of inappropriate and ill-timed management control information (Section 6.3.3.3). Woodford Management felt that the organisational arrangements that should theoretically have allowed information to flow effectively between hierarchical levels had ultimately not been implemented. However, the interviewees considered that altering the organisational arrangements was not the solution; instead, they attributed the problem to a lack of trust caused by the emergence of an asymmetrical information gap. In management control literature, an information gap normally arises when a subordinate has more information relevant to the decision process than his or her superiors (Dunk, 1993). Yet, in this study, a reverse information asymmetry gap was perceived to exist, as HSE management were deemed to have more information relevant to the decision process than Woodford Management. This lack of information was perceived to reduce job satisfaction and to weaken the motivation and morale of Woodford Management.

Two issues were identified as connected with this issue. Firstly, the flow of information was weakened by political interference, which resulted in decisions not being communicated to Woodford Management until political agreement had been achieved (Section 6.3.2.3). As highlighted in Section 3.1.3.2, while the HSE was given responsibility for the provision of healthcare services, the DoH had retained overall responsibility for the provision of these services and for the implementation of healthcare policy as devised by Government. This complex relationship created difficulties and several interviewees felt that the DoH had remained excessively involved in the organisation's day-to-day operations. This created frustration as it not only delayed the communication process but also implied that decisions were often made based on party political preferences, which militated against rational decision making and the most effective use of resources. Secondly, as discussed in Section 7.1.2, Woodford Management were largely dependent upon the HSE's system to provide management control information and, as a result, interviewees argued that HSE management had more control information available to them than Woodford Management. For example, WM4 noted '*they know the results, before we do, it puts us on the back foot straight away'.*

Consequently, this study's findings echoed previous research that has suggested that effective information flows and systems are important issues influencing the operation of management control practices (Ferreira and Otley; Malina and Selto, 2001; Otley, 1999). The findings identified a singular information asymmetry gap, whereby HSE management had more decision-relevant information than Woodford managers. This information asymmetry gap was perceived to have led to an erosion of trust and to affect the job

satisfaction of Woodford Management, as well as their motivation to perform. These findings, coupled with the evidence presented in Section 7.1.4, demonstrated that the national organisational arrangements that were in situ weakened the motivation and morale of Woodford Management.

7.1.6 Summary

The discussion presented in this section has demonstrated that national management and organisational arrangements were perceived to influence the operation of the management control practices in Woodford during the economic and fiscal crisis. The economic and fiscal crisis was perceived to have initiated a change in the attention provided to and use made of management control information by HSE management. Furthermore, ambiguities associated with the budget allocation process were shown to have undermined Woodford Management and to have encouraged gaming, as organisations that failed to meet their targets were saved, or 'bailed out', by HSE management, leading to a potential incentive to fail to meet targets. Finally, flaws associated with the organisational arrangements in place were perceived to weaken motivation and morale and, subsequently, to influence responses to the operation of the management control practices. In particular, a lack of operational autonomy was shown to result in frustration, which affected job satisfaction in terms of how Woodford Management felt about their role. Meanwhile, poor information flows caused an information asymmetry gap to occur, which led to an erosion of trust and affected the motivation of Woodford Management to perform.

7.2 The Organisational Context - Incongruity and Divergence

7.2.0 Introduction

The organisational context of the study was a large, acute, public teaching hospital, Woodford, which stated its overarching mission as being to provide high-quality care for its patients (Section 4.3.3). The structural and governance arrangements, comprising an executive, a senior and a clinician management structure, were established to ensure that the required activities associated with the operation of management control practices were carried out. Executive management (i.e. Woodford Management) were held accountable to HSE management for organisational performance. Senior management were responsible for reporting to Woodford Management on matters relating to service delivery, human resources, information technology and hospital quality programmes. They were supported in their role by a service management group and a support services board. Clinical management, then, were organised into 15 clinical divisions, which were established by

grouping specialist areas of expertise with related service and resource requirements. The purpose of this section is to explore how contextual factors associated with these organisational arrangements were perceived to influence the operation of management control practices during the economic and fiscal crisis.

7.2.1 The Use of Management Control Information by Woodford Management

Previous empirical studies have identified a 'contagion effect' in the use of management control information in performance evaluation (Barrett *et al*, 1992; Hopwood, 1974). The contagion effect refers to a manager's tendency to evaluate their subordinates as they themselves are evaluated (Hartmann, 2000). Section 7.1.2 showed that, as a consequence of the economic and fiscal crisis, HSE management were perceived to have begun placing a high emphasis on the achievement of budget reduction targets and to be using budget control information in an inflexible manner such that reasonable explanations of failure to meet budget targets were unlikely to be accepted. Thus, if contagion had occurred, Woodford Management may have adopted the same style of usage. However, the evidence from interviews with Woodford Management suggested that they were reluctant to adopt the same style of usage utilised by their superiors when evaluating the performance of individuals or clinical divisions at Woodford. The following comment is indicative of the assessment made by Woodford Management of the HSE management's style of usage and its impact upon Woodford Management's own style:

> '*We are not passing the grief down about the budget. What we were exposed to last week was ridiculous. I said to the Area Manager… I perfectly understand where you are coming from and I can understand you being like you are but bullying me is not going to have a positive outcome. I am not going to bully the people below me. I said if you behave like that to me - don't expect me to behave like that to staff. I am just not going to do it. And yes, maybe we just need to go that little bit further but I think there are ways around it. If people knew costs and if people knew the implications. People don't. They haven't a clue. We need to make people more aware, but we don't need to bully them'* . *(WM3)*

The findings illustrated that there was a personal reluctance amongst members of Woodford Management to impose the same budgetary pressure on others to which they themselves had been subjected. HSE managers were perceived to be somewhat removed from the reality of the circumstances within the Hospital and, consequently, it was felt that it was easier for them to adopt such an inflexible style of usage, as noted by WM5:

> '*Managers working in a hospital are more understanding but the higher up you go… the less to the frontline you are, the easier it is to fob it off. Whereas when you sit here and see a consultant in their gown and blood …saying we need to get this for the patient or he will die you are more emotively attached to the situation, it is impossible to be merciless …whereas when I pick up the phone then and ring the boss 20 -30 miles away it's much easier to say no'.* (*WM5)*

Woodford Management recognised the need for cost saving and were willing to place a high emphasis on the achievement of budget reduction targets. However, the inflexible approach adopted by HSE management was considered inappropriate to this setting, and a more flexible style of usage was viewed to be appropriate. Woodford Management asserted that budgets should provide goals to indicate if budget-related performance is good or bad but should be used in a careful manner and viewed as just one indicator of a broader concern with organisational performance. However, important organisational obstacles were identified that impeded Woodford Management from being able to adopt such an approach. One such obstacle was the inability of the budget control practice to align with internal structures. This is discussed in the next subsection.

7.2.2 A Failure to Align Budget Information with Internal Structures

Woodford's internal structures were organised around a Senior Management and a Clinician Division structure, but the budget control practice had not been developed to align with these internal structures and, therefore, the organisation was incapable of supplying disaggregated budget control information for the individual service groups, support services or clinical divisions. Instead, costs were analysed on an item basis for the Hospital as a whole (Section 6.2.2.1). For instance, the findings demonstrated that non-pay expenditure was categorised into 21 individual cost items, including medicine and blood, but could not be traced to divisions. This failure to assign costs to divisions precluded the analysis that was necessary for effective use of budget information. The result was that the internal structures were not supported by relevant budget information.

In spite of its limitations, the findings demonstrated that the budget control practice informed the decision-making processes of Woodford Management. For example, it was explained that Woodford Management would closely monitor budget information in order to prevent and correct unfavourable deviations from the budget (Section 6.3.3.1). However, the inability to analyse variances creates management control difficulties. For instance, if a substantial unfavourable variance is for a particular cost item (e.g. medicine), an inability to

appropriately trace the cause of the variance to a Clinician Division has the potential to result in inappropriate, and at the very least unsubstantiated, decisions being made. Thus, if medicine expenditure was found to be unfavourable, it was argued that attention would be directed towards examining and reducing expenditure in the oncology division, as this specialism would be considered to be a significant driver of medicine expenditure. Yet, in the absence of the relevant information being available, it was impossible to accurately determine the true cause of the variance and, consequently, it was feasible that incorrect decisions were being made. The frailties of the budget control practice also prevented Woodford Management from using budget control information for performance evaluation purposes. Specifically, it was not possible to evaluate the budget expenditure of the Clinician Divisions in a deliberate manner, as the budget control practice was unable to establish budget information for these cost objects. The implication of this issue in terms of the use made of budget control information by Woodford Management is further discussed in Section 7.3.4.

Previous literature has suggested that improving the quality of budget control information can enhance both financial and operational performance (Section 2.2.1.5). The findings from this study supported these assertions by demonstrating that, if the budget control practice could have identified and aggregated costs for clinical divisions (i.e. provided divisional budget information), Woodford Management would have been able to make better-informed decisions on related issues. Furthermore, the failure of the budget control practice to support the internal structural arrangements was perceived to give rise to potentially incorrect decisions being made and, ultimately, an inability to adopt a more flexible style of performance evaluation. The implications of this issue in terms of accountability are discussed in the next subsection.

7.2.3 An Accountability Vacuum Created by a Culture of No Blame

Management control practices are intended to hold individuals (or sometimes groups of individuals) accountable either for their actions or for the results they or their organisations produce (Merchant and Otley, 2007). The DoH has included accountability as one of the four core principles in the current healthcare strategy. It is defined as including financial, professional and organisational accountability to deliver quality, efficiency and effectiveness (Department of Health, 2001). Although Woodford Management was perceived to be held accountable for its budget performance (Section 7.1.2), this approach to accountability had not been mirrored within the organisation. The preceding section showed that inadequacies associated with the budget control practice implied that service groups, support services or

Clinician Divisions could not be told prior to the performance period what was expected of them in terms of budget expenditure and, consequently, their performance could not be evaluated.

This showed that individuals could exert considerable organisational power without being held accountable for the budget implications of their decisions or behaviours. They therefore, had no incentive to cooperate with management control activities or to consider management control information (Section 6.3.1.2). This lack of accountability was perceived to result in an apathetic response to the management control practices. There was widespread agreement amongst all interviewees that the delegation of budget information would increase individual involvement with management control activities. It was contended that, if individuals were provided with budget information aligned with their service group, support service or clinician division, it would have an immediate and direct impact upon their involvement (Section 6.3.1.3). The perception amongst most interviewees was that the dearth of budget information was attributable to an unwillingness to relinquish control on the part of Woodford Management. While the frailties of the budget control practice were recognised by some others, the evidence suggested that these individuals were frustrated by Woodford Management's inability to solve the apparent weaknesses.

The findings from this study also revealed that a growing lack of accountability had allowed a culture of '*no blame'* (EM1) to develop. The perception of interviewees that emerged from the findings was that individuals did not hold themselves or each other financially or organisationally accountable and that, as a result, complacency had become progressively more accepted. Examples provided included approving overtime-sheets without verifying that work had been completed and agreeing to the provision of additional services without determining their necessity. The findings also suggested that an inability to understand how individuals' decisions and behaviours could influence desired results had led to a lack of accountability. HSE and Woodford Management were characterised as discussing the '*millions and billions'* of reductions that were required (Section 6.3.3.3). These desired results were regarded as being too abstract for individuals to relate to and, hence, they were deemed to have a demotivational impact. In several instances, a simple initiative of providing '*price tag information'* for items that were routinely used was suggested as a potential way of resolving this issue. It was contended that the provision of individual cost information would lead to greater involvement with budget information as individuals would be able to assess the budget implications of their decisions. The evidence indicated that the

budget control practice was unable to provide this information (Section 7.2.1). The following comment recorded was characteristic of the views expressed by interviewees:

> *'I would be certainly of the view that if you give people the information then they can make an informed judgement. Basic examples ... if you had a range of dressings on a ward, and you put the price up next to each dressing then somebody could say, "I didn't realise it was three times the price of that…and I can use A instead of B." Now maybe not everyone would do it but at least you are giving them the information, so that at least like they can make an informed decision.* *(SM4)*

Moreover, a failure to develop individual or group level reward systems was also cited as an issue influencing accountability. Individual performance evaluation processes had not been developed, rendering it impossible to link individual behaviour with rewards and/or punishments. While individuals who were performing well craved greater accountability and became frustrated when their performance was not recognised, it was also apparent that, for many individuals, the lack of accountability resulted in the acceptance of mediocre performance. It was acknowledged that the development of individual performance evaluations that linked performance with individual rewards/punishments was unfeasible given the size of the organisation, public pay agreements and the extent of union resistance. Instead, group reward systems were proposed as having the potential to cultivate a culture of accountability. This involved allowing service groups, support services or clinical divisions that had achieved desired performance levels (i.e. budget, activity or operational control targets) to be rewarded by enhancing these areas. For example, it was suggested that painting a waiting room, purchasing a new piece of equipment or buying new chairs for the staffroom could foster a culture of accountability and provide an incentive to all employees to become more involved with the management control practices (Section 6.3.3.2).

These findings are consistent with the wider body of management control literature, which has argued that accountability is an important issue influencing the operation of management control practices (Merchant and Otley, 2007). Previous literature has shown that three of the key conditions essential for management control practices to be effective are: (i) providing information about the performance expected prior to the evaluation period; (ii) evaluating performance after the performance period; and (iii) good performance being rewarded and bad performance being punished (Section 2.2.1). The study's findings showed that each of the three conditions posed a challenge for the operation of management control practices at

Woodford. The budget control practice was considered incapable of satisfying any of the conditions outlined. Although the activity and operational control practices could accommodate conditions (i) and (ii), the failure to provide incentives or, perhaps more importantly, deterrents to ensure that individuals behaved in a manner congruent with organisational objectives undermined individual motivation to engage with management control practices. The findings indicated that greater accountability could be fostered in two ways. Firstly, the current approach to budget reporting was limited and lacked the ability to drill down beyond summary level. The budget control practice should have had the ability to provide sufficient detail. Secondly, a reward system that appealed to the vocational nature of individuals ought to have been considered. This would have provided an incentive and motivation to encourage individuals to hold themselves and each other accountable for their decision making and behaviour.

7.2.4 Summary

Woodford's management and organisational arrangements were perceived to influence the operation of its management control practices during the economic and fiscal crisis. Woodford Management were viewed as accepting that placing a higher emphasis on budget reduction targets was necessary; however, they were also perceived to be unwilling to adopt the inflexible style of usage utilised by HSE management, arguing, instead, that budget control information should be used in a more flexible manner. The necessary organisational arrangements were not, however, in place to put this style of usage into effect. Individuals could not be held accountable for organisational performance, as they did not have access to the management control information required to manage it. Furthermore, it was not possible to provide them with the necessary information because the budget control practice was incapable of providing disaggregated budget control information aligned with the internal processes and structures. The implications of these interrelated accountability, authority and structural issues were that individuals became apathetic or indifferent towards the operation of management control practices. In the next section, the attitudes and responses of clinicians, who act as dominant individuals in a hospital context, will be discussed.

7.3 The Clinician Control Relationship - Tension and Conflict

7.3.0 Introduction

There has been a continual movement to encourage clinicians to become more involved in the management of Irish hospital services (Section 3.1.3.2). This policy is predicated on the belief that clinicians are major resource consumers in hospitals and that clinician

involvement in management will lead to improved organisational performance. In fact, previous research has shown clinicians to be the main consumers of organisational resources, with their decision making accounting for up to 70 per cent of expenditure (Abernethy and Stoelwinder, 1995; Broyles and Reilly, 1988, Cardinaels *et al*, 2004) and, consequently, a lack of clinician engagement is a significant issue influencing the operation of management control practices. In Woodford, clinician involvement was facilitated through the formation of 15 clinical divisions established by grouping specialisations with related service and resource requirements (Section 5.2.1.3). The purpose of this section is to explore how the clinician-control relationship was perceived to influence the operation of management control practices in Woodford during the economic and fiscal crisis.

7.3.1 The Use of Management Control Information by Clinicians

The findings from this study revealed that the clinician division structure was not functioning in the manner envisaged and interviewees provided numerous examples of divisional management's failures to carry out their responsibilities. These included the cancellation of divisional meetings due to poor attendance, bi-annual reporting processes not taking place and a failure to discuss management control information amongst divisional management (Section 6.3.1.1). Clinicians attributed their failure to fulfil management control responsibilities to an anticipated change in the clinical division structure. They reported that HSE and Woodford Management had been discussing abolishing clinician divisions and implementing a clinical directorate structure for a number of years but had, as yet, failed to do so. This ambiguity was perceived to have had a demotivational effect, which influenced clinician involvement with management control practices. However, some interviewees believed that the uncertainty surrounding the divisional structure was used as an excuse.

Although structural ambiguity was an important factor, the study's findings revealed that clinician involvement with management control practices was a complex issue. Three key issues influencing this involvement were identified: (i) the perceived relevance and usefulness of management control information; (ii) the professional orientation of clinicians; and (iii) the clinician-management relationship. The implications of each of these issues will be discussed in the following subsections but it is worth first considering the implications associated with the economic and fiscal crisis.

The overall theme to emerge from the findings was that the implications of the three contextual issues identified had been exacerbated by the fiscal crisis. As discussed in Section 7.1.1, prior to the fiscal crisis, the focus of management control practice was to ensure that

the additional funding available each year was utilised to augment and enhance the delivery of services. However, this had been altered by the fiscal crisis and clinicians were less willing to be involved with management control practices that sought to reduce, retain and modify the provision of services (Section 6.3.4.1). Consequently, the relevance of their misgivings was amplified, which affected their response to the operation of these practices. In other words, the findings showed that, despite their concerns, clinicians were more willing to accept and engage with management control information and activities when their professional objectives were congruent with the management control objectives; however, once management control objectives challenged the priorities of their professional orientation, their concerns were exacerbated and used to justify their levels of involvement. The following comment typified the response of clinicians to the operation of management control practices in the aftermath of the fiscal crisis:

> *'It is a case of priorities. The priority of clinicians is patient care. The typical phone call will be "I know you have no money but we need to treat this patient. This new medication is available and treatment is going to cost an absolute fortune." That's their focus. So while some would be aware of the financial situation and others wouldn't, at the same time, they are all able to compartmentalise and say, well that's no problem. Now I need to treat my patient and I need this expensive drug.'* *(WM4)*

The perception to emerge was that many clinicians adopted the view that management control practices were of secondary importance as they focused their attention on patient care and meeting clinical controls and standards. The study did, however, point to some variation amongst clinicians with regard to the appropriateness of the response adopted. Some clinicians accepted this response as appropriate in terms of maintaining their overriding professional duty to their patients and asserted that budget-related performance was not their concern or responsibility. On the other hand, many other clinicians expressed frustration with this type of response. These clinicians were exasperated that budget expenditure was not being utilised as efficiently as possible and felt that more consideration should be given to budget control issues. Thus, the findings indicated that clinician responses were not uniform, but rather a continuum, with a strong lack of enthusiasm on one side of the axis and a willingness to devote more attention to management control issues on the other.

