Professional vs financial capital in the field of health care—struggles for the redistribution of power and control

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Abstract

The field of health care, like all fields of social life, is a site of continuous games for power and control. This paper applies the conceptual tools of the French sociologist Pierre Bourdieu—in particular the notions of field and capital—to analyse the diverse roles, and partially divergent objectives of the various institutions and individuals involved in the functions of financing, production, and consumption of health services. Participants in these struggles are seen to have different chances of winning or losing, depending on their relative power, which is determined by the distribution of differently valued capitals in this specific field. The expectations associated with the transition to market based control mechanisms in the field of Finnish health care, and the experiences of those directly involved in this transition are analysed. The nature and implications of the process of transition from a planning allocation system to a competition based resource allocation system are studied on the basis of extensive interviews and observations conducted in one university hospital and two central hospitals in Finland. © 1999 Elsevier Science Ltd. All rights reserved.

1. Introduction

I participated in two accounting courses about three years ago[...]. Without those courses I, together with the nurses, couldn’t possibly have managed with those accountants and the health administration...if I hadn’t had any knowledge of this (accounting). I am afraid that if accounting comes to these clinical units from outside it doesn’t just... If one has no idea (of accounting methods)—as those with medical education don’t have—then it doesn’t come as a mere accounting service, but also in the form of instructions. The desire of power and control is always linked very strongly with this hospital environment through these kinds of services, for some reason it always is. I don’t see a possibility for disinterested, selfless accounting, instead it always involves the idea that: “As I take care of some of your tasks I shall kindly also make some decisions on your behalf.” I emphasize that when we do the final (service) pricing[...] it has to be done here. It has to be done in such a simple way that it can be performed here, over here in the clinical side. The financial department can then provide all kinds of background material, but if we were to allow the construction of these (prices) to slip out of our hands, then we would lose lots of other things as well. I would be totally helpless if I hadn’t been on those courses. I would be absolutely incompetent now, begging for help somewhere...
there (pointing to the direction of the administration building)[...]. It wouldn’t be that I would only be given some accounting services, but instead, in this system, it would immediately lead to operational control by means of accounting. (a chief physician)

The field of health care, like all fields of social life, is a site of continuous games for power and control. Battles in this field are due to the diverse roles, and partially divergent objectives, of the various institutions and individuals involved in the functions of financing, production and consumption of health services. By borrowing the conceptual tools of French sociologist Pierre Bourdieu, the participants in these struggles can be seen to have differing chances of winning or losing, depending on their relative power, which is determined by the distribution of differently valued capitals in this specific field. The inseparability of the types of capital and the field in which they operate has been expressed by Bourdieu and Wacquant (Wacquant, 1992, p. 101) as follows:

A capital does not exist and function except in relation to a field. It confers a power over the field, over the materialized or embodied instruments of production or reproduction whose distribution constitutes the very structure of the field, and over the regularities and the rules which define the ordinary functioning of the field[...]

Within publicly funded health care systems, political decision-makers possess remarkable sources of economic capital. Representing the third party which collects finance for public services, politicians not only have the power to cap total resource consumption, but also to decide about the distribution of funds among service providers. However, although politicians, policy makers and planners, together with hospital managers or “administrators”, have had an influence over decisions about major developments in health care, clinical doctors have traditionally been regarded as the ones who have exerted the main control over the operational management of hospitals (Saltman, 1987). While exercising occupational control based on their professional capital—referred to as “clinical freedom”—physicians have made decisions concerning which patients to admit, how to investigate and treat them, and how long to keep them in hospital, thereby shaping the total services provided by the hospitals (Harrison & Pollitt, 1994, pp. 35–36). A characteristic feature of the management of health care organizations has thus been a high degree of professional self-governance. As a result, the ability of politicians to evaluate the efficiency of resource utilization, or to interfere in complex operational processes managed by health professionals, has been extremely limited.