The findings also suggested that a clinician's position on this continuum may be connected to their area of specialism. The evidence from the interviews indicated that clinicians in the

Cardiac division were considered to be more willing to engage with management control practices than their counterparts in the Emergency and Oncology divisions. Four factors were deemed to contribute to this: (i) the provision of incremental budget resources to the Cardiac division in recent times (Section 6.1.1); (ii) good working relationships between the Cardiac Business Manager and Woodford Management and between the Cardiac Business Manager and Cardiac clinicians (Section 6.1.3); (iii) a higher level of controllability associated with the provision of Cardiac services; and (iv) a more defined relationship between inputs and outputs in the Cardiac Division (Section 6.1.4). The findings also signalled that a clinician's position on the continuum could be influenced by his or her age, educational background and professional experience. For example, it was suggested by interviewees that clinicians who had trained outside of Ireland were more likely to be positioned on the enthusiasm side of the continuum (Section 6.3.4.1). The design of this study did not allow such relationships to be explored and this issue is, therefore, highlighted as a potential area for further research in Section 8.4.

The study's findings provide a contribution to the literature examining the responses of clinicians to the operation of management control practices (Section 3.3.2). Previous studies have reported clinicians to be antagonistic towards the operation of management control practices. These studies have shown clinicians to view such practices as a fundamental threat to the values of the medical professional that should be rigorously resisted and challenged (Jacobs, 2004; Jones and Dewing, 1997; Preston *et al,* 2001). However, other research has also reported clinicians to be accepting of the need for management control practices and willing to accept greater management responsibility and central involvement with management control practices (Kurunmaki *et al,* 2003; Kurunmaki, 2004; Llewellyn, 2001). The findings from this study add to this body of research in revealing that the responses of clinicians will be dependent upon the management control objectives: if the objectives of management control practices are congruent with the professional objectives of clinicians, they will be more willing to accept the need for these and so will become involved with management control information and activities. However, should the management control objectives become incongruent with clinicians' professional objectives, they will alter their response. In such circumstances, clinicians will become less willing to be involved with management control information and activities, albeit to varying extents.

Prior empirical studies suggest that clinicians will purposefully resist and challenge the operation of management control practices that are at odds with their professional objectives (Broadbent *et al,* 2001). However, evidence of such resistance was not found amongst

clinicians at Woodford. Specifically, there was no evidence of clinicians hiding information or delaying the implementation of management control initiatives. Instead, they sought to ignore the management control practices and continue with their clinical day-to-day activities oblivious to their operation. For example, time afforded previously to the collation and analysis of management control information was diverted to delivering services, while attendance at management meetings declined as clinicians reprioritised their time (Section 6.3.3.3). As discussed in Section 7.2.3, the accountability arrangements were not in place to hold clinicians accountable for their decisions or behaviours and they, therefore, did not need to purposefully challenge the operation of the management control practices. At Woodford, clinicians could decide to use whatever tests, procedures, devices or therapies they chose to treat their patients. Unlike hospital organisations in other countries, there were no restrictions (control practices) to adhere to and no accountability arrangements in place to hold them responsible for the budget implications of their decisions (Section 6.3.1.3). Furthermore, interviewees explained that, if clinicians failed to cooperate with management control activities (i.e. did not provide the necessary information or attend a management control meeting), they were not held accountable for their behaviour (Section 6.3.1.2).

7.3.2 Professional Orientation

Previous literature has shown the professional orientation of clinicians to be an important issue influencing clinician responses to the operation of management control (Section 3.3.3.3). These studies contend that the professional training and education of clinicians have instilled powerful social controls, which include an emphasis on patient welfare and a desire to adopt the best medical practice available. As a consequence, clinicians find it difficult to relate to efficiency-driven management control objectives, which results in harmful side effects due to role conflict. Role conflict occurs where a job involves expectations that are incongruent with individual beliefs, which subsequently leads to frustration and negative work outcomes (Abernethy and Stoelwinder, 1990; 1995; Bouillon *et al*, 2006; Comerford and Abernethy, 1999). The findings from this study confirmed the importance of professional orientation in influencing the operation of management control practices in a hospital setting. Nevertheless, role conflict among clinicians was not a response identified at Woodford, as clinicians could largely ignore management control practices if they so wished. The following comment points to the influence of professional orientation on the responses of clinicians to the operation of management control practices:

> *'It is reasonable to say that the majority of clinicians want to see patients. They don't understand this idea of a service plan. The idea for them is, patients come to*

the front door, they need to be treated, Oh I can't do them, because I can only do 5,000 this year instead of 6,000…is a concept that's alien to them in how they are trained. Because they are not trained to ration healthcare. This needs to be accepted and dealt with by management.' *(WM2)*

The difficulties associated with nurturing clinician involvement regarding accountability were, however, acknowledged and interviewees sounded a note of caution that controls seeking to restrict clinicians' autonomy would have harmful consequences in terms of commitment and work effort (Section 6.3.1.1). The study's findings indicated that there was a need to accept that clinical responses were driven by a desire to fulfil the needs of individual patients and to protect their professional autonomy. Accordingly, rather than attempting to control clinical responses, interviewees suggested that '*tactics*' (WM3) that would encourage the alignment of management control and clinical professional objectives should be considered (Section 6.3.4.1). Three approaches for encouraging involvement with management control practices were suggested by clinicians. Firstly, clinicians argued that they were less likely to be attracted to abstract concepts (e.g. needing to improve efficiency) that are not recognisable as being relevant to their day-to-day activities, whereas they were much more likely to be interested in clinical issues. Consequently, they felt that inducements appealing to their vocational nature were more likely to result in their increased involvement. This issue was best exemplified in Section 6.3.3.2 where it was explained that, if a clinician was involved in achieving a budget saving (e.g. had successfully negotiated with a medical device supplier), a percentage of that saving should be returned to the particular clinician to invest in a way he or she considered appropriate. It was argued that such a strategy would lead to improved clinician involvement due to the perception of receiving a tangible benefit related to individual action. In this way, the study's findings suggested that the design of a tailored incentivisation process, which aligned management control objectives with the vocational nature of clinicians as individuals, would deliver meaningful benefits in terms of clinician involvement with management control practices. Woodford Management acknowledged the potential advantages of such initiatives. However, as was highlighted in Section 7.1.3, they maintained that they did not have the authority to authorise such initiatives during the economic and fiscal crisis.

Secondly, clinicians explained that they were highly competitive and egotistical by nature (Section 6.3.4.3) and argued that, if management control practices could exploit these characteristics, this would lead to greater clinician involvement. In this regard, it was suggested that if benchmarking or comparison information were to be provided, this would

create a ‘reputation’ effect and involvement would automatically increase, as clinicians would not like their performance to be considered unsatisfactory. This suggestion reinforces the need for budget control practices to be aligned with internal processes and structures in order to supply relevant disaggregated budget information. Prior studies by Lehtonen (2007) and Eldenburg *et al*, (2010) have also advocated a need to provide benchmarking or comparison information to order to induce a ‘reputation’ effect.

Finally, clinicians asserted that their medical education did not teach them to consider the efficiency of their decisions but, rather, to concentrate on the needs of their individual patients. They described the medical education curriculum as containing little or no ‘management’ education. The perception emerging from the evidence presented in Section 6.3.4.2 was that clinicians could not be expected to consider the wider resource implications of their decisions if their training and education had not prepared them to do so. It was suggested that clinicians needed to be educated about the management control practices in operation and to be enrolled in courses that explained the need for and benefits of greater management control. The interviewees argued that this education needed to take place at each stage of a clinician’s professional career and that, in the absence of such education being provided, clinicians were unlikely to become involved with management control activity practices. However, the findings indicated that the accomplishment of any or all of these tactics would be difficult and pointed to a pervading sense of distrust of both HSE and Woodford Management. The clinician-management relationship is discussed in detail in Section 7.3.4.

These findings supported and extended the findings of the study of Abernethy and Stoelwinder (1995), which examined the effect of the interaction between professional orientation and management control on role conflict and the subsequent impact on organisational outcomes. Abernethy and Stoelwinder’s (1995) results indicated that role conflict is reduced when professionals do not operate in a hospital context where output controls restrict them in their self-regulatory activities. The findings from this study provided strong support for the view that creating an organisational context that encourages rather than enforces clinician involvement will have a positive effect on job satisfaction and overall organisational performance. Consequently, these findings revealed the professional orientation of clinicians to be an important contextual factor; however, contrary to previous research findings, this study showed that the operation of management control practices did not necessarily lead to role conflict and possible harmful side effects identified in the management control literature such as gaming, budgetary slack and data manipulation.

Instead, the professional orientation of clinicians was perceived to cause them to become apathetic or indifferent to the operation of management control practices. The implementation of control practices that would attempt to restrict clinical activities was considered to be organisationally undesirable and, as an alternative, it was suggested that attempting to better align management control and clinician objectives would lead to greater clinician involvement without the dysfunctional consequences. Furthermore, from the perspective of clinicians, the study provides an important insight into how management control practices should operate in order to balance the competing demands of clinician and control objectives. Future research should seek to investigate the effects of such strategies on clinician involvement.

7.3.3 Perceived Usefulness and Relevance of Management Control Information

The perceived usefulness and relevance of management control information was found to influence the responses of clinicians to the operation of management control practices. In several instances, interviewees explained that clinicians could not be told the specific budget for their area of specialisation, nor how it related to service activity, yet they were informed that budget reductions were being imposed on their divisions. This led to tensions and frustration on the part of clinicians and they believed that decisions were being made based on subjective judgements rather than quantified control information (Section 6.3.3.3). Most clinicians assumed that the dearth of budget information was attributable to an unwillingness to relinquish control on the part of Woodford Management. While the frailties of the budget control practice were recognised by some clinicians, the evidence suggests that these individuals were frustrated by Woodford Management's inability to solve the apparent weaknesses. One clinician summarised the implications of this issue:

> *'On what planet can we control for expenditure when, as a division, we don't know what we are spending? In my ten years, as a Chair of this division, I was never presented with a divisional budget. I don't know if the budget for this division is €10 million or €100 million. It's a ludicrous situation'.* *(EConsul)*

Consequently, the findings from this study provided clear evidence that a sufficient degree of disaggregation is an important issue influencing clinician's perceptions of the relevance and usefulness of budget control information.

In contrast, activity control information had been disaggregated to individual clinical divisions at Woodford. However, deficiencies associated with the provision of budget

control information were argued by interviewees to have a knock-on effect on the perceived usefulness of the activity control information. The purpose of the activity control practice was to ensure that a certain level and type of activity were delivered for the budget provided. In this way, the activity control practice should have provided a link between planned activity and assigned budget resources. However, the frailties associated with the budget control practice prevented this connection from being made, as it was not possible to link budget information with activity levels. This issue contributed to the activity control information being perceived as '*irrelevant*' (EConsul) and '*pointless*' (ONSM). Accordingly, the findings indicated that the level of integration between the budget and activity control practice was an important issue associated with clinician evaluations of activity control information's relevance and usefulness.

Furthermore, the ability of individuals to influence desired activity results emerged as an important factor influencing the perceived usefulness of the activity information. In effect, this issue related to the controllability principle, which mandates that managers should only be held accountable for events and results that are reasonably under their control (Ferrara, 1966; Horgren *et al*, 2004, Merchant, 1987, 1989). The controllability principle has been found to be difficult to execute in many circumstances (McNally, 1980; Atkinson, 1987, Choudhury, 1986) but the findings revealed it to be particularly pertinent to the issue of usefulness of activity control information. Seventy percent of the care provided by Woodford was emergency related and, consequently, the ability to influence desired results was severely restricted. This issue was found to be particularly pertinent amongst clinicians in the Emergency and Oncology Divisions, where the nature of the services provided was deemed to negate any attempts to control activity levels. The implications of this issue were exemplified in Section 6.3.1.4, where an interviewee outlined a scenario in which a clinician in the Emergency Division was treating a patient suffering from a myocardial infraction. The interviewee argued that, theoretically, the clinician had the ability to influence the desired activity results and could decide that providing care would have an adverse effect on performance; however, this clinician also asserted that the desired activity results would have no bearing on this scenario, as the consequences of not providing care were explained to be '*quite simply death'* (EConsul). While acknowledging that the particular example cited is a little inflammatory, it does raise an important issue: clinicians in a hospital context do have the ability to influence desired results. The question then is to what extent they should utilise this ability. Unlike other sectors, it is suggested that there is a fine line between controllability and desired results in a hospital context and this must be acknowledged and respected.

Overall, the provision of operational control information was perceived as relevant and useful (Aidemark, 2001; Kaplan and Norton, 1993). However, opinions were mixed regarding the perceived adequacy of the operational control information supplied. In the Emergency Division, clinicians believed that operational control information was generated to meet HSE reporting requirements. They felt that there was insufficient operational control information available and that this gap hampered their ability to manage their division; they provided vivid examples to illustrate the frustrations felt among clinicians in their division. For example, it was argued that, where a problem or issue arose, the management control information was not sufficiently timely to facilitate arrangements to be made to address the problem. It was explained that, at the end of each month, the Chair received a performance report detailing, among other things, patient waiting times. Clinicians deemed the provision of this information to be too late to inform decision making and it was argued that an effective operational control practice providing real-time control information was required. This finding supports the research of Chenhall and Morris (1984), which suggests that managers, who need to respond rapidly to environmental changes in uncertain situations, perceive timely information as an important priority. Thus, increased reporting frequency was favourably associated with clinicians' beliefs about information relevance. In contrast, individuals in the Cardiac Division were largely satisfied with the availability and timeliness of operational information. The evidence pointed to clinicians in this division as being centrally involved in the design and collection of operational information, which may explain their positive attitude. Overall, the findings from this study support previous research suggesting that participation in the design of operational performance measures may have positive effects (Argyris, 1952, Brownell, 1982).

7.3.4 The Clinician-Management Relationship

The clinician-management relationship was, in general, perceived to influence the responses of clinicians to the operation of the management control practices. The findings revealed that in many instances the relationship between clinicians and Woodford Management was poor, described by interviewees as '*fraught*' (SM1), '*contentious*' (EConsul) and '*problematic*' (SM4). However, the evidence from the interviews indicated that clinicians in the Cardiac Division perceived their working relationships with Woodford Management to be '*constructive, there is a healthy respect'* (CChair). As highlighted in Section 7.2.2, two issues were believed to contribute to this: (i) the provision of incremental budget resources to the Cardiac Division in recent times (Section 6.1.1); and (ii) good working relationships between the Cardiac Business Manager and Woodford Management and between the Cardiac Business Manager and Cardiac clinicians (Section 6.1.3).

The economic and fiscal crisis caused significant budget reduction targets to be imposed on the Hospital. Clinicians did not consider that Woodford Management had effectively communicated or managed these difficult and unusual circumstances (Section 6.3.4.2). Instead, Woodford Management were perceived to have adopted a '*cloak and dagger approach'* (OConsul), only consulting with individual clinicians when a specific issue or problem needed to be resolved. The findings revealed that the failure of Woodford Management to create the necessary level of trust had not only led to a high level of frustration but had also caused clinicians to withdraw their involvement with management control practices. Woodford Management recognised their failure to develop effective communication processes and, consequently, attempts to improve communication with clinicians were being made. For example, the Clinical Director (a member of Woodford Management) had recently begun to meet with large groups of clinicians to discuss the budget reduction issues at Woodford. While clinicians broadly regarded this initiative as a favourable development, they also argued that the absence of useful and meaningful budget information would weaken the effectiveness of such initiatives. As discussed in Section 7.2.2, the inability of the budget control practice to provide disaggregated budget information created considerable frustration amongst clinicians.

The findings also revealed that Woodford Management's decision to centralise control of non-direct pay expenditure had a negative impact on their relationship with clinicians. Prior to the fiscal crisis, clinician divisions had the authority to utilise the annual non-direct pay budget as they considered appropriate. The implications of this decision are best illustrated by an example set out in Section 6.3.2.1 whereby a request for the replacement of a light bulb in a teaching room had been refused so many times that one clinician, out of sheer frustration, had personally purchased the light bulb. The decision to centralise authority in this instance was considered to be the '*straw which broke the camel's back'* (EConsul). The findings indicated that Woodford Management recognised that centralisation was not the correct course of action and the potential for harmful implications was acknowledged. However, while a more considered style of usage was recognised to have far greater potential, it was argued that they were under too much pressure from HSE management to ensure that budget reduction targets were achieved. In essence, it emerged that they felt powerless to carry out their activities in the correct way and, instead, were forced to behave in a manner that prioritised results being achieved quickly. It was difficult to fully ascertain the implications of this decision to adopt a centralised approach. While it was implemented to ensure that budget reduction targets were achieved, it was possible that it did more harm than good. As discussed in Section 7.2.2, clinicians make autonomous decisions to admit

patients and treat them as they considered most appropriate. While clinicians may possibly have exploited this autonomy as a means of resisting the centralised approach adopted, there was no direct evidence to indicate that they purposefully resisted attempts to achieve budget reduction targets, though it was clear that the decision had damaged their relationship with Woodford Management and had dampened their motivation to engage with budget reduction activities.

Clinicians were also perceived to be sceptical about the capabilities of Woodford Management. They expressed scepticism about the frequently made claim that all fault was attributable to HSE management. Clinicians believed that Woodford Management failed to promote the organisation's agenda adequately at a national level, which resulted in the provision of insufficient resources. They contended that Woodford Management did not have the ability to successfully negotiate at this higher level:

> *'If you look at the medical core of consultants, almost 100 per cent of them have worked overseas in some of the top centres. Almost 100 per cent of managers have never worked outside the hospital. They don't have that exposure or experience that might make them look differently at it. Yes, many of them have done courses and many of them have done degrees but they haven't had that exposure to other places or other health systems'.* *(WM2)*

Finally, clinicians who had, in the past, become involved with management control activities were frustrated by the lack of attention given to their input. For instance, it was argued that, in many circumstances, clinicians had invested considerable time and effort into providing advice and recommendations (Section 6.3.4.4). Yet the findings showed that Woodford Management had failed to respond appropriately to clinician input. In fact, clinicians reported that management had both failed to incorporate their recommendations and, moreover, failed to acknowledge receiving them. They considered that such an inadequate response by Woodford Management created considerable frustration and unwillingness among clinicians in relation to becoming involved in future initiatives. Clinicians were cynical about the readiness of Woodford Management to truly involve them in management control activities. Furthermore, they questioned the ability of Woodford Management to resolve the many complex and multifaceted issues arising. As a result, clinicians experienced considerable frustration and resentment within this working relationship. They further argued that if there had been greater consultation and a genuine willingness on the part of Woodford Management to seek their cooperation, they would have become more involved. This failure

to communicate led to an erosion of trust and affected the motivation and subsequent involvement of clinicians.