An emerging questioning of the ethics of health professionals, an increasingly vociferous criticism of mechanisms of occupational self-control, a strengthening of accusations concerning the overall inefficiency of public service providers, together with widespread concern over the rapidly escalating cost of public health service provision, contributed to the dramatic health system reforms in many Western societies during the 1980s and early 1990s. In numerous countries, including Finland, a principal aim of the changes was to alter the balance of control in the field of health care, to submit health care professionals to the discipline of market control mechanisms, variously labelled “planned markets”, “quasi-markets”, and “market-type mechanisms” (Glennerster, 1994, pp. 3–4; Besley & Gouveia, 1994).

The explicitly stated objective of introducing market forces in Finnish health care provision during the early 1990s was to bring about a profound change in the operational culture of public health institutions—to change the ways of thinking, talking, and acting of health professionals. Greater efficiency of service providers was to be sought by making health care practices subordinate to private sector operational models and financial reports. The aim was to raise the value of economic vs professional capital in the field of health care, and to increase accordingly the power of health care financiers over that of service producers. This reform of Finnish health care provision can be seen to have been driven by a broad and complex set of socio-historical and political
aspirations to effect a profound cultural transformation not only in the field of health care, but within the whole of the public sector—a transformation comparable to that seen across the wider international context (see Rose & Miller, 1992; Hood, 1995). The Finnish reforms thus represent a particular form of the transformation of the notion of accountability in social policy (see Fowles, 1993), and of the shift in underlying codes of public sector accountability (see Gray & Jenkins, 1993). No longer considered an internal matter within social service organizations, calls for the explicit accountability of professionals to the consumers and financiers of public services gain increased emphasis in this context.

Based on extensive interviews and observations in one university and two central hospitals,\(^1\) this paper discusses the expectations associated with the transition to market based control mechanisms in the field of health care, and the experiences of those directly involved in this transition in Finland. It employs two central concepts of Pierre Bourdieu’s work—the notions of field and capital. Bourdieu’s approach is distinct from Marxist approaches, in that it emphasizes the symbolic as well as the economic aspects of capital, and the quantities of different kinds of capital possessed by individuals in their respective fields (Thompson, 1991, p. 29). It is distinct also from Foucauldian approaches in so far as these focus primarily on power/knowledge relations and subjectivity, and tend to neglect issues of competition in a particular domain at a specific point in time. Bourdieu’s work has been applied and discussed extensively by anthropologists, sociologists and political scientists across a number of domains.

\(^{1}\)Thirty-two interviews were held with persons working in hospitals and related organizations. Those interviewed included hospital managers, financial managers, doctors, nurses, health economists, an accountant and a municipal representative. Each interview was scheduled to last at least an hour. In addition, 41 meetings were observed, including meetings between hospital representatives and municipal decision-makers, between hospital managers and clinical unit representatives, hospital management group meetings, as well as meetings of chief physicians and ward sisters. The duration of the meetings observed varied from thirty minutes to four hours; 80% of the meetings lasted in excess of 2h. All interviews, and the majority (70%) of meetings attended, were tape-recorded.

and settings (Calhoun, LiPuma, & Postone, 1993). Recently, his work has been utilized by researchers in management\(^2\) and accounting\(^3\). This paper aims to contribute to this growing body of work by examining the power games that characterise the field of health care in Finland today.

2. Re-writing the rules of the game—from planning to market allocation

[...] By changing the terminology the equivalent elements will be found here (in the health sector) as in ordinary business[...]. The same principles, the same concepts... I think that if we consider it as a question of craftsmanship and administrative organising it is better that hospitals operate according to the same logic as the other spheres of production[...] (a health economist)

Finnish health care has traditionally been provided largely by the public sector. Financial resources for health care are collected through governmental and local taxation systems, while the responsibility for organizing health services has been imposed on local authorities, known as municipalities. Until the end of 1992, the government retained a firm hand on the development of health care delivery via an official planning system. Financial control over the locally operated health service system was exercised by a rolling five-year national plan combined with a governmental subsidy system keyed to the national plans. The objective of the centralized planning system, which had been introduced by the 1972 Primary Care Act, was to secure equality in the regional distribution of health-related resources. During the early years of the planning allocation era, more resources were directed to less-developed areas in