While the general management literature has begun to recognise the importance of developing and managing trusting relationships, there has been relatively little research examining the impact of trust on the operation of management control practices. Comerford and Abernethy (1999) and Robbins (2007) have identified trust as an important issue but have also expressed a need for its implications to be further explored. The findings from this study showed that a lack of trust had implications in terms of frustration and commitment and hindered efforts to encourage clinician involvement. Furthermore, the study findings have identified key issues influencing the clinician-management trust relationship. Finally, the working relationships that exist between clinician and hospital management have been identified by several studies as an important factor influencing the operation of the management control practices in a hospital context (Kurunmaki, 1991; Preston *et al*, 2001; Jacobs, 2004; Modell and Lee, 2001; Robbins, 2007). These studies report that the implementation of management control practices results in the development of inferior working relationships between clinicians and management. They suggest that this occurs because implementation increases management's awareness of medical practice and this then enables them to exercise control over hospital activities. This redistribution of power and shift in control from clinicians to management is generally considered by clinicians to be a subversion of their professional judgement and an unnecessary incursion into their sphere of authority. The findings in this study reinforced previous findings in the literature indicating that poor clinician-management relationships are an important factor influencing the operation of management control practices. However, in contrast to previous studies, the implementation of management control practices was not reported to have caused a transfer of power from clinicians to management; rather, this study's findings suggested that the balance of power was shared between management (with control established on the basis of management control information) and clinicians (with control established on the basis of their professional standing).

7.3.5 Summary

At Woodford, clinicians in general were perceived to regard management control practices as being of secondary importance and to evaluate decisions by reference to clinical standards and controls alone. Three key issues influencing clinician responses were identified: (i) the professional orientation of clinicians; (ii) the perceived usefulness and value of management control information; and (iii) clinician-management relationships. The implications of these

factors included frustration, resentment, mistrust and cynicism and were shown to have caused clinicians to become apathetic or indifferent to the operation of management control practices. Furthermore, the fiscal crisis, which caused management control objectives to focus on the reduction and modification of service delivery, was shown to have amplified the implications of these issues. However, clinicians did not seek to purposefully resist and challenge the operation of these practices; rather, they remained indifferent towards their operation and, instead, focused on continuing to carry out their day-to-day clinical activities. Finally, the study pointed to the existence of variation between clinicians with regard to the appropriateness of the style of usage adopted. Some clinicians accepted this style as appropriate, while, others expressed frustration with the style adopted. Thus, the findings suggested that the responses of clinicians were not uniform, but rather a continuum, with a strong lack of enthusiasm on one side of the axis and a willingness to give more attention on the other.

7.4 Conclusion

This chapter has drawn together the findings from both phases of this empirical study in order to achieve the overarching objective of examining the operation of management control practices in a healthcare context during an economic and fiscal crisis. The findings demonstrated that the specific nature of the Irish hospital context posed challenges for the operation of management control practices. In particular, they revealed the influences of factors associated with the (i) national healthcare structure, (ii) organisational context, and (iii) clinician-control relationship. Each of these issues was perceived to influence the perceptions and attitudes of individuals towards the operation of the management control practices in place. The next chapter highlights the conclusions and contributions of the study and discusses the implications of its findings, as well as summarising its strengths and weaknesses and identifying areas for future research.

CHAPTER 8: CONCLUSION

8.0 Introduction

The study's objective was to examine the operation of management control practices in a healthcare context during an economic and fiscal crisis. To achieve this, an in-depth case study of a large, acute, public hospital in Ireland was conducted. The research was framed by a review of the literature on management control practices (Chapter 2), an examination of the characteristics of the Irish hospital context and empirical studies of management control practices in hospitals (Chapter 3). In addition, the literature on research methodologies was explored in order to ensure that the study's philosophical orientation was aligned with the research objective and approach selected (Chapter 4). This grounded the design of the empirical phases of the study and allowed the collection and analysis of data to be planned based on an awareness of both the prior literature and the context of the study itself. A preliminary phase was designed and conducted with the aim of developing an understanding of the type of management control practices that were in operation and to acquire a broad understanding of the factors influencing the operation of these practices (Chapter 5). The main phase of the study examined more thoroughly how management control practices operate in a healthcare context during an economic and fiscal crisis. In particular, this phase explored how contextual factors were perceived to influence individual attitudes and responses to the operation of the management control practices in operation (Chapter 6). The findings focused on four main themes: the organisational context in which the management control practices operated, the nature of the external environment, the appropriateness of the management control practices themselves and the attributes and features of the individuals considered in the study. The findings also revealed that each of the themes identified could not be considered in isolation, as they were all highly interrelated. The findings from both phases were considered together in order to allow the study's overarching objective to be achieved (Chapter 7). The purpose of Chapter 8 is to conclude the study. It begins by providing an overview of the main conclusions from the research. The contributions of the research are summarised in Section 8.2. Its implications are set out in Section 8.3. The merits and limitations of the research are outlined in Section 8.4. Finally, further opportunities for investigation are presented in Section 8.5. The chapter concludes in Section 8.6.

8.1 The Conclusions from the Research

The study's objective was to examine the operation of management control practices in a healthcare context during an economic and fiscal crisis. In order to meet its research objective, the study adopted a broader and more holistic perspective than previous management control studies and, in so doing, its findings contributed to the attainment of an

improved understanding of the topic. In particular, the study's findings revealed that the operation of management control practice at HSE level was perceived to have changed during the crisis. Based on this examination, the study highlighted three principal aspects in this regard. Firstly, the volume, detail and frequency of budget information being collated were deemed to have intensified. Secondly, the significance of the operational control practice was perceived to have declined as increased attention was paid to the budget control practice. Thirdly, the focus of the activity control practice was perceived to have altered. Prior to the economic crisis, the focus of this practice had been to ensure that incremental funding made available each year was utilised to increase activity levels in keeping with the healthcare policies devised by the DoH. However, during to the crisis, the focus of the activity control practice was perceived to be concerned with establishing appropriate activity levels in order to ensure that budget reduction targets could be achieved. Overall, the study's findings showed that little attention was given to the activity control practice, as its merits were considered to be negligible given the increasing, and largely uncontrollable, demand for healthcare services.

The study also demonstrated that the economic and fiscal crisis had initiated a perceived change in the use made of management control information by HSE management. HSE management were perceived to have begun placing a higher emphasis on budget reduction targets and to be using budget information in an inflexible manner, so that reasonable explanations of failure to meet budget reduction targets were unlikely to be accepted. The implications associated with this style of usage were examined by the study. In terms of positive implications**,** Woodford Management perceived themselves as having become much more involved with budget information as a result. Furthermore, they believed that they worked together to achieve budget reduction targets and working relationships amongst these individuals were perceived to have improved. However, the use made of management control information by HSE management was also viewed as having negative implications. Woodford Management reported that they experienced considerable job-related stress and they indicated that working relationships with their superiors had deteriorated. In addition, the study found that, in an effort to strengthen their discussions and to relieve the tensions associated with HSE management's style of usage, Woodford Management had begun to bring their clinical colleagues to performance evaluation meetings. It was argued that HSE management were not able to dismiss the explanations and concerns of Woodford Management as easily in the presence of these individuals, as they could use their clinical knowledge and expertise to communicate the difficulties they encountered within Woodford.

Previous findings in the literature would suggest that Woodford Management may have engaged in harmful behaviour, such as data manipulation, in order to relieve the tensions associated with the use made of management control information by HSE management. However, evidence of data manipulation was not reported, although it is plausible that such behaviour was not feasible since the majority of the budget control information was collated by HSE management, thus restricting the ability of Woodford Management to engage in manipulation of the data. The study's findings did, however, indicate that there was a potential for harmful side effects, such as gaming and budgetary slack, to occur. However, these outcomes were not found to be associated with the use made of management control information by HSE management but, rather, with HSE management's custom of allocating additional resources in the final quarter of the financial year. The study revealed that this custom had evolved from a cultural history whereby a supplementary budget would be provided in the final quarter of a year. The findings suggested that, during the fiscal crisis, this custom had the potential to encourage a perverse form of gaming behaviour, whereby Woodford Management could avoid the full implementation of initiatives aimed at achieving budget reduction targets in order to ensure that the Hospital received an *un*favourable evaluation, thus benefitting from greater financial leniency later in the year. The study's findings also demonstrated that this custom destabilised budget reduction efforts by undermining Woodford Management's authority. Furthermore, it was perceived to diminish the motivation and morale of Woodford Management.

Woodford Management recognised the need for cost saving and were willing to place a high emphasis on the achievement of budget reduction targets. However, they were also perceived to be unwilling to adopt the inflexible style of usage utilised by HSE management, arguing, instead, that budget control information should be used in a more flexible manner. The necessary organisational arrangements were not, however, in place to put a more flexible style of usage into effect. Within Woodford, individuals could not be held accountable for budget-related performance, as they did not have access to the budget information required to manage it. Furthermore, it was not possible to provide them with the necessary information because the budget control practice was incapable of providing disaggregated budget control information. Woodford's internal structures had been organised around a senior management and clinical divisional structure; however, the budget control practice had not been developed to align with these internal structures and, as a result, this practice was incapable of providing disaggregated budget control information related to service groups, support services or clinical divisions. Woodford Management were, as a result, unable to evaluate budget-related performance in a flexible manner. Instead, the study's

revealed that they had adopted an inflexible style of usage that involved directing attention to specific pay, non-pay and income items and centralising control of non-direct pay expenditure in order to meet budget reduction targets.

It is difficult to fully ascertain the implications associated with the use made of budget control information by HSE and Woodford Management in relation to budget-related performance. Woodford had achieved the budget reduction targets imposed in 2008, 2009 and 2010 and, at the same time, had managed to increase activity levels. Consequently, the study's findings suggested that the style of usage adopted by both HSE and Woodford Management had improved budget-related performance in the initial years of the crisis. The perception to emerge was that the inflexible style of usage removed organisational slack, which had accumulated prior to the economic and fiscal crisis and, as a result, budget-related performance had improved. Woodford did not, however, achieve its budget reduction targets in 2011 and was unlikely to do so in 2012. In this regard, it emerged that the cumulative effect of the budget reduction targets imposed by HSE management was viewed as being too difficult and that, irrespective of the use made of budget control information by HSE management, achieving the more recently imposed budget reduction target had become unfeasible.

In addition, the findings signalled that the centralised style of usage adopted by Woodford Management may have induced harmful side effects that could be regarded as dysfunctional from a budget performance perspective. Clinicians had considerable autonomy in deciding to use whichever tests, procedures, devices and therapies they deemed necessary. While there was no direct evidence to indicate that clinicians purposefully resisted attempts to achieve budget reduction targets, it was clear that this style of usage had dampened clinician motivation to engage with budget reduction initiatives. Woodford Management recognised that centralisation may not have been the correct style of usage and the potential for harmful side effects was acknowledged. While it was conceded that a more flexible style of usage could have had far greater potential in improving budget-related performance, it was argued that they were under too much pressure to ensure that budget reduction targets were achieved. In essence, it emerged that Woodford Management had felt powerless to carry out their activities in the most appropriate way and, instead, were forced to adopt a style of usage that prioritised results being achieved quickly. Therefore, the findings revealed that the centralised style of usage, while initially successful in removing organisational slack, may also have led to harmful side effects in the longer term. These effects included reduced

motivation to participate in the budget reduction initiatives and an apathetic or indifferent response to the operation of management control practices.

In general, clinicians were perceived to regard management control practices as being of secondary importance and to evaluate decisions by reference to clinical standards and controls alone. Three key issues influencing clinician responses were identified. Firstly, the findings from this study confirmed the importance of professional orientation in influencing clinician responses to the operation of management control practices. However, role conflict and possible harmful outcomes such as gaming, budgetary slack and data manipulation were not implications identified amongst clinicians at Woodford. Instead, the professional orientation of clinicians was found to cause them to become apathetic or indifferent to the operation of management control practices and to seek to focus exclusively on continuing with their clinical activities oblivious to their operation. Weaknesses associated with the accountability arrangements implied that clinicians could not be held financially accountable for their decisions or behaviours and they, therefore, did not need to actively challenge the operation of management control practices.

Secondly, the perceived usefulness and relevance of management control information was found to influence the responses of clinicians to the operation of management control practices. The failure to make disaggregated budget information available was perceived to have led to tensions and frustrations on the part of clinicians in each of the three clinician divisions examined. It was believed that decisions were being made based on subjective judgements rather than quantified control information. The findings suggested that, pending the budget control practice being able to identify and accumulate costs at a clinician division level, clinicians will not engage with budget-related issues. Deficiencies associated with the provision of budget control information were also broadly perceived to have a knock-on effect on the perceived usefulness of the activity control information. The purpose of the activity control practice was to ensure that a certain level and type of activity was delivered for the budget provided. In this way, the activity control practice ought to provide a link between planned activity and assigned budget resources. However, the frailties associated with the budget control practice prevented this connection from being made, as it was not possible to link budget information with activity levels. Accordingly, the findings demonstrated that a lack of integration between the budget and activity control practices was an important issue influencing these practices.

The ability to influence desired activity results was also perceived as influencing the perceived usefulness and relevance of the activity information. The perception to emerge was that, while activity control information was considered a good idea theoretically, the increasing and largely uncontrollable demand for services caused it to be viewed as futile and ineffectual. This issue was found to be particularly pertinent amongst clinicians in the Emergency and Oncology Divisions, where the nature of the services provided was deemed to negate any attempts to control activity levels. Overall, the provision of operational control information was seen as relevant and useful amongst clinicians in each of the three divisions. Clinicians from the Cardiac division were, however, found as being particularly satisfied. The evidence pointed to clinicians in this division being centrally involved in the design and collection of operational information, which may have explained their positive attitude. In contrast, clinicians from the Emergency Division expressed concern about the adequacy of the operational information provided. More specifically, these clinicians considered that the operational control information was reported too infrequently to inform their decision making, which suggests that clinicians who need to respond rapidly to environmental changes in uncertain situations perceive timely information as important. Furthermore, these clinicians expressed frustration at the inability of operational control information to reflect and manage organisational interdependence. In particular, a need for operational control information to account for the effects of decisions on interacting divisions was articulated.

Thirdly, the implications of the clinician-management relationship were highlighted. Woodford Management were perceived by clinicians to have failed to effectively communicate the difficult and unusual economic and fiscal circumstances within which they were operating. For example, in several instances, interviewees explained that they were not told the specific budget for their area of specialisation, yet they were informed that budget reductions were being imposed. As highlighted earlier, this led to tensions and frustration as they believed that decisions were being made based on subjective judgements rather than relevant budget information. Most individuals assumed that the dearth of budget information was attributable to an unwillingness to relinquish control on the part of Woodford Management. While the frailties of the budget control practice were recognised by some clinicians, the evidence suggested that these individuals felt frustrated by Woodford Management's inability to solve the apparent weaknesses. These issues also led to resentment and cynicism and were believed by many interviewees to have caused individuals to become apathetic or indifferent to the operation of management control practices.

Woodford Management recognised their failure to develop effective communication processes and, consequently, attempts to improve communication were being made. For example, the Clinician Director (a member of Woodford Management) had begun meeting with groups of clinicians to discuss budget-related performance issues. While such initiatives were broadly regarded as a favourable development, it was argued that the absence of disaggregated budget information would weaken the effectiveness of such initiatives. A sense of disinclination with regard to the provision of disaggregated budget information (if it had been available) was apparent amongst Woodford Management. This reluctance appeared to stem from the belief that the professional orientation of clinicians would prevent them from participating effectively and, consequently, Woodford Management relied on retaining budget control information in order to maintain their authority and standing in the organisation.

Clinicians were also found to be cynical about the readiness of Woodford Management to truly involve them in management control activities. They argued that, had there been greater consultation and a genuine willingness on the part of Woodford Management to seek their participation, they would have become more involved. However, they believed that Woodford Management only consulted with clinicians when a specific issue or problem needed to be resolved. Not only did this failure cause a high level of frustration but it also led clinicians to withdraw their involvement with management control practices. Clinicians were also sceptical about the capabilities of Woodford Management. For instance, they expressed scepticism about the frequently made claim of Woodford Management that all fault was attributable to HSE management. Clinicians believed that Woodford had failed to promote the organisation's agenda adequately at a national level, which resulted in the insufficient provision of budget-related resources. They contended that Woodford Management did not have the managerial ability to negotiate at this higher level.

Consequently, clinicians in general were perceived to regard management control practices as being of secondary importance and to evaluate decisions by reference to clinical standards and controls alone. Three key issues influencing clinician responses were identified: (i) the professional orientation of clinicians; (ii) the perceived usefulness and value of management control information; and (iii) clinician-management relationships. The implications of these factors included frustration, resentment, mistrust and cynicism and were shown to have caused clinicians to become apathetic or indifferent to the operation of management control practices. Furthermore, the fiscal crisis, which caused management control objectives to focus on the reduction and modification of service delivery, was shown to have amplified

these issues. However, clinicians did not seek to purposefully resist and challenge the operation of these practices; rather, they remained indifferent towards their operation and, instead, focused on continuing to carry out their day-to-day clinical activities.

The study did, however, point to some variation amongst clinicians with regard to the appropriateness of the response adopted. Some clinicians accepted this response as appropriate in terms of maintaining their overriding professional duty to their patients and asserted that budget performance was not their concern or responsibility. On the other hand, many other clinicians expressed frustration with the response. These clinicians were exasperated that organisational resources were not being utilised as efficiently as possible and felt that more consideration should be given to management control issues. Thus, the findings indicated that clinician responses were not uniform, but rather a continuum, with a strong lack of enthusiasm on one side of the axis and a willingness to devote more attention to management control issues on the other. The findings also suggested that a clinician's position on the continuum may have been connected to their area of specialism. Clinicians in the Cardiac Division were regarded as being more willing to engage with management control practices than their counterparts in the Emergency and Oncology Divisions. Four factors were deemed to contribute to this: (i) the provision of incremental budget resources in recent times; (ii) good working relationships between the Cardiac Business Manager and Woodford Management and between the Cardiac Business Manager and Cardiac clinicians; (iii) a higher level of controllability associated with the provision of Cardiac services; and (iv) a more defined relationship between inputs and outputs in the Cardiac Division.

8.2 The Contributions of the Research

This study investigated the operation of management control practices in a healthcare context during an economic and fiscal crisis and, in so doing, has yielded valuable insights that contribute to the literatures on management control and management control in healthcare. In particular, the study highlights how an externally-induced organisational crisis, in this case an economic and fiscal crisis, influences the operation of management control practices. The effects of an economic crisis have been highlighted as important but under-researched (Arnold, 2009; Hartmann, 2000; Hopwood, 2008; Van der Stede, 2015). To effectively contribute to this research gap, the study incorporated three management control practices, thereby addressing concerns previously raised that examining control practices individually may influence any conclusions drawn (Malmi and Brown, 2008; Otley, 1999). It also provided pertinent insights by exploring the manner in which the pressures caused by the economic and fiscal crisis were transmitted in the organisational hierarchy. In particular,

the findings revealed how different parties adopted defensive mechanisms in order to cope with the economic and fiscal crisis. HSE management were perceived to have adopted a high emphasis on budget control information and to have used an inflexible style of performance evaluation. Woodford Management were found to recognise the need for cost saving and were willing to place a high emphasis on the achievement of budget reduction targets. However, they were also found to be unwilling to adopt the inflexible style of usage utilised by HSE management and they argued that budget control information should be used in a more flexible manner. The necessary organisational arrangements were not, however, in place to put a more flexible style of usage into effect. Instead, Woodford Management were perceived to have adopted an inflexible style of usage that involved directing attention to specific pay, non-pay and income items and centralising control of non-direct pay expenditure in order to meet budget reduction targets. Finally, clinicians in general were found to regard management control practices as being of secondary importance and to evaluate decisions by reference to clinical standards and controls alone.

A further contribution made by the study lies in its consideration of the use made of management control information. Numerous studies have concluded that it is the way in which management control practices are used, as opposed to their mere existence, which determines their effects (Ferreira and Otley, 2009). However, the management control literature, has had a tendency to focus on examining the conditions that render a particular style of usage in performance evaluation more (or less) effective (Hartmann, 2000). As a result, evidence of the effects associated with the use made of management control information is piecemeal in terms of the types of outcomes studied (Briers and Hirst, 1995). To contribute to this literature, this study explored the use made of management control information at different organisational levels and among different professional groupings and, in this way, enabled a deeper understanding of the area to be acquired.

In addition, the study makes a contribution to the further development of Ferreira and Otley's (2009) Performance Management and Control framework. The study suggests that the framework was beneficial in eliciting a description of a management control system in operation. However, in the context of this study, where organisational objectives, strategies, key success factors, performance measures and targets were formulated by an external stakeholder, the relevance and validity of Questions One to Five of the framework were found to be marginal. Consequently, it is suggested that, where management control practices are implemented in order to monitor and report on the progression of an individual subunit's performance, it may be advantageous to reduce the emphasis on questions related

to the formulation of objectives (e.g. vision, mission, key success factors, key performance measures, strategies and plans and target setting) and prioritise questions relating to the means by which these goals should be achieved (e.g. performance evaluation, reward systems, usage and information flows).

The study makes a contribution to the management accounting in healthcare literature by providing additional insights into the responses of clinicians to the operation of management control practices. In particular, it examined this issue through an array of organisational members including not only clinicians themselves but also hospital managers and nurse service managers. Furthermore, the study investigated the responses of clinicians to the operation of management control practices during a fiscal and economic crisis, a topic that had not been studied previously. Its findings reinforce previous findings in the literature indicating that poor clinician-management relationships are an important factor influencing the operation of management control practices. However, in contrast to previous studies, the operation of management control practices was not reported to have caused a transfer of power from clinicians to management; rather, this study's findings suggest that the balance of power was shared between management (with control established on the basis of management control information) and clinicians (with control established on the basis of their professional standing). However, contrary to expectations based on previous studies, clinicians were not found to purposefully resist or defend themselves against the operation of management control practices that were incongruent with their professional objectives. Instead, the study contributes to the literature by demonstrating that clinicians tended to choose to ignore management control practices and continue their clinical activities oblivious to their operation. The study also pointed to variation amongst clinicians in terms of the appropriateness of the response adopted.

A further contribution of the study to the management accounting in healthcare literature relates to its exploration of how hospital management responded to these practices. In particular, this study addresses some of the limitations of previous research regarding this issue by investigating the use made of management control practices at middle-level management. Woodford Management were found to be unwilling to adopt the inflexible style of usage employed by their superiors and regarded a flexible style to be more appropriate. However, the findings also demonstrated that the necessary organisational arrangements were not in place to put their preferred, flexible, style of usage into effect. Instead, Woodford Management were found to have adopted an inflexible style of usage which involved directing attention to specific pay, non-pay and income items and

centralising control of non-direct pay expenditure in order to meet budget reduction targets. The findings revealed that the inflexible style of usage, while initially successful in eliminating organisational slack, may also have induced harmful side effects. Such effects included a decreased motivation to participate in the budget reduction initiatives and an apathetic or indifferent response to the operation of management control practices.

8.3 The Implications of the Research

It has been noted that published accounting research is frequently inaccessible to practitioners. In fact, Van der Stede (2015, p. 173) contends that there is a need to ensure that researchers 'conduct properly executed academic studies on practice-relevant issues that yield potentially applicable insights'. He explains that this implies producing 'useable knowledge, as opposed to academically self-referential knowledge'. With this in mind, the purpose of this section is to distil the practical implications emanating from this research study. These are discussed below.

HSE management's high emphasis on budget reduction targets and their inflexible use of budget control information were found to have mixed implications. Broadly, the findings indicated that their approach had a favourable effect on Woodford Management's involvement with budget information and on efforts to improve budget-related performance. Nevertheless, if these impacts were to endure, greater attention needed to be given to the information flow process, performance evaluation, reward systems and budget tightness to ensure that the potential for harmful side effects was minimised. Furthermore, the custom of releasing contingency funds at year-end needed to be evaluated and efforts should have been made to develop a system of rewarding the achievement of budget targets.

Similarly, Woodford Management's high emphasis on budget control targets and their centralised control of budget control information were also found to have mixed implications. The perception to emerge from the findings was that, while these strategies may have been effective initially, in the longer term, this style of usage may have been damaging to budget-related performance. The provision of disaggregated budget information aligned with internal structures would have permitted budget information to be used in a more flexible manner and allowed individuals to consider the budget implications of their decisions.

The misalignment between authority and accountability also needed to be evaluated. Although Woodford Management were held accountable for performance, their ability to

make decisions was limited. A failure to delegate authority to make decisions leads to frustration, which affects job satisfaction and motivation. On this basis, consideration should have been given to granting greater authority to Woodford Management. Alternatively, the limited authority held by Woodford should have been recognised within the performance evaluation processes. Within Woodford, appropriate accountability arrangements needed to be put in place in order to ensure that individuals participated with management control activities and information. A failure to hold individuals accountable for the authority devolved had led to apathetic responses. In this regard, improving the provision of disaggregate budget information would have helped to ensure greater accountability. In addition, a reward system that appealed to the vocational nature of individuals should have been developed. This would have provided an incentive and motivation to encourage individuals to hold themselves and others accountable for decision-making.

Woodford Management needed to recognise that the responses of clinicians to management control practices were not uniform. On the one hand, there was a cohort of clinicians who viewed management control practices as being of secondary importance and who remained unwilling to participate with management control activities. On the other hand, there was a second cohort of clinicians who were more willing to become involved with these practices. Addressing the contextual issues identified, in particular issues connected to the relevance and usefulness of management control information would have encouraged this cohort of clinicians to become involved with management control activities and information.

8.4 The Merits and Limitations of the Research

In drawing any conclusions from this research, it is essential to consider certain parameters relating to the interpretation of the study. Its strengths lay in the methodological approach adopted. Each aspect of the study, in terms of its design, implementation and analysis, was carefully executed. While the research design was formed on the basis of the study's research objective, the overarching qualitative research approach contrasted with the quantitative approaches that dominate the management control literature. In this way, this study responded to the calls that have been made for more in-depth studies of management control issues (Chenhall, 2003; Otley and Pollanen, 2000). This study employed three main research methods: interviews, organisational documentation and archival records. The advantages of the qualitative case-based approach adopted included its capacity to acquire a rich, contextual understanding of the operation of management control practices in an Irish hospital during an economic and fiscal crisis. The research design also had merits with regard to the rigour injected into the different aspects of the research process, which included

data management and collection, interview guide design, acquiring informed consent, interview recording, transcription and a pre-planned and detailed systematic approach to data analysis. Utilising Ferreira and Otley's (2009) Performance Management and Control framework to frame the preliminary phase was also valuable as it helped to hone the scope and design of the main phase of the study, which significantly improved the utility of the findings. Finally, a significant advantage of the study design was revealed in the openness and trust that was demonstrated by the respondents in their discussion of the issues arising and their different perceptions in relation to them.

Despite these advantages, the findings, contributions and implications of the study must be considered in light of its limitations. As the study adopted an interpretative orientation and was conducted using a qualitative mode of enquiry, the limitations inherent in such an approach need to be acknowledged. In particular, the extent to which it is possible to draw wider generalisations from the research findings is limited. While the study's findings provide valuable insights into the operation of management control practices in a healthcare context during a fiscal and economic crisis, it is not possible to determine the extent to which such findings would be replicated in a different research context. However, the research objective and subsequent methodological, design and method choices were not made in order to lead to empirical generalisations but to allow an in-depth understanding to be achieved.

There are limitations associated with the selection of the case-study approach adopted also, as it has been challenged on the basis of its vulnerabilities in terms of reliability of documentation, boundary definitions and ethical considerations (Yin, 2009). Although it was impossible to fully eliminate these limitations, the rigorous research design documented in Chapter 4 ensured that such drawbacks were minimised. The potential risk of interviewee bias is, however, acknowledged. The interviews were conducted during an economic and fiscal crisis and, therefore, the interviewees were working in close proximity to the stresses and tensions inherent in this context. Where possible, organisational documentation and archival records were utilised to triangulate findings and to help explain the attitudes and perceptions of the individuals. In addition, individual viewpoints and experiences were discussed with other individuals in order to construct a full understanding. The findings also discussed the feelings and emotions of individuals (e.g. job related tension, job satisfaction, motivation and morale). However, these findings were founded upon the perceptions expressed by the interviewees themselves and no attempt was made to quantitatively measure these variables. The limitations associated with this issue are recognised and offer a potential opportunity for future research. Finally, the study explored the operation of these

management control practices at a particular point in time and did not adopt a longitudinal approach. Future research that has a longitudinal dimension would be of merit.

8.5 The Opportunities from the Research

A number of directions for future research may be highlighted as arising from the key findings, implications and limitations of the study. In the first instance, this study sought to explore the operation of management control practices in a healthcare context during an economic and fiscal crisis. The findings, however, developed from an in-depth case study of one large, acute, teaching hospital in Ireland and, consequently, there is further opportunity to expand this area of research beyond this very specific setting. Future studies should give consideration to how other externally-induced organisational events influence the operation of management control practices in a healthcare context. In addition, future research should examine the operation of management control practices in a variety of healthcare contexts in order to compare and contrast empirical findings. Specifically, further research in the voluntary and private hospital sector would provide valuable insights.

This study also examined the implications associated with a perceived high emphasis on budget reduction targets and the use of budget control information in an inflexible manner so that reasonable explanations of failure to meet budget reduction targets are unlikely to be accepted. The study's finding suggested that this usage style leads to improved budget-related performance up to an undefined point related to budget difficulty. However, this finding has been developed from a case study of a single organisation. Future studies should, therefore, give consideration to the relationship between the use made of management control information, budget difficulty and budget performance and, in particular, it is suggested that a quantitative examination of this issue would be beneficial.

A further potential area for research is a deeper investigation of clinicians' attitudes and responses to the operation of management control practices. The findings from this study suggested that clinician responses are not uniform, but rather represent a continuum, with a strong reluctance on one side of the axis and a willingness for greater engagement on the other. The study suggested that position on the axis is influenced by the education, professional experience and age of an individual clinician. For example, it was suggested by interviewees that clinicians who had trained outside of Ireland were more likely to be positioned on the enthusiasm side of the continuum. The design of this study did not facilitate the exploration of such relationships and, hence, future research could seek further insights to enable a better understanding of the relationship between individual features

(characteristics) and clinician responses. The findings also suggested that a clinician's position on this continuum may be connected to their area of specialism. The evidence from the interviews indicated that clinicians in the Cardiac division were considered to be more willing to engage with management control practices than their counterparts in the Emergency and Oncology divisions. Four factors were deemed to contribute to this: (i) the provision of incremental budget resources to the Cardiac division in recent times (Section 6.1.1); (ii) good working relationships between the Cardiac Business Manager and Woodford Management and between the Cardiac Business Manager and Cardiac clinicians (Section 6.1.3); (iii) a higher level of controllability associated with the provision of Cardiac services; and (iv) a more defined relationship between inputs and outputs in the Cardiac Division (Section 6.1.4). Future research could seek further insights to enable a better understanding of the relationship between departmental characteristics and clinician responses.

Finally, the findings from this study provided strong support for the view that creating an organisational context that encourages rather than compels clinician involvement will have a positive effect on clinician responses to the operation of management control practices. Three approaches for managing the competing demands of clinician and control objectives were suggested. Firstly, clinicians argued that they were less likely to be attracted to abstract concepts (e.g. needing to improve efficiency) that are not recognisable as being relevant to their day-to-day activities, whereas they were much more likely to be interested in clinical issues. Consequently, they felt that inducements appealing to their vocational nature were more likely to result in their increased involvement. Secondly, clinicians explained that they were highly competitive and egotistical by nature and argued that, if management control practices could exploit these characteristics, this would lead to greater clinician involvement. In this regard, it was suggested that if benchmarking or comparison information were to be provided, this would create a 'reputation' effect and involvement would automatically increase, as clinicians would not like their performance to be considered unsatisfactory. Thirdly, clinicians asserted that their medical education did not teach them to consider the efficiency of their decisions but, rather, to concentrate on the needs of their individual patients. They described the medical education curriculum as containing little or no 'management' education. The perception emerging from the evidence was that clinicians could not be expected to consider the wider resource implications of their decisions if their training and education had not prepared them to do so. It was suggested that clinicians needed to be educated about the management control practices in operation and to be enrolled in courses that explained the need for and benefits of greater management control.

Future research should seek to investigate the effects of such strategies on clinician responses.

8.6 Conclusion

This study has examined the operation of management control practices in a healthcare context during an economic and fiscal crisis. This chapter completed the study by highlighting its conclusions while also outlining the study's key contributions to both the management control and the management accounting in healthcare literature. In this context, it also discussed the practical implications of the study and delineated its merits and limitations. The chapter concluded by providing a range of suggestions for further research on the basis of the findings. It is hoped that the understanding achieved will improve the operation of management control practices in a healthcare context, support the more efficient use of healthcare resources and, ultimately, ensure sustainability.

BIBLIOGRAPHY

Abernethy, M. A. (1996) 'Physicians and resource management: the role of accounting and non-accounting controls', *Financial Accountability and Management*, vol. 12, no. 2, pp. 189-204.

Abernethy, M. A. and Stoelwinder, J. U. (1990) 'The relationship between organisation structure and management control in hospitals: an elaboration and test of Mintzberg professional bureaucracy model', *Accounting, Auditing and Accountability Journal*, vol. 3 no. 3, pp. 105-120.

Abernethy, M. A. and Guthrie, C. H. (1994) 'An empirical assessment of the "fit" between strategy and management information system design', *Accounting and Finance*, vol. 34, no. 2, pp. 49-66.

Abernethy, M. A. and Stoelwinder, J. U. (1995) 'The role of professional control in the management of complex organizations', Accounting *Organisations and Society*, vol. 20, no.1, pp. 1-17.

Abernethy, M. A. and Chua, W. F. (1996) 'A field study of control system redesign: the impact of institutional processes on strategic choice', *Contemporary Accounting Research*, vol. 13, no. 2, pp. 596-606.

Abernethy, M. A. and Brownell, P. (1999) 'The role of budgets in organisations facing strategic change: an exploratory study', *Accounting, Organisations and Society*, vol. 24, no. 3, pp.189-204.

Abernethy, M. A. and Lillis, A. M. (2001) 'Interdependencies in organisation design: a test in hospitals', *Journal of Management Accounting Research*, vol. 13, no. 1, pp. 107-129.

Abernethy, M.A. and Vagnoni, E. (2004) 'Power, organisation design and managerial behaviour' *Accounting, Organisation and Society*, vol. 29, no. 3, pp. 207-225.

Abernethy, M. A., Horne, M., Lillis, A. M., Malina, M. A. and Selto, F. H. (2005) 'A multi-method approach to building causal performance maps from expert knowledge', *Management Accounting Research*, vol. 16, no. 2, pp. 135-155.

Abernethy, M. A., Chua, W. F., Grafton, J. and Mahama, H. (2006) 'Accounting and control in healthcare: behavioural, organizational, sociological and critical perspectives', in: C. S. Chapman, A. G. Hopwood and M. D. Shields (Eds) *Handbook of Management Accounting Research*, vol. 2, Oxford: Elsevier Science, pp. 805-829.

Abernethy, M. A., Bouwens, J. and Van Lent, L. (2010) 'Leadership and control system design', *Management Accounting Research*, vol. 21, no. 1, pp. 2-16.

Ahrens, T. (2008) 'Overcoming the subjective-objective divide in interpretive management accounting research, *Accounting, Organisations and Society*, vol. 33, no. 2, pp. 292-297.

Ahrens, T. and Dent, J. F. (1998) 'Accounting and organisations: realizing the richness of field research' *Journal of Management Accounting Research*, vol. 10, no. 1, pp. 1-39.

Aidemark, L. G. (2001) 'The meaning of balanced scorecards in the health care organisation', *Financial Accountability and Management*', vol. 17, no. 1, pp. 23-40.

Aidemark, L. G. and Funck, E. K. (2009) 'Measurement and health care management', *Financial Accountability and Management*, vol. 25, no. 2, pp. 253-276.

Anthony, R.N. (1965) *Management Planning and Control Systems: A Framework for Analysis*, Boston: Harvard Business School Press.

Aranya, N. (1990) 'Budget instrumentality, participation and organizational effectiveness', *Journal of Management Accounting Research*, vol. 2, no. 1, pp. 67-77.

Argyris, C. (1990) 'The dilemma of implementing controls: The case of managerial accounting', *Accounting, Organisation and Society*, vol. 15, pp. 503-511.

Argyris, C. (1952) *The Impact of Budgets on People*, Controllership Foundation, Cornell University, Ithaca, NY.

Arnold, P. J. (2009) 'Global financial crisis: The challenge to accounting research', *Accounting, Organisations and Society*, vol. 34, no. 6, pp. 803-809.

Baker, C. R. and Bettner, M. S. (1997) 'Interpretive and critical research in accounting: a commentary on its absence from mainstream accounting research', *Critical Perspectives on Accounting*, vol. 8, no. 4, pp. 293-310.

Baker, G. R. and Denis, J. L. (2011) 'Medical leadership in health care systems: from professional authority to organisational leadership', *Public Money and Management*, vol. 31, no. 5, pp. 355-362.

Ballantine, J., Brignall, S. and Modell, S. (1998) 'Performance measurement and management in public health services: A comparison of U.K and Swedish practice', *Management Accounting Research*, vol. 9, no. 1, pp. 71-94.

Banker, R. D., Datar, S. M., & Rajan, M. V. (1987) 'Measurement of productivity improvements: An empirical analysis', *Journal of Accounting, Auditing & Finance*, vol. *2, no.*4, pp. 319-347.

Barrett, T. F., McDonagh, P. and Granleese, J. (1992) 'The contagion effect in performance evaluation: evidence from the evaluations of marketing managers: a research note', *The British Accounting Review*, vol. 24, no. 4, pp. 331-341.

Becker, H. and Geer, B. (1957) 'Participant observation and interviewing: a comparison', *Human Organisation*, vol. 16, no. 3, pp. 28-32.

Berry, A. J. and Otley, D. (2004) 'Case-based research in accounting', in C. Humphrey and B. Lee (eds), *The Real Life Guide to Accounting Research: A Behind the Scenes View of Using Qualitative Research Methods*, London: Elsevier, pp. 231-255.

Berry, A. J., Coad, A. F., Harris, E.P., Otley, D. T. and Stringer, C. (2009) 'Emerging themes in management control: a review of recent literature', *The British Accounting Review*, vol. 41, no.1, pp. 2-20.

Bhimani, A. (2002) 'European management accounting research: traditions in the making', *European Accounting Review*, vol. 11, no.1, pp. 99-117.

Birnberg, J. G., Turopolec, L. and Young, S. M. (1983) 'The organisational context of accounting', in readings in *Accounting for Management Control*, Springer, pp. 107-131.

Bisbe, J. and Otley, D. (2004) 'The effects of the interactive use of management control systems on product innovation', *Accounting, Organisations and Society*, vol. 29, no. 8, pp. 709-737.

Bonner, S. E. and Sprinkle, G. B. (2002), 'The effects of monetary incentives on effort and task performance: Theories, evidence, and a framework for research', *Accounting, Organisations and Society*, vol. 27, no. 4, pp. 303-345.

Bourn, M. and Ezzamel M. (1986) 'Costing and budgeting in the NHS', *Financial Accountability and Management*, vol. 2, no. 1, pp. 53-72.

Bouwens, J. and Abernethy, M. A. (2000) 'The consequences of customization on management accounting system design', *Accounting, Organisations and Society*, vol. 25, no. 3, pp. 221-241.

Brennan, N. (2003) *Report of the Commission on Financial Management and Control Systems in the Health Service*, Dublin: Stationery Office.

Briers, M. and Hirst, M. (1990) 'The role of budgetary information in performance evaluation', *Accounting, Organisation and Society*, vol. 15, no. 4, pp. 373-398.

Broadbent, J., Jacobs, K. and Laughlin, R. (2001) 'Organisational resistance strategies to unwanted accounting and finance changes: the case of general medical practice in the UK', *Accounting, Auditing and Accountability Journal*, vol. 14, no. 5, pp. 565-586.

Broadbent, J. and Laughlin, R. (2009) 'Performance management systems: a conceptual model', *Management Accounting Research,* vol. 20, no. 4, pp. 283-295.

Brownell, P. (1982) 'The role of accounting data in performance evaluation, budgetary participation and organizational effectiveness', Journal *of Accounting Research,* pp. 12-27.

Brownell, P. (1985) 'Budgetary systems and the control of functionally differentiated organisational effectiveness' *Journal of Accounting Research*, pp. 502-512.

Brownell, P. and Hirst, M. (1986) 'Reliance on accounting information, budgetary participation and task uncertainty: tests of a three-way interaction', *Journal of Accounting Research*, pp. 241-249.

Brownell, P. and Dunk, A. S. (1991) 'Task uncertainty and its interaction with budgetary participation and budget emphasis: some methodological issues and empirical investigation', *Accounting, Organisations and Society*, vol.16, no. 8 pp. 693-703.

Broyles, R.W and Reilly, B.J. (1988) 'Physicians, patients, and administrators: A realignment of relationships', *Hospital & Health Services Administration* vol.; 33, no.5, pp. 36-49.

Burns, T. and Stalker, G.M. (1961) *The Management of Innovation*. London: Tavistock Institute.

Bruns, W. J. and Waterhouse, J. H. (1975) 'Budgetary control and organisation structure', Journal *of Accounting Research*, Autumn, pp. 177-203.

Bryman, A. (2004) *Social Research Methods,* 2nd Edn, Oxford: Oxford University Press.

Bryman, A. and Bell, E. (2015) *Business Research Methods*, Oxford: Oxford University Press.

Bukh, P. N. and Malmi, T. (2005) 'Re-examining the cause-and-effect principle of the balanced scorecard', *Accounting in Scandinavia*, pp. 87-113.

Burke, S., Thomas, S., Barry, S. and Keegan, C. (2014) 'Indicators of health system coverage and activity in Ireland during the economic crisis 2008-2014: from 'more with less' to 'less with less', Health *Policy*, vol. 117, no. 3, pp. 275-278.

Burkert, M., Fischer, F. M. and Schäffer, U. (2011) 'Application of the controllability principle and managerial performance: the role of role perceptions', *Management Accounting Research*, vol. 22, no. 3, pp. 143-159.

Burgess, R.G. (2002) *In the field: An Introduction to Field Research*. Routledge.

Burrell, G. and Morgan, G. (1979) *Sociological Paradigms and Organisational Analysis*, London: Heinemann Educational Books Ltd.

Cardinaels, E. (2009) 'Governance in non-for-profit hospitals: effects of board members' remuneration and expertise on CEO compensation', *Health Policy*, vol. 93, no. 1, pp. 64-75.

Cardinaels, E., Roodhooft, F. and Van Herck, G. (2004) 'Drivers of cost system development in hospitals: Results of a survey', *Health Policy*, vol. 69, no. 2, pp. 239-252.

Cardinaels, E. and Soderstrom N. S. (2013) 'Managing in a complex world: Accounting and governance choices in hospitals', *European Accounting Review*, vol. 22, no. 4, pp. 647-684.

Casemix Ireland (2010) '*Financial Implications of the Irish Casemix Programme'*. Available at: www.casemix.ie/index.jsp?p=141&n=160 Chandler, A. D. (1962) *Strategy and Structure-Chapters in the History of American Industrial Enterprise*, Cambridge: MIT Press.

Chapman, C. S. (1997) 'Reflections on a contingent view of accounting', *Accounting, Organisation and Society*, vol. 22, no. 2, pp. 189-205.

Chapman, C. S. (1998) 'Accountants in organizational networks', Accounting, *Organisations and Society*, vol. 23, no. 8, pp. 737-766.

Chenhall, R. H. and Morris, D. (1986) 'The impact of structure, environment and interdependencies on the perceived usefulness of management accounting systems' *Accounting Review*, vol. 61, pp. 16-35.

Chenhall, R. H. and Morris, D. (1995) 'Organic decision and communication processes and management accounting systems in entrepreneurial and conservative business organisations', *Omega*, vol. 23, no. 5, pp. 485-497.

Chenhall, R. H. and Smith, D. (2011) 'A review of Australian management accounting research: 1980-2009', *Accounting and Finance*, vol. 51, no. 1, pp. 173-206.

Chenhall, R. H. (1998) 'The relationship between strategic priorities, management techniques and management accounting', *Accounting, Organisation and Society*, vol. 23, no. 3, pp. 243-264.

Chenhall, R. H. (2003) 'Management control system design within its organisational context', *Accounting, Organisation and Society*, vol. 28, no. 2, pp. 127-168.

Chenhall, R. H. (2007) 'Theorizing contingencies in management control systems research', in C. S. Chapman, A. G. Hopwood and M. D. Shields (eds), *Handbook of Management Accounting Research Volume 1*, London: Elsevier, pp. 163-205.

Child, J. (1975) 'Managerial and organisational factors associated with company performance: A contingency analysis', *Journal of Management Studies*, vol. 12, no. 1, pp. 12-27.

Choudhury, N. (1986) 'Responsibility accounting and controllability', *Accounting and Business Research*, vol. 16, no. 63, pp. 189-198.

Chow, C. (2010) 'Looking back, peeking ahead', *Journal of Management Accounting Research*, vol. 22, no. 1, pp. 67-72.

Chua, W. F. (1986), 'Radical developments in accounting thought', *The Accounting Review*, vol. 61, no. 4, pp. 601-632.

Chua, W. F. (1996) 'Issues in substantive areas of research: Field research in accounting', in A. J. Richardson (eds), *Research Methods in Accounting: Issues and Debates*, Vancouver: the Canadian General Accountants Research Foundation, pp. 209-228.

Chua, W.F. and Preston, A. (1994) 'Worrying about accounting in health care', *Accounting, Auditing and Accountability Journal*, vol. 7, no. 3, pp. 4-17.

Coffey, A. and Atkinson, P. (1996) *Making Sense of Qualitative Data*, Thousand Oaks, CA: Sage.

Cohen, D. I., Jones, P., Littenberg, B. and Neuhauser, D. (1982) 'Does cost information availability reduce physician test usage? a randomized clinical trial with unexpected findings', *Medical Care*, pp. 286-292.

Collier, P.M. (2005) 'Entrepreneurial control and the construction of a relevant accounting', *Management Accounting Research,* vol. 16, no. 3, pp. 321- 339.

Collins, F. (1982) 'Managerial accounting systems and organisational control: A role perspective', *Accounting, Organisations and Society*, vol. 7, no. 2, pp. 107-122.

Collis, J. and Hussey, R. (2003) *Business Research: A Practical Guide for Undergraduate and Postgraduate Students*, 2nd Edn., Baskingstoke: Palgrave, Macmillan.

Comerford, S. E., and Abernethy, M. A. (1999) 'Budgeting and the management of role conflict in hospitals', *Behavioral Research in Accounting*, vol. 11, pp. 93-110.

Coombs, R. W. (1987) 'Accounting for the control of doctors: Management information systems in hospitals', *Accounting, Organisations and Society*, vol. 12, no. 4, pp. 389-404.

Cooper, D. J. and Morgan, W. (2008) 'Case study research in accounting', *Accounting Horizons*, vol. 22, no. 2, pp. 159-178.

Covaleski, M. A., Dirsmith, M. W., and Michelman, J. E. (1993) 'An institutional theory perspective on the DRG framework, case-mix accounting systems and health-care organizations', *Accounting, Organisations and Society*, vol. 18, no. 1, pp. 65-80.

Creswell, J. W. (2003) *Research Design Qualitative, Quantitative and Mixed Methods*: *Approaches*, 2nd Edn., Thousands Oaks, CA: Sage Ltd.

Central Statistics Office (2014) 'Live Register January 2014' Dublin: Available at: http://www.cso.ie/en/releasesandpublications/er/lr/liveregisterjanuary2014.

Central Statistics Office (2014) 'Census Report 2011' Dublin: Available at: http://www.cso.ie/en/census/census2011reports.

Central Statistics Office (2013) 'Population and Labour Force Projections 2016 – 2046 Census Report 2011' Dublin: Available at: http://www.cso.ie/en/.reports.

Davis, S. and Albright, T. (2004) 'An investigation of the effect of balanced scorecard implementation on financial performance', *Management Accounting Research*, vol. 15, no. 2, pp. 135-153.

Deci, E. L., Koestner, R., & Ryan, R. M. (1999) 'A meta-analytic review of experiments examining the effects of extrinsic rewards on intrinsic motivation' Psychological bulletin, vol. 125, no.6, pp. 627.

De Geuser, F., Mooraj, S. and Oyon, D. (2009) 'Does the balanced scorecard add value? Empirical evidence on its effect on performance', *European Accounting Review*, vol. 18, no. 1, pp. 93-122.

Dent, J. F. (1987) 'Tensions in the design of formal control systems: A field study in a computer company', *Accounting and Management: Field Study Perspectives*, pp. 119-145.

Dent, J. F. (1990) 'Strategy, organisation and control: Some possibilities for accounting research', *Accounting, Organisations and Society*, vol. 15, no.1, pp. 3-25.

Denzin, N. K. and Lincoln, Y. S. (2011) *The SAGE Handbook of Qualitative Research*, London: Sage Publications.

Department of Finance (2012) 2012 *Medium Term Fiscal Statement*, Dublin: Government Publications.

Department of Health and Children (2001) *Quality and Fairness: A Health System for You*, Dublin: Stationery Office.

Department of Health and Children (2003) *The Health Service Reform Programme*, Dublin: Stationery Office.

Department of Health and Children (2004) *The Health Act 2004*, Dublin: Stationery Office.

Department of Health and Children (2003) *The Health Service Reform Programme*, Dublin: Stationary Office.

Department of Health (2010) *Report of the Expert Group on Resource Allocation and Financing in the Health Sector*, Dublin: Stationary Office.

Department of Health (2012) The *Governance Bill 2012*, Dublin: Stationery Office

Department of Public Expenditure and Reform (2011) *The Public Sector Reform Programme*, Dublin: Stationery Office.

Dey, I. (2003) *Qualitative Data Analysis: A User Friendly Guide for Social Scientists*, Routledge.

Doolin, B. (1999) 'Casemix management in a New Zealand hospital: Rationalisation and resistance', *Financial Accountability and Management*, vol. 15, no. 3-4, pp. 397-417.

Drury, C. and El-shishini, H. (2005) *Applying the Controllability Principle and Measuring Divisional Performance in UK Companies'*, Chartered Institute of Management Accountants.

Duckett, S. J. (1995) 'Hospital payment arrangements to encourage efficiency: the case of Victoria', *Australia. Health Policy*, vol. 34, no. 2, pp. 113-134.

Dunk, A. S. (1992) 'Reliance on budgetary control, manufacturing process automation and production subunit performance: a research note', *Accounting, Organisations and Society,* vol.17, no. 3-4, pp. 195-203.

Dunk, A. S. (1993) 'The effect of budget emphasis and information asymmetry on the relation between budgetary participation and slack', *Accounting Review*, pp. 400-410.

Dunk, A.S. and Nouri, H. (1998) 'Antecedents of budgetary slack: A literature review and synthesis', *Journal of Accounting Literature*, vol. *17*, pp.72.

Dyer, W. G., and Wilkins, A. L. (1991) 'Better stories, not better constructs, to generate better theory: A rejoinder to Eisenhardt', Academy of Management Review, vol. 16, no. 3, pp. 613-619.

Easterby-Smith, M., Thorpe, R. and Lowe, A. (2002) *Management Research*, 2nd edn., London: Sage Publications.

Eden, R., Lay, C. and Maingot, M. (2006) Preliminary findings on ABC-adoption in Canadian hospitals: reasons for low rates of adoption, *The Irish Accounting Review*, vol. 13, no. 2, pp. 21-34.

Eisenhardt, K. M. (1989) 'Building theories from case study research', *Academy of Management Review*, vol. 14, no. 4, pp. 532-550.

Eldenburg, L. (1994) 'The use of information in total cost management', *The Accounting Review*, vol. 69, no. 1, pp. 96-121.

Eldenburg, L., Hermalin, B. E., Weisbach, M. S. and Wosinka, M. (2004) 'Governance, performance objectives and organisational form: evidence from hospitals', *Journal of Corporate Finance*, vol. 10, no. 4, pp. 527-548.

Eldenburg, L. and Krishnan, R. (2007) 'Management accounting and control in health care: An economics perspective, in Chapman, C. S., Hopwood, A. G. and Shields M. D. (Eds.) *Handbook of Management Accounting Research*, vol. 2, Oxford: Elsevier Science, pp. 859-883.

Eldenburg, L., Soderstrom, N., Willis, V. and Wu, A. (2010) 'Behavioural changes following the collaborative development of an accounting information system', *Accounting, Organisations and Society*, vol. 35, no. 2, pp. 222-237.

Emmanuel, C., Otley, D. and Merchant, K. (1990) *Accounting for Management Control*, 2nd edn., London: Chapman and Hall.

Epstein, M. J and Manzoni, J.F. (1998) 'Implementing corporate strategy: From tableaux de bord to balanced scorecards', *European Management Journal*, vol. 16, no. 2 pp. 190-203.

ESRI (2011) '*Activity in Acute Public Hospitals in Ireland, 2010 Annual Report'*, Available at: www.esri.ie/health_information.

Ezzamel, M. (1990) 'The impact of environmental uncertainty, managerial autonomy and size on budget characteristics', *Management Accounting Research*, vol. 1, pp. 181-197.

Ezzamel, M. and Bourn, M. (1990) 'The roles of accounting information systems in an organisation experiencing financial crisis', *Accounting, Organisations and Society*, vol. 15, no. 5, pp. 399-424.

Feltham, G. A. (1977) 'Cost aggregation: an information economic analyses', *Journal of Accounting Research*, vol. 15, pp. 42-70.

Ferlie, E. (1996) *The New Public Management in Action*, Oxford University Press.

Ferreira, L. D. and Merchant, K. A. (1992) 'Field research in management accounting and control: a review and evaluation', *Accounting, Auditing and Accountability Journal*, vol. 5, no. 4, pp. 3-34.

Ferreira, A. and Otley, D T. (2009) 'The design and use of performance management systems: an extended framework for analysis', *Management Accounting Research*, vol. 20, no. 4, pp. 263-282

Fetter, R. B. (1991) 'Hospital payment based on diagnosis-related groups', *Journal of the Society for Health Systems*, vol.3, no. 4, pp. 4-15.

Fetter, R. B. and J. L Freeman (1986) 'Diagnosis related groups: produce line management within hospitals', *Academy of Management Review*, vol. 11, no. 1, pp. 41-54.

Fisher, J. (1995) 'Contingency-based research on management control systems: categorisation by level of complexity', *Journal of Accounting Literature*, vol. 14, pp. 24.

Fisher, J.G. (1998) 'Contingency theory, management control systems and firm outcome: past results and future outcomes', *Behavioural Research in Accounting*, vol. 10, pp. 47-64.

Fitzgerald, L. and Stuart, J. (1992) 'Clinicians into management: on the change agenda or not?' *Health Services Management Research,* vol. 5, pp. 137-146.

Flamholtz, E. G., Das, T. K. and Tsui, A. (1985) 'Toward an integrated framework of organisational control', *Accounting, Organisations and Society*, vol. 10, no. 1, pp. 35-50.

Fowkes, F. G. R. (1985) 'Doctors' knowledge of the costs of medical care', *Medical Education*, vol. 19, no. 2, pp. 113-117.

Gallhofer, S. and Haslam, J. (1997) 'Beyond accounting: the possibilities of accounting and "critical" accounting research', *Critical Perspectives on Accounting*, vol. 8, no. 1, pp. 71-95.

Gill, J. and Johnson, P. (2002) *Research Methods for Managers*, 3rd edn, London: Sage Publications.

Giraud, F., Langevin, P. and Mendoza, C. (2008) 'Justice as a rationale for the controllability principle: a study of managers' opinions', *Management Accounting Research*, vol. 19, no. 1, pp. 32-44.

Glouberman, S. and Mintzberg, H. (2001) 'Management the care of health and the cure of disease. Part I: Differentiation and Part II: Integration', *Health Care Management Review*, vol. 26, no. 1, pp. 56-84.

Golafshani, N. (2003) 'Understanding reliability and validity in qualitative research', *The Qualitative Report*, vol. 8, no. 4, pp. 597-606.

Gordon, L.A. and V.K. Narayanan, (1984) 'Management accounting systems, perceived environmental uncertainty and organizational structure: an empirical investigation', *Accounting, Organisations and Society*, vol. 9, no.1, pp. 33-47.

Govindarajan, V. (1984) ‘Appropriateness of accounting data in performance evaluation: an empirical examination of environmental uncertainty as an intervening variable’, *Accounting, Organisations and Society*, vol. 9, no. 2, pp. 125-135.

Govindarajan, V. (1988) ‘A contingency approach to strategy implementation at the business-unit level: integrating administrative mechanisms with strategy’, Academy *of Management Journal*, vol. 31, December, pp. 828-853.

Groot, T. and Selto, F. (2009) *Advanced Management Accounting*, Pearson Education Limited.

Gul, F. and Chia, Y. (1994) ‘The effects of management accounting systems, perceived environmental uncertainty and decentralization on managerial performance: a test of a three-way interaction’, *Accounting, Organisations and Society*, vol. 19, no. 4-5, pp. 413-426.

Gupta, A.K. and V. Govindarajan (1984) ‘Business unit strategy, managerial characteristics, and business unit effectiveness at managerial strategy’, *Academy of Management Journal*, vol. 27, no. 3, pp. 25-39.

Hageman, A. (2008) ‘A review of the strengths and weaknesses of archival, behavioural, and qualitative research methods: Recognising the potential benefits of triangulation’, *Advances in Accounting Behavioural Research*, vol. 11, pp.1-30

Hansen, S. C., Otley, D. T. and Van der Stede, W. A. (2003) ‘Recent developments in budgeting: An overview and research perspective’, *Journal of Management Accounting*, vol. 15, no. 1, pp. 49-70.

Harrison, G. L. (1993) ‘The cross-cultural generalisability of the relation between participation, budget emphasis and job-related attitudes’, *Accounting, Organisations, and Society*, vol. 17, no. 3, pp. 1-15.

Hartmann, G. H. (2000) ‘The appropriateness of RAPM: toward the further development of theory’, *Accounting, Organisations and Society*, vol. 25, no. 4, pp. 451-482.

Hartmann, F. and Slapničar, S. (2009) ‘How formal performance evaluation affects trust between superior and subordinate managers’, *Accounting, Organisations and Society*, vol. 34, no. 6, pp. 722-737.

Hartmann, F., Naranjo-Gil, D. and Perego, P. (2010) 'The effects of leadership styles and use of performance measures on managerial work-related attitudes', *European Accounting Review*, vol. 19, no. 2, pp. 275-310.

Hayes, D. C. (1977) 'The contingency theory of managerial accounting', *Accounting Review*, pp. 22-39.

Henri, J. F. (2006) 'Management control systems and strategy: a resource-based perspective', *Accounting, Organisations and Society*, vol. 31, no. 6, pp. 529-558.

Hilton, R. W. (1979) 'The determinants of cost information value: an illustrative analysis' *Journal of Accounting Research*, pp. 411-435.

Hirst, M. K. (1983) 'Reliance on accounting performance measures, task uncertainty and dysfunctional behaviour: some extensions', *Journal of Accounting Research*, vol. 21, no. 2, pp. 596-605.

Hirst, M. K. (1987) 'The effects of setting budget goals and task uncertainty on performance: A theoretical analysis'. *The Accounting Review*, vol. 62, no. 4, pp. 774-784.

Hirst, M.K., & Yetton, P. (1984) 'Influence of reliance on accounting performance measures and job structure on role ambiguity for production and non-production jobs', *Australian Journal of Management*, vol. 9, pp. 53-62.

Hofstede, G. H. (1976) *The Game of Budget Control*. The Netherlands: Koninklijke Van Gorcum and Comp.

Hofstede, G. (1981) 'Management control of public and not-for profit activities', *Accounting, Organisation and Society*, vol. 6, no. 3, pp. 193-211.

Hood, C. (1991) 'A public management for all seasons', *Public Administration*, vol. 6, no. 3, pp. 3-19.

Hood, C. (1995) 'The new public management in the 1980s: Variations on a theme', *Accounting Organisations and Society*, vol. 20, no. 2-3, pp. 93-109.

Hopper, T. and Powell, A. (1985) 'Making sense of research into the organisational and social aspects of management accounting: a review of its underlying assumptions', *Journal of Management Studies*, vol. 22, no. 5, pp. 429-465

Hopwood, A. G. (1972) 'An empirical study of the role of accounting data in performance evaluation', *Journal of Accounting Research*, Supplement, pp. 156-182.

Hopwood, A.G. (1973) *An Accounting System and Managerial Behaviour*, London: Saxon House.

Hopwood, A. G. (1974a) *Accounting and Human Behaviour*, London: Haymarket Publishing Limited.

Hopwood, A.G. (1974b) 'Leadership climate and the use of accounting data in performance evaluation'. *The Accounting Review*, vol. 49, July, pp. 485-495.

Hopwood, A. G. (2008), 'Management accounting research in a changing world'. *Journal of Management Accounting Research*, vol. 20, no. 1, pp. 3-13.

Hopwood, A. G. (2009) 'Accounting and the environment', *Accounting, Organisations and Society*, vol. 34, no. 3, pp. 433-439.

Horngren, C. T. (2004) 'Management accounting: Some comments', *Journal of Management Accounting Research*, vol. 16, no. 1, pp. 207-211.

HSE (2009) '*HealthStat: Supporting High Performance in the Irish health system'*, Available at: http://www.hse.ie/eng/Healthstat/healthstatbooklet.pdf.

HSE (2008) 'National Service Plan 2009' Available at www.hse.ie/eng/services/Publications/corporate/HSE_National_Service_Plan_2010.pdf

HSE (2009) 'National Service Plan 2010' Available at www.hse.ie/eng/services/Publications/corporate/HSE_National_Service_Plan_2010.pdf

HSE (2010) 'National Service Plan 2011' Available at www.hse.ie/eng/services/Publications/corporate/HSE_National_Service_Plan_2011.pdf

HSE (2011) 'National Service Plan 2012' Available at www.hse.ie/eng/services/Publications/corporate/HSE_National_Service_Plan_2012.pdf

HSE (2012) 'National Service Plan 2013' Available at www.hse.ie/eng/services/Publications/corporate/HSE_National_Service_Plan_2013.pdf

HSE (2013) 'National Service Plan 2014' Available at www.hse.ie/eng/services/Publications/corporate/HSE_National_Service_Plan_2014.pdf

Health Information Authority (2013) '*Health Insurance Authority Annual Report and Accounts 2012'*, Dublin: Stationary Office.

Hussey, J. and Hussey, R. (1997) *Business Research*, Macmillan Publications.

Ittner, C. D. and Larcker, D. F. (1998) 'Are non-financial measures leading indicators of financial performance? An analysis of customer satisfaction', *Journal of Accounting Research*, vol. 6, pp. 205-238.

Ittner, C. D. and Larcker, D.F. (2001) 'Assessing empirical research in management accounting: a value-based management perspective', *Journal of Accounting and Economics*, vol. 32, pp. 349-410.

Ittner, C. D. Larcker, D. F. and Meyer, M. W. (2003) 'Subjectivity and the weighting of performance measures: Evidence from a balanced scorecard'. *The Accounting Review*, vol. 78, no. 3, pp. 725-758.

Ittner, C. D. Larcker, D. F. and Randall, T. (2003) 'Performance implications of strategic performance measurement in financial services firms', *Accounting, Organisations and Society*, vol. 28, no. 7, pp. 715-741.

Jacobs K. (2005) 'Hybridisation or Polarisation: doctors and Accounting in the UK, Germany and Italy', *Financial Accountability and Management*, vol. 22, no. 2, pp. 135-162.

Jaworski, B. J. and Young, S. M. (1992) 'Dysfunctional behaviour and management control: an empirical study of marketing managers', *Accounting, Organisations and Society*, vol. 17, no. 1, pp. 17-35.

Jiang, H. J., Lockee, C., Bass, K., Fraser, F. and Norwood, E. P. (2009) 'Board oversight of quality: any difference in process of care and mortality', *Journal of Health Care Management*, vol. 54, no.1, pp. 15-30.

Johnson, H. T. and Kaplan, R. S. (1991) *Relevance lost: The Rise and Fall of Management Accounting*, Harvard Business Press.

Johnson, P. and Duberley, J. (2000) *Understanding Management Research*, London: Sage Publications.

Jones, C. S. and Dewing, I. P. (1997) 'The attitudes of NHS clinicians and medical managers towards changes in accounting controls' *Financial Accountability and Management*, vol. 13, no. 3, pp. 261-280.

Kaplan, R. S. (1994) ‘Management accounting (1984-1994): Development of new practice and theory’, *Management Accounting Research*, vol. 5, no. 3-4, pp. 247-260.

Kaplan, R. S. and Norton, D. P. (1996) *Translating Strategy into Action: The Balanced Scorecard*, Boston, MA: Harvard Business School Press.

Kaplan, R. S. and Cooper, R. (1998) *Cost and Effect: Using Integrated Cost Systems to Drive Profitability and Performance*, Boston, MA: Harvard Business School Press.

Karmarkar, U. S., Lederer, P. J. and Zimmerman, J. L. (1990) ‘Choosing manufacturing production control and cost accounting systems, *Measures for Manufacturing Excellence*, pp. 353-396.

Kenis, I. (1979) ‘Effects of budgetary goal characteristics on managerial attitudes and performance’, *The Accounting Review*, vol. 54, pp. 707-721.

Khandwalla, P. (1972) ‘The effects of different types of competition on the use of management controls’, *Journal of Accounting Research*, Autumn, pp. 275-285.

Khandwalla, P. (1977) *Design of Organizations*, New York: Harcourt Brace Jovanovich.

Kim, K. K. (1988) ‘Organisational Coordination and Performance in Hospital Accounting Information Systems’. *The Accounting Review*, vol. 63, no. 3, pp. 472 - 489.

King, N. (2012) Template analysis, in Symon, G. and Cassell, C. (eds.) *Qualitative Methods and Analysis in Organizational Research*, pp. 118-134, London: Sage publications.

King, R., Clarkson, P. M. and Wallace, S. (2010) ‘Budgeting practices and performance in small healthcare businesses’, *Management Accounting Research*, vol. 21, no. 1, pp. 40-55.

Kohn, A. (1999) *Punished by Rewards: The Trouble with Gold Stars, Incentive Plans, A's, Praise, and Other Bribes*, Houghton Mifflin: Harcourt.

Kren, L. (1992) ‘Budgetary participation and managerial performance: the impact of information and environmental volatility’, *The Accounting Review*, pp. 51 l-526.

Kren, L. and Liao, W. M. (1988) ‘The role of accounting information in the control of organisations: A review of the evidence’, *Journal of Accounting Literature*, vol. 7, no. 3, pp. 280-309.

Kurunmäki, L. (1999) ‘Professional vs. financial capital in the field of health care - struggles for the redistribution of power and control’, *Accounting, Organisations and Society*, vol. 24, no. 2, pp. 95-124.

Kurunmäki, L., Lapsley, I. and Melia, K. (2003) ‘Accountingization v. legitimation: a comparative study of the use of accounting information in intensive care’, *Management Accounting Research*, vol. 14, no. 2, pp. 112-139.

Kurunmäki, L. (2004) ‘A hybrid profession - the acquisition of management accounting expertise by medical professionals’, *Accounting, Organisations and Society*, vol. 29, no. 3-4, pp. 327-347.

Kvale, S. (2008) *Doing Interviews*, London: Sage Publications.

Langfield-Smith, K. (1997) ‘Management control systems and strategy: a critical review’, *Accounting, Organisations and Society*, vol. 22, no. 2, pp. 207-232.

Langfield-Smith, K. (2008) ‘Strategic management accounting: how far have we come in 25 years’, *Accounting, Organisations and Society*, vol. 21, no. 2, pp. 204-228.

Larcker, D. F. (1981) ‘The perceived importance of selected information characteristics for strategic capital budgeting decisions’, *The Accounting Review*, pp. 519-538.

Lau, C. M. and Buckland, C. (2001) ‘Budgeting-the role of trust and participation: a research note’, *Abacus*, vol. 37, no. 3, pp. 369-388.

Lau, C. M. and Moser, A. (2008) ‘Behavioural effects of nonfinancial performance measures: the role of procedural fairness’, *Behavioural Research in Accounting*, vol. 20, no. 2, pp. 55-71.

Laughlin, R. (1987) ‘Accounting systems in organisational contexts: a case for critical theory’, *Accounting, Organisations and Society*, vol. 12, no. 5, pp. 479-502.

Laughlin, R. (1995) ‘Methodological themes: empirical research in accounting: alternative approaches and a case for middle range thinking’, *Accounting, Auditing and Accountability Journal*, vol. 8, no.1, pp. 63-87.

Laughlin, R., and Lowe, E. A. (1990) ‘A Critical Analysis of Accounting Thought: Prognosis and Prospects for Understanding and Changing Accounting Systems Design’, London: Critical Accounts, Macmillan.

Lawrence, P. R., Lorsch, J. W. and Garrison, J. S. (1967) 'Organisation and environment: managing differentiation and integration', Boston, MA: Division of Research, *Graduate School of Business Administration*, Harvard University.

Lehtonen, T. (2007) 'DRG-based prospective pricing and case-mix accounting - exploring the mechanisms of successful implementation', *Management Accounting Research*, vol. 18, no. 3, pp. 367-395.

Lincoln, Y. S. and Denzin, N. K. (2000) 'The seventh moment: out of the past', *Handbook of Qualitative Research*, vol. 2, pp. 1047-1065.

Lindsay, R. M. and Ehrenberg, A. S. C. (1993) 'The design of replicated studies', *The American Statistician*, vol. 47, no. 3, pp. 217-228.

Llewellyn, S. (2001) 'Two-way windows: clinicians as medical managers', *Organisation Studies*, vol. 22, no. 4, pp. 593-623.

Locke, E.A. (1968) 'Towards a theory of risk motivations and incentives', *Organisational Behaviour and Human Performance*, vol. 3, pp. 157-89.

Locke, E., & Schweiger, D. (1979) 'P*articipation in Decision-Making: One More Look*', Greenwich, CT: JAI Press,

Lukka, K. (1988) 'Budgetary biasing in organisations: Theoretical framework and empirical evidence', *Accounting, Organisations and Society*, vol. 13, no.3, pp. 281-301.

Lukka, K. (2010) 'The roles and effects of paradigms in accounting research', *Management Accounting Research*, vol. 21, no. 2, pp. 110-115.

Lukka, K.. and Modell, S. (2010) 'Validation in interpretive management accounting research', *Accounting, Organisations and Society*, vol. 35, no. 4, pp. 462-477.

Lyons, T. (2012, June 10th) 'HSE under microscope as budget woes', *The Irish Independent*, Available at: http://www.independent.ie/business/irish/hse-under-microscope-as-budget-woes-grow-26862845.html.

Macintosh, N. B. (1994) *Management Accounting and Control Systems: An Organizational and Behavioural Approach*, New York: Wiley.

Magner, N., Welker, R. B. and Campbell, T. L. (1996) 'Testing a model of cognitive budgetary participation processes in a latent variable structural equations framework', *Accounting and Business Research*, vol. 27, no. 1, pp. 41-50.

Mai, L. and Goyal, M. (1991) 'Span of control, task interdependence and usefulness of MAS information in not-for-profit government organisations', *Accounting, Organisation and Society*, vol. 7, no. 4, pp. 249-266.

Malina, M. A. and Selto, F. H. (2001) 'Communicating and controlling strategy: an empirical study of the effectiveness of the balanced scorecard', *Journal of Management Accounting Research*, vol. 13, no. 1, pp. 47-90.

Malmi, T. (2001) 'Balanced scorecards in Finnish companies: a research note', *Management Accounting Research*, vol. 12, no. 2, pp. 207-220.

Malmi, T. and Brown, D. A. (2008) 'Management control systems as a package - opportunities, challenges and research opportunities', *Management Accounting Research*, vol. 19, pp. 287-300.

Malmi, T. and Granlund, M. (2009) 'In search of management accounting theory', *European Accounting Review*, vol. 18, no. 3, pp. 597-620.

Marginson, D. and Ogden, S. (2005) 'Coping with ambiguity through the budget: The positive effects of budgetary targets on managers' budgeting behaviours', *Accounting, Organisations and Society*, vol. 30, no. 5, pp. 435-456.

Marshall, C. and Rossman, G. B. (1999) *Designing Qualitative Research*, London; Thousand Oakes.

McDermott, R., Callanan, I. and Buttimer, A. (2002) 'Involving Irish clinicians in hospital management roles-towards a functional integration model', *Clinician in Management*, vol. 11, no. 1, pp. 37-46.

McNamara, T. (2015) 'Implementing sustainable change during fiscal cuts', *The Journal of the Health Management Institute of Ireland*' pp. 28-32.

Merchant, K. (1981) 'The design of the corporate budgeting system: influences on managerial behaviour and performance', *The Accounting Review*, vol. 4, pp. 813-829.

Merchant, K. (1984) 'Influences on departmental budgeting: an empirical examination of a contingency model', *Accounting, Organisations and Society*, vol. 9, no. 4, pp. 291-307.

Merchant, K. A. (1985) 'Budgeting and the propensity to create budgetary slack', *Accounting, Organisations and Society*, vol. 10, no. 2, pp. 201-210.

Merchant, K. A. (1989) *Rewarding Results: Motivating Profit Centre Managers*, Harvard Business School Press.

Merchant, K. A. (1990) 'The effects of financial controls on data manipulation and management myopia', *Accounting, Organisations and Society*, vol. 15, no. 4, pp. 297-313.

Merchant, K. A. and Otley, D. (2006) A review of the literature on control and accountability in

Merchant, K. A., and Stede, W. (2006) 'Field-based research in accounting: accomplishments and prospects', *Behavioural Research in Accounting*, vol. 18, no. 1, pp. 117-134.

Merchant, K. and Van der Stede, W. (2011) '*Management Control Systems: Performance Measurement, Evaluation and Incentives*', Harlow, UK: Prentice Hall.

Merchant, K. A., Van der Stede, W. A., & Zheng, L. (2003) 'Disciplinary constraints on the advancement of knowledge: the case of organizational incentive systems', *Accounting, Organizations and Society*, vol. *28*, no. 2, pp. 251-286.

Mia (1989) 'The impact of participation in budgeting and job difficulty on managerial performance and work motivation: A research note' *Accounting, Organisations and Society*, vol. 14, pp. 347-358.

Mia, L. and Chenhall, R. H. (1994) 'The usefulness of management accounting systems, functional differentiation and managerial effectiveness', *Accounting, Organisations and Society*, vol. 19, no. 1, pp. 1-13.

Miles, M. B. and Huberman, A. M. (1994), *Qualitative Data Analysis: An Expanded Sourcebook*, Sage Publications.

Miles, R. W. and Snow, C. C. (1978) *Organisational Strategy, Structure and Process*. New York: McGraw Hill.

Mintzberg, H. (1997) 'Towards healthier hospitals', *Health Care Management Review*, vol. 22, no. 4, pp. 9-18.

Moers, F. (2006) 'Doing archival research in management accounting', *Handbooks of Management Accounting Research*, vol. *1*, pp. 399-413.

Morgan, G. and Smircich, L. (1980) 'The case of qualitative research', *Academy of Management Review*, vol. 5, no. 4, pp. 491-500.

Naranjo-Gil, D. and Hartmann, F. (2007) 'Management accounting systems, top management team heterogeneity and strategic change', *Accounting, Organisations and Society*, vol. 32, no.7, pp. 735-756.

Noeverman, J., Koene, B. A. and Williams, R. (2005) 'Construct measurement of evaluative style: a review and proposal'.

Nolan, A.., Barry, S. and Thomas, S (2014) *The Impact of the Financial Crisis on the Healthcare System and Health in Ireland.* World Health Organisations: Denmark

Norreklit, H. (2000) 'The balanced on the balanced scorecard a critical analysis of some of its assumptions', *Management Accounting Research*, vol. 11, no. 1, pp. 65-88.

Norreklit, H. (2003) 'The balanced scorecard: What is the score? A rhetorical analysis of the balanced scorecard', *Accounting, Organisation and Society*, vol. 28, no. 6, pp. 591-619.

Nyland, K. and Pettersen, I.J (2004) 'The Control Gap: The Role of Budgets, Accounting Information and Non Decisions in Hospital Settings', *Financial Accountability and Management*, vol. 20, no.1 pp. 77-102.

O'Shea, Y. (2009) *Clinical Directorates in the Irish Health Services*, Dublin: Blackhall Press.

O'Connell, T. and Feely, J. (1997) 'Hospital doctors' knowledge of drug costs and generic names', *Irish Medical Journal*, vol. 90, no. 8, pp. 298-298.

OECD (2013) *Health at a Glance 2013*: Paris.

OECD (2015) Fiscal- Sustainability of Health Systems: Paris

Office for Health Management (1999) *Clinicians in Management*, The Office for Health Management: Dublin, Stationary Office.

Office for Health Management (2001) 'Clinicians in Management - Discussion Paper No. 1: Introduction and case studies', *International Journal of Management Science*, vol. 23, no. 5, pp. 485-497.

Onsi, M. (1973) 'Factor analysis of behavioural variables affecting budgetary slack', *The Accounting Review*, vol. 48, pp. 535-548.

Otley, D. (1978) 'Budgetary use and managerial performance', *Journal of Accounting Research,* vol. 16, pp. 122-149.

Otley, D. (1999) 'Performance management: a framework for management control systems research', *Management Accounting Research* vol. 10, pp. 363-382.

Otley, D. (2008) 'Did Kaplan and Johnson get it right?' *Accounting, Auditing and Accountability Journal* vol. 21, pp. 229-239.

Otley, D. T., and Pierce, B. J. (1995) 'The control problem in public accounting firms: an empirical study of the impact of leadership style', *Accounting, Organisations and Society*, vol. 20, no. 5, pp. 405-420.

Otley, D., Broadbent, J. and Berry, A. (1995) Research in management control: an overview of its development', *British Journal of Management*, vol. 6, no. 12, pp. 31-44.

Otley, D. T. and Pollanen, R. (2000) 'Budgetary criteria in performance evaluation: a critical appraisal using new evidence', *Accounting, Organisations and Society*, vol. 25, pp. 483-496.

Otley, D. T. and Fakiolis, A. (2000) 'Reliance on accounting performance measures: dead end or new beginning?' *Accounting, Organisations and Society*, vol. 25, p. 497-510.

Ouchi, W.G. (1979) 'A conceptual framework for the design of organisational control mechanisms'. *Management Science*, vol. 25, no. 9, pp. 833-848.

Ouchi, W. G. (1980) 'Markets, bureaucracies and clans' *Administrative Science Quarterly*, March, pp. l29- 141.

Parker, L. D. (2012) 'Qualitative management accounting research: assessing deliverables and relevance', *Critical Perspectives on Accounting*, vol. 23, no.1, pp. 54-70.

Patton, M. Q. (2002) *Qualitative Research and Evaluation Methods*, 3rd edn, Sage Publications.

Perrow, C. (1967) 'A framework for the comparative analysis of organisations', *American Sociological Review*. vol. 32, pp. 194-208.

Perrow, C. (1970) *Organisational Analysis: A Sociological View*, California: Wadsworth Publishing Company.

Pettersen, I. J. (2001) 'Implementing management accounting reforms in the public sector: the difficult journey from intentions to effects', *European Accounting Review*, vol. 10, no. 3, pp. 561-581.

Pierce, B. and O'Dea, T. (2003) 'Management accounting information and the needs of managers: perceptions of managers and accountants compared', *The British Accounting Review*, vol. 35, no. 3, pp. 257-290.

Pizzini, M. J. (2006) 'The relation between cost-system design, managers' evaluations of the relevance and usefulness of cost data, and financial performance: an empirical study of US hospitals', *Accounting, Organisations and Society*, vol. 31, no. 2, pp. 179-210.

Porter, M. E. (1998) *Competitive Advantage: Creating and Sustaining Superior Performance*, New York: Free Press.

Power, M. and Laughlin, R., (1992) 'Critical Theory and Accounting' in Alveson, N. & Willmott, H. (eds), Critical Management Studies, pp. 115135

Preston, A. D., Cooper, F. and Coombs, R. (1992) 'Fabricating budgets: a study of the production of management budgeting in the National Health Service', *Accounting, Organisations and Society*, vol. 17, no. 6, pp. 561-93.

Prospectus (2003) *Audit of Structures and Functions in the Health Service*. Dublin: Stationery Office.

Punch, K. (2005) *Introduction to Social Research: Quantitative and Qualitative Approaches*, 2nd edn. London: Sage Publications Ltd.

Puxty, A. G. (1998) *The Social and Organizational Context of Management Accounting*, UK: International Thomson Business Press.

Remenyi, D., Williams, B., Money, A. and Swartz, E. (1998) *Doing Research in Business and Management*, London: Sage Publications Ltd.

Robbins, G. (2007) 'Obstacles to implementation of new public management in an Irish hospital', *Financial Accountability and Management*, vol. 23, no. 1, pp. 55-71.

Robinson, J. C. (2001) 'Organisational economics and health care markets', *Health Service Research*, vol. 36, no. 1, pp. 177-178.

Ross, A. (1995) 'Job related tension, budget emphasis and uncertainty: a research note', *Management Accounting Research*, vol. 6, no. 1, pp. 1-11.

Ryan, B., Scapen, R. W. and Theobald, M. (2002) *Research Methods and Methodology in Finance and Accounting*, 2nd edn. London: Thomson Publishing.

Ryan, M., Yule, B., Bond, C. and Taylor, R. J. (1996) 'Do physicians' perceptions of drug costs influence their prescribing?', *Pharmacoeconomics*, vol. 9, no. 4, pp. 321-331.

Saunders, M., Lewis, P. and Thornhill, A. (2006) *Research Methods for Business Students*, 4th edn., London: FT Prentice Hall.

Scapens, R. W. (1990) 'Researching management accounting practice: the role of case study methods', *British Accounting Review*, vol. 22, no. 3, pp. 259-281.

Scapens, R. W. and Bromwich, M. (2010) 'Management accounting research: 20 years on', *Management Accounting Research'*, vol. 21, no.4, pp. 278-284.

Schiff, M. and Lewin, A. Y. (1970) 'The impact of people on budgets', *The Accounting Review*, pp. 259-268.

Shank, J. K. and Govindarajan, V. (1993) 'What drives cost? A strategic cost management perspective', *Advances in Management Accounting*, vol. 2, pp. 27-46.

Shields, J. F. and M. D. Shields (1998) 'Antecedents of Participative Budgeting', *Accounting, Organisations and Society*, vol. 23, no. 1, pp. 49-76.

Shields, M.D., F.J. Deng, and Y. Kato (2000) 'The design and effects of control systems: tests of direct-and indirect-effects models' *Accounting, Organisations and Society*, vol. 25, pp. 185-202.

Silva. P. and Ferreira, A. (2010) 'Management control in primary healthcare services: evidence from a field study', *Qualitative Research in Accounting and Management*, vol. 7, no. 4, pp. 424-449.

Silverman, D. (2013) *Doing Qualitative Research: A Practical Handbook*, London: Sage Publications Ltd.

Simons, R. (1987) 'Accounting control systems and business strategy: an empirical analysis', *Accounting, Organisations and Society*, vol. 12, no. 4, pp. 357-374.

Simons, R. (1995) *Levers of Control: How Managers Use Innovative Control Systems to Drive Strategic Renewal*, Boston: Harvard Business School Press.

Smith, A. (2005) *Clinicians in Management*, Dublin: Office of Health Management.

Stake, R. E. (1995) *The Art of Case Study Research*, London: Sage Publications Ltd.

Stredy, A. (1960) *Budget Control and Cost behaviour*, New York: Prentice Hall.

Stringer, C. (2007) 'Empirical performance management research: observations from AOS and MAR', *Qualitative Research in Accounting and Management*, vol. 4, pp. 92-114.

Smyth, N. (2015) *Health Information Paper: Trends and Priorities to Assist Service Planning 2016*. Dublin: Stationery Office.

Thompson, J.D. (1967) *Organisations in Action*. New York: McGraw-Hill.

Tuomela, T. S. (2005) 'The interplay of different levers of control: a case study of introducing a new performance measurement system', *Management Accounting Research,* vol. 16, no.3, pp. 293-320.

Van der Stede, W. A. (2000) 'The relationship between two consequences of budgetary controls: Budgetary slack creation and managerial short-term orientation', *Accounting, Organisations and Society*, vol. 25, no.6, pp. 609-622.

Van der Stede, W. A. (2003) 'The effect of national culture on management control and incentive system design in multi-business firms: evidence of intracorporate isomorphism', *European Accounting Review*, vol. *12, no.* 2, pp. 263-285.

Van der Stede, W. A. (2011) 'Management accounting research in the wake of the crisis: Some reflections', *European Accounting Review*, vol. 20, no. 4, pp. 605-623.

Van der Stede, W. A. (2015) 'Management Accounting: Where From, Where Now, Where To?' *Journal of Management Accounting Research*, vol. 27, no. 1, pp. 171-176.

Van der Stede, W. A., Young, S. M. and Chen, C. X. (2005) 'Assessing the quality of evidence in empirical management accounting research: the case of survey studies', *Accounting, Organisations and Society*, vol. 30, no. 7, pp. 655-684.

Widener, S.K. (2007) 'An empirical analysis of the levers of control framework', *Accounting, Organisations and Society*, vol. 32, no. 2, pp. 757-788.

Wiley, M. (2005) 'The Irish health system: developments in strategy structure and delivery since 1980', *Health Economic*, vol. 14, no. 1, pp. 169-186.

Willcocks, S. (1994) 'The clinical director role in the NHS: utilizing a role-theory perspective, *Journal of Management in Medicine*, vol. 8, no. 5, pp. 68-76.

Weisenfeld, L. W., & Killough, L. N. (1992) 'A review and extension of using performance reports: a field study based on path-goal theory', *Journal of Management Accounting Research*, vol. 4, pp. 209–225.

Yin, R. K. (2009) *Case Study Research: Design and methods*, London: Sage publications Ltd.

Zimmerman, J. L. (1997) *Accounting for Decision-Making and Control*, 2nd edn. Chicago: McGraw-Hill.

Zimmerman, J. L. (2001) 'Conjectures regarding empirical managerial accounting research', *Journal of Accounting and Economics*, vol. 32, no. 1-3, pp. 411- 427.

APPENDICES

Appendix A

Philosophical Assumptions of Social Science Research

Philosophical Assumptions of Social Science Research

Of the many models that have attempted to define paradigms in social science theory, that developed by Burrell and Morgan (1979) has attracted the most attention. According to Easterby-Smith, Thorpe, and Lowe (2002), the use of this model to explore the philosophical assumptions underpinning a research study provides the researcher with a checklist of factors to consider when making methodological choices. Furthermore, they argue that it provides an appropriate mechanism to structure the methodological discussion in presenting the research and, ultimately, makes explicit the implicit dimensions underlying the choices researchers make when deciding on a methodology, which is particularly important given that these are often outside of the researcher's conscious awareness (Johnson and Duberley, 2000). The framework devised by Burrell and Morgan (1979), presented in Figure 4.3, consists of a two-by-two matrix based on two bipolar continuums. One continuum posits alternative approaches to social science (ranging from 'subjective' to 'objective') and the other contains different assumptions about the nature of society (ranging from the 'sociology of regulation' to the 'sociology of radical change'). Burrell and Morgan (1979) combine these two dimensions to present four distinct paradigm clusters: (i) functionalist, (ii) interpretive, (iii) radical humanist and (iv) radical structuralist. The following discussion presents each of these in turn.

Functionalist Paradigm: The functionalist paradigm assumes that human action is rational and rests on the premise that one can understand organisational behaviour through hypothesis testing, much like the natural sciences. Functionalists tend to view social concerns from the perspectives of realism, positivism and determinism and adopt nomothetic methodologies that focus predominantly on providing explanations of coordination, integration, cohesion, satisfaction of needs and social order.

Interpretivist Paradigm: The interpretivist paradigm, in contrast, supports the belief that reality is constructed through subjective perception and that, therefore, predictions about it cannot be made. It holds that human beings cannot be studied using models developed for the physical sciences because they are qualitatively different from natural events. The interpretivist approach to social inquiry tends to be nominalist, anti-positivist and voluntaristic and it is carried out using primarily ideographic methodologies.

Radical Humanist Paradigm: The radical humanist paradigm is similar to the interpretivist paradigm in viewing the world from an anti-positivist perspective. However, its frame of reference emphasises the importance of overthrowing or transcending the limitations of existing social arrangements. Theorists adopting this paradigm are mainly concerned with

releasing the social constraints that limit human potential and they often draw on it to justify their desire for revolutionary change. Consequently, it is largely anti-organisation in vision.

Radical Structuralist Paradigm: The radical structuralist paradigm advocates the sociology of radical change, but from an objectivist perspective. Radical structuralists focus on structural relationships within the social world and emphasise the analysis of structural conflict, modes of domination and contradiction. Ultimately, they believe that radical change is built into the nature and structure of society.

Research in the social sciences is generally concerned with the choice between the interpretivist and functionalist sides of the spectrum. The position on the subjective-objective continuum is prescribed based on a range of philosophical assumptions related to ontology, epistemology, human nature and methodology. Each of these assumptions is reviewed in the following discussion of the key research assumptions underpinning this area of research activity in general and this study in particular. It is useful, first to note that, within the research methodology literature; there is a plethora of terms used interchangeably to differentiate between the subjective-objective approaches to research. For example, the objectivist perspective has alternatively been referred to as quantitative, positivist, scientific, experimentalist, traditionalist and functionalist. Conversely, the subjectivist perspective has been denoted as qualitative, anti-positivist, phenomenological, humanist, interpretivist and social constructionist (Hussey and Hussey, 1997).

Ontological Assumptions - The first of the four axes on the subjective-objective continuum pertains to a basic question of ontology: 'whether the reality to be investigated is external to the individual or the product of individual consciousness' (Burrell and Morgan, 1979, p.4). The two extremes on this axis are realism and nominalism. The realist position holds that there is a world of tangible structures, external to the individual, and that these external structures are empirically identifiable and measurable. Therefore, the realist ontology contends that the social world has a reality independent of the cognition of individuals and that, equally, the phenomena being investigated are independent of the researchers examining them (Lincoln and Denzin, 2000). At the opposite end of the spectrum, the nominalist position contends that, in contrast, reality is a product of the cognition of individuals and that the social world beyond this cognition is nothing more than 'names, concepts and labels which are used to structure reality' (Burrell and Morgan, 1979, p.4). In other words, the nominalist position believes that social reality is constructed by those participating in the social world and that there is no single objective truth.

Epistemological Assumptions - The second assumption is concerned with epistemology. Epistemology involves 'assumptions about the grounds of knowledge and how one might begin to understand the world and communicate this knowledge to fellow human beings' (Burrell and Morgan, 1979, p. 6). Epistemological assumptions are predicated upon whether it is possible to identify and communicate the nature of knowledge as being hard, real and capable of being transmitted in tangible form or, conversely, whether knowledge is subjective and based on experience alone. The extremes in this continuum are positivism and anti-positivism. Positivism ks to 'explain and predict what happens in the social world by searching for regularities and causal relationships' (Burrell and Morgan, 1979, p. 5). In contrast, anti-positivism is 'set against the utility of a search for laws or underlying regularities in the world of social affairs, the social world is essentially relativistic and can only be understood from the point of view of the individuals who are directly involved in the activities which are to be studied (Burrell and Morgan, 1979, p. 5). Thus, anti-positivism rejects the standpoint of the observer and 'one has to understand from the inside rather than the outside'. Thus, while the positivist approach is characterised by a clear set of underlying principles and tenets, the anti-positivist approach is characterised by a more diversified and heterogeneous trend in the philosophy of science.

Human Nature Assumptions - The third continuum concerned with assumptions pertaining to human nature. The extremes in this continuum are determinism and voluntarism. Determinism regards individuals and their activities as being 'completely determined' by the situation in which they are located. Thus, human nature is viewed as a product of the environment. At the other extreme, voluntarism views humans as 'completely autonomous and free-willed' and, therefore, the creator of the environment in which they are located (Burrell and Morgan, 1979, p. 6).

Methodological Assumptions - It is argued that the ontological, epistemological and human nature stances adopted in the research process will influence the methodological position and overall research approach adopted (Easterby-Smith *et al,* 2002). Methodology can be classified as either ideographic or nomothetic. Gill and Johnson (2002) assert that a nomothetic research method entails the development of a conceptual and theoretical structure prior to its testing through empirical observation. According to Remenyi, Williams, Money and Swartz (1998), the nomothetic research approach allows the researcher to deduce a new theory by analysing and then synthesising ideas and concepts already present in the literature. It then emphasises the deduction of ideas or facts from the new theory in order to provide a more coherent framework than the theories that preceded it. However, Gill and

Johnson (2002) argue that the most important aspects are the logic of the nomothetic approach and its operationalisation process, which involves the subsequent testing of the theory through its confrontation with the empirical world. According to Collis and Hussey (2003), nomothetic is the dominant research approach in the natural sciences, where laws constitute the basis of explanation, which allows for the anticipation of phenomena and the prediction of their occurrence, hence, permitting them to be controlled. Within the ideographic approach, the theory follows the data. As Gill and Johnson (2002) note, learning is achieved by reflecting upon particular past experiences and through formulation of abstract concepts and theories. The greatest strength of inductive research is its flexibility, as this research approach does not require the establishment of prior theories or hypotheses. On the contrary, theories are built based on observations, thereby allowing a problem or issue to be approached in several different ways with alternative explanations of what is occurring. It is particularly suited to the study of human behaviour, including within organisations.

According to Gill and Johnson (2002), experimental and survey methods are associated with the nomothetic approach, whilst ethnography, action research and case-study methods are associated with the ideographic approach. Thus, experiments and surveys are predominantly used for theory testing and ethnography and action research for theory building. Notably, Eisenhardt (1989) argues that case studies can be used to accomplish both theory testing and theory generating. According to Eisenhardt (1989), case studies can begin with a deductive reasoning approach with a problem definition and lead to an inductive reasoning process of theory building.

Appendix B

Preliminary Phase – Interview Guide

Preliminary Phase - Interview Guide

Date:	Interviewee:
Time:	Case :

-Discuss purpose of research.

-Stress the respondents' perceptions are sought and contribution valued.

-Outline confidentiality guarantees and requisition consent to record interview.

Section A - Background Information

a) What is your job title?

b) How long have you worked in the HSE?

c) How long have you been in your current role?

d) Who do you report to in the organisation?

e) Who reports to you in the organisation?

Section B - Design of Management Control Practices

a) What management control practices are used in the organisation?

b) How management control practices generated are, adapted and communicated?

c) Are those practices driven by the vision and mission of the hospital, the HSE or both?

d) How are key success factors issues brought to the attention of employees and managers? Are key performance measures linked to key success factors?

e) How does the organisation go about setting performance targets?

f) Does the organisational structure impact on the operation of the management control practices which are in place? What is the lowest level of management who report on performance?

Section C: Use of Management Control Practices

a) Can you identify particular strengths in the management control system currently in operation? *Probe for detail* - what parts of the systems? - Why are they strengths?

b) Can you identify any aspects of the management control system which need to be changed or improved? *Probe for detail* - what parts of the system? - What sorts of improvements? - What would you like to include in the system?

c) What if any rewards financial or non-financial will managers/employees/organisation gain by achieving performance targets or conversely, what penalties will they suffer by failing to achieve them?

d) How does the management control information flow in the organisation – feedback and feedforward?

e) How are the management control practices used in the organisations? Does usage vary at different hierarchical levels?

f) Are you aware of any potentially adverse consequences of the way the management control practices are used by (i) the hospital (ii) the HSE?

g) How, if at all, have the performance mechanisms altered in light of the change dynamics of the organisation and its environment?

h) How strong and coherent are the links between the components of the management control practices and the ways in which they are used?

Section D - Conclusion

a) Is there anything else that you feel is important in relation to the operation of management control practices

APPENDIX C:

Main Phase – Interview Guide

Main Phase - Interview Guide

Date:	**Time:**
Venue:	**Interviewee:**

A. Purpose of the Study

This study is part of my PhD. It is motivated by a personal in interest in the healthcare sector. Since the establishment of the HSE in 2005 there has been a significant penetration of management control practices e.g. budgetary controls, national service plans, key performance measures, matrixes of financial and non-financial performance measures etc. While management control practices can have considerable potential in health service management, there is lack of knowledge with respect to how these practices operate in a healthcare context. This is despite considerable interest and the fact the countries across the world continue to devote vast amounts of resources into the design and implementation of these management control practices. This study focuses on three management control practices - budgetary control, services planning & HealthStat. I am going to pose a range of questions under a number of heading that will require you, in the main, to reflect on your experiences to the operation of management control practices and any impact that may have arisen both as an individual and also at an organisational level. Please feel free to deviate from these questions if you deem relevant. Would you have any objections to the interview being tape-recorded? This would enable me to listen carefully and gain the greatest benefit from the interview. It also ensures that the accuracy of the data collected is preserved. As explained in my email, confidentiality is assured to all participants.

B. Background Information

1. How long have you worked in the Irish Healthcare system?

2. How long have you worked in this hospital?

3. How long have you held your current position?

4. Can you provide me with a brief description of your training and educational background?

C. Individual Involvement

1. How would you regard your commitment to the following management control practices?

(i) Budgetary control practice
(ii) Activity planning practice
(iii) HealthStat practice

2. How do you feel about interacting with management control practices?

3. What job activities require you to interact most with management control practices?

4. How would you describe the purpose your involvement?

D. Organisational Issues

1. What do you think management control practices should achieve overall in the hospital? In your work area? Based on your experiences, did they achieve this?

2. How well are the management control practices achieving a balance between freedom to manage and accountability for results?

3. In your opinion what organisational factors influence the how appropriate management control practices are for accomplishing organisational control? Which issue do you consider the most influential? Why.

C. External Issues

1. In your opinion do external factors influence how appropriate management control practices are for accomplishing organisational control?

2. Which management control issue do you consider the most influential? Why

E. Management Control Issues

1. In your opinion do aspects/characteristics of the management control practices influence how appropriate management control practices are for accomplishing organisational control?
[Probes] - Accuracy

- Report on vital items
- Ease of using data
- Appropriate data
- Reflection of performance
- Timeliness
- Coffee room talks

2. What is your assessment of the communication process across the organisation with regard to dissemination of management control information in general?

3. Does the communication process differ depending on the management control practices being considered? E.g. budgetary information, service planning, KPI's etc. …

4. Are there any other issues with influence the appropriateness of management control information?

5. Which management control issue do you consider the most influential? Why?

F. Individual Issues

1. A One of the key issues highlighted in research data, was the low level of involvement by clinicians with management control practices? Do you consider this to be an issue? If yes, can you identify explanations for this lack of involvement?

1. B, One of the key issues highlighted from my preliminary research is, that in the main, that management were more positive in their perceptions regarding the operation of management control practices in comparison with clinician management? Do you consider this to be an issue? Do you have any observations on why this might be?

2. Is there anything the organisation has or could do to improve participation?

3. Have training and resources been put in place to educate people about the management control practices which have been implemented?

4. Do you feel you know enough about general management and each of management control practices to be able to use them effectively? How did you learn and develop your skills?

5. What influence has your professional training had upon involvement with to management control practices?

6. Are there any other issues with influence individual issues which influence the operation of management control practices?

7. Which individual issue do you consider the most influential? Why?

G. Decision Making & Behaviour

1. For you individually, has the change (presumably increase) in the availability of management control information affected your **decision-making**?

[Probes] - Cost consciousness
- Track process of individuals & units - benchmarking
- Management by exception
- Individually accountable

2. If decision making hasn't been affected **why**?

[Probes] - Lack of trust in data
- Practices viewed as unnecessary
- Lack of relevance

3. For you individually, how has the change (presumably increase) in the availability of management control information affected/controlled your **behaviour**?

[Probes] - Belief or values
- Off limit activities
- Made your actions more or less visible
- Gaming
- Job tension / Role stress / Working relationships
- Motivation

4. If behaviour hasn't been affected **why**?

H. Looking Ahead

1. What type of supports and /or changes would you like to be made to the management control practices going forward? Do you feel they will be forthcoming?

2. What factors present the greatest challenge to the hospital management going forward?

3. Any final comments or observations.

APPENDIX D

Case Study - Document and Archival Database

Case Study Database		
No.	**Item**	**Source**
1.	Live Register January 2014	Central Statistics Office
2.	Census Report 2011	Central Statistics Office
3.	Population / Labour Force Projections 2016 - 2046	Central Statistics Office
4.	2012 Medium Term Fiscal Statement	Department of Finance
5.	Quality and Fairness: A Health System for You	Department of Health & Children
6.	The Health Service Reform Programme	Department of Health & Children
7.	The Health Act 2004	Department of Health & Children
8.	The Health Service Reform Programme	Department of Health & Children
9.	Report of the Expert Group on Resource Allocation and Financing in the Health Sector	Department of Health
10.	The Governance Bill 2012	Department of Health
11.	The Public Sector Reform Programme	Department of Public Expenditure and Reform
12.	Activity in Acute Public Hospitals in Ireland, 2010 Annual Report	ERSI
13.	HealthStat: Supporting High Performance in the Irish health system	HSE
14.	National Service Plan 2009	HSE
15.	National Service Plan 2010	HSE
16.	National Service Plan 2011	HSE
17.	National Service Plan 2012	HSE
18.	National Service Plan 2013	HSE
19.	National Service Plan 2014	HSE
20.	Health Insurance Authority Annual Report and Accounts 2012	HSE
21.	*Health at a Glance 2013*	OECD
22.	Fiscal- Sustainability of Health Systems	OECD
23.	Clinicians in Management	Office for Health Management
24.	Audit of Structures and Functions in the Health	Stationary Office

	Service	
25.	Woodford Annual Report	Deputy General Manager
26.	Woodford HealthStat Reports	HSE
27.	Budget Performance Report	Finance Manager
28.	Modes of Operation of Clinical Divisions	Chair of Oncology

APPENDIX E

Nvivo Analysis

Codes Developed During the Early Stages of Data Analyses			
Code	**Description**	**Participants**	**Citations**
Accountability Issues	References made to accountability issues	5	9
Adverse Outcomes	Reference to adverse outcomes for patients.	2	4
Authority & Autonomy	References made the issue of having the authority or authority to make decisions.	10	18
Availability of Management Control Information	References made to the availability of management control information	8	25
Benchmark & Comparison	References made to differences between Woodford Hospital & other acute hospitals in the Irish healthcare sector.	4	6
Clinician - Management Relationship	Reference made to the manner in which clinicians and management communicate with each other.	9	31
Clinician Attributes	References made regarding the attributes and skills required by clinicians if they are going to successfully engage with management control practices	6	11
Clinician Knowledge of Management Control Information	References made to the knowledge displayed by clinicians of management control information.	2	3
Clinician Performance - Informal Controls	References made to the importance of informal controls play in ensuring clinicians performance is maintained.	1	1
Clinician Professional Experience	References made to clinician professional experience.	6	8
Clinician Training & Education	Reference made to the training or education of clinician - which influences their professional orientation.	5	6
Collection of Management Control Information	Reference to the data collection of management control information.	4	8

Conflicting Goal Sets	References by the difficult of managing conflicting goal sets	8	17
Control of Operating Processes by Clinicians	References made to clinicians controlling core operating processes.	4	5
Controllability Principle	References made to the uncontrollability of management control measures	2	5
Cost Containment Control Practice	References made to the cost containment control practices	5	6
Data Manipulation	References made to data manipulation of management control information.	3	3
Emotive Nature of Healthcare	References to the emotive nature of healthcare service influencing the operation of management control practices.	3	3
External Uncertainty	References made to external incidents such as a serious influenza influencing the operation of management control practices.	1	1
Fiscal Economic Issues	References made to fiscal economic issues.	6	9
Focus of Attention	References made to the focus provided to performance measures.	6	12
Frustrated	References made to individuals becoming frustrated.	3	6
Healthcare National Strategy	Reference to healthcare principles and goals	1	1
HSE - Control	Reference to the HSE using management control information to control behaviour.	3	5
HSE - Governance Relationships	References made to the role of parent organisation in terms of governance relationships.	7	12
Information Flow	References made to the communication of management control	10	35

	information.		
Interdependencies	References to performance measures being affected by interdependencies and decisions taken elsewhere in the organisation.	3	3
Integration Among the Control Practices	References made to the degree of integration among control practices.	4	6
IT Infrastructure	References made to IT infrastructure	4	8
Job satisfaction	References made to management control information instilling a sense of satisfaction.	1	1
Job-Related Stress	References to increased job-related stress.	4	6
Knowledge of Cost Item	References to a lack of knowledge regarding the cost of budget items.	3	10
Lack of Direction	References to individual not having a clear sense of direction - which influences the operation of management control practices.	1	1
Leadership Effect	References regarding the effect a 'good' or 'bad' leader has on the operation of management control practices.	4	5
Management Professional Experience	References made about the professional experience of management (executive).	1	2
Media	References made media - use of performance information by the media & the media's influence the operation of management control practices.	5	9
Motivation	References made to the operation of management control practices	4	4

	impacting upon motivation.		
Organisational Control	References made to the organisations using management control information to improve organisational control.	11	31
Organisational Decision - Making	References made to how management control information influences decision-making	6	11
Organisational Performance	References made to performance of Woodford Hospital	3	4
Participation	References made to the issue of participation in the management control process	7	17
Participation - Clinical	References made regarding the need for clinical participation.	8	16
Performance Evaluation	References made to performance evaluation processes - rewards and punishments.	10	24
Personality	References made to influence personality has on the operation of management control practices	3	3
Political Inference	References made to political inference into healthcare issues.	2	3
Public Scrutiny	Reference made to the public scrutiny influencing the operation of management control practices.	1	1
Reactive Behaviour	Reference made to behaving in a reactive manner.	1	1
Recruitment & Promotion	References made to the recruitment and promotion processes.	4	5
Reluctance & Avoidance	References to/regarding reluctance to engage with management control information	6	22
Selection of Performance Measures	Reference regarding the number of performance measures being of relevance.	5	6

Target Setting	Reference made to the existence of target.	5	5
Target Setting	References with regard to how uncertainty influences the target setting process.	3	3
Task Unpredictability	References made to the fact that there are high levels of unpredictability in the control environment	4	6
Technology - Work Processes	References to how work processes influence the operation of management control practices.	1	1
Training & Education - Management Control Practices	References made to training & education	8	10

APPENDIX F

Operational Targets and Measures

The Operational Control Practice					
Access		**Integration**		**Resources**	
Metric	**Target**	**Metric**	**Target**	**Metric**	**Target**
Adult elective procedure	NT, > 6 mths	Day case procedures	IT, 75 %	Variance from budget	Budget is target
Child elective procedure	NT, > 3 mths	Admission on day of procedures	IT, 75 %	WTE variances from ceiling	Staff ceiling is target
EP acute admission	NT, > 6 hrs	Inpatient ALOS	Individual hospital	% of staff lost to absenteeism	NT, = 3.5 %
GP to hospital referral	IT, > 70 days	Overall ALOS	Best in Ireland	No. of meetings per WTE	Best in Ireland
Consultant to physio referral	IT, > 70 days	Percentage of cases entered into HIPE	NT, 80%	No. of new patients per WTE consultant	Best in Ireland
Consultant to hospital referral for diagnostics	IT, > 70 days	Appropriateness of admission & discharge	NT, 80%	Consultant clinic rates	NT, = 10 %
Consultant led OPD clinics	IT, 0 waits over 90 days			Public versus private split of activity	NT, 80: 20
Note: NT = National target, IT = International target, WTE = Whole time equivalents, ALOS = Average length of stay, EP - Emergency presentations					
Source: Health Stat User Guide (2009)					

APPENDIX G

Responsiblties of Clinician Divisions

The Modes of Operation for Clinician Divisions - Extract

Responsibilities for Divisional Chairs

i. Lead and manage the development of an annual plan for the division involving the appropriate medical, nursing, administrative and support service staff.
ii. Co-ordinate the implementation of the annual plan for the division, agreed with the Executive Management Board
iii. Manage the resources approved for the division. Any reallocations of budget must be agreed with the EMB.
iv. Organise and chair the divisional meetings, operational team meetings and other meetings, as required. The chairperson should actively seek to reach decisions on the basis of consensus at these meetings.
v. Over the development of bi-monthly reports for the EMB, reporting on the performance of the division.
vi. Promote co-operation with other hospitals, services and healthcare providers in the Health Board area on activities within the remit of the division
vii. Ensure that clinical audits are conducted within each division on a regular basis.
viii. Promote co-operation with other hospitals, services and healthcare providers in the Region on activities within the remit of the division

Responsibilities for Clinician Divisions

i. It is proposed that a divisional meeting should be held monthly, attended by all of the consultants within the division. It is suggested that: (i) the relevant nurse service manager(s), and (ii) the divisional administrator (who will provide support to the Chair of the division) also attend these meetings so that they are fully aware of the issues arising within the division.
ii. It is suggested that an operational team should be established within each division to make decisions on issues relating to the general operation of the division. The operational team should meet every two weeks. Membership of the operational team should include, at a minimum, the following individuals: (i) the Chair of the division, (ii) the relevant nurse service manager(s) and (iii) the divisional administrator.
iii. It is proposed that chairs of divisions will meet as a group once every 3 months to discuss issues of interest to all the divisions and the CUH Group as a whole. The chairs of divisions meeting should be attended by two members of the EMB

Source: Organisational Documentation