\(^{2}\)See an analysis of the introduction of business planning in the provincial museums and cultural heritage sites of Alberta, Canada (Oakes, Townley, Cooper, in press).

the northern and eastern parts of the country. Government subsidies were given to hospitals and health-centres for new facilities, equipment and posts approved by the state, the subsidies amounting to between 31 and 64% of the initial cost. In subsequent years, on average 40% of recurrent expenditures (e.g. material and personnel) were paid by direct state subsidies (Linnakko & Back, 1994).

The 1972 legislation spoke of cooperation between local and national agencies, and a number of local, regional and national actors were incorporated in the official planning process. Accordingly, the annual planning requests, required to reflect strict national guidelines for the planning period, were generated by health provider institutions, then submitted to the responsible municipal government(s) for approval, and finally transmitted to the national bodies via the health and social services offices of provincial governments. In 1982, Finland was designated by the World Health Organization as a model country for the achievement of the ambitious ‘Health For All’ goals, because of the developed system of locally controlled publicly responsible health management (Saltman, 1988).

At the local level, however, the planning allocation system was increasingly perceived during the 1980s to have generated a different mix of outcomes than originally intended. Within the formal planning structure, the economic power of the national authorities—based on substantial state subsidies—was sufficiently strong to enable the national actors to select or reject the requests of local bodies. Government officers not only had the right to refuse support for proposed investments, but also to cut off state support for previously agreed expenditure, as punishment if the municipalities were not following the national guidelines. The local authorities — who continued to fund a substantial share of the rapidly growing health expenditure from their tax revenue, and who were firmly tied to the following of the five-year plans set on the basis of national policy targets negotiated by the National Board of Health, the Ministry of Social Affairs and Health, the Cabinet, and Parliament—were starting to express increasing frustration at being required to pay for a system over which they had no effective control. At an institutional level, on the other hand, the tight rationing of new resources through the “permanent planning process” was seen to encourage health care providers to engage in budget games, to redouble their efforts to obtain new resources in future years instead of forcing them to utilize existing resources more efficiently (Saltman, 1988; Linnakko & Back, 1994).

The Finnish experiences since the late 1970s, although conditioned by local circumstances, have largely mirrored the growing dissatisfaction with health care systems across the world. The rapid development in health care has continued to strengthen the perceived ability of medical professionals to restore health, thereby producing a tendency for health sector costs to rise steadily in economic conditions that were simultaneously tightening. In parallel, and across the same period, the ambiguity of the objectives of health care, and the particular problem of measuring the output of health care providers, have become matters for public attention. Health care professionals, despite representing key decision-makers in the use of resources, have been depicted as acting with little formal financial responsibility, and there have been increasingly frequent accusations that public sector service providers operate wastefully and unresponsively towards service consumers (Lapsley, 1992, pp. 235–237). These rapid changes in both the financial and social circumstances of health service production gave rise to an intensification in the search for new health policy instruments. Together, these developments have led to a re-writing of the rules of the game in the field of health care, a re-writing that can be viewed as an attempt to increase the sway of health care financiers by shifting the relative power of economic and professional capital.

2.1. The State Subsidy Act, 1992

An epoch of competitive markets for Finnish publicly funded health service provision was launched by the revised State Subsidy Act that came into force at the beginning of 1993. As a result, government officials stopped preparing detailed resource allocation plans, and state subsidies started
to be allocated to municipalities. This was in place of the previous system under which government assigned allowances directly to the hospitals. Also, the basis of allocation was changed: while previously the amount of subsidy was calculated on the basis of the actual costs of operating existing health care institutions, from 1993 the amount allocated was calculated per capita, adjusted for the incidence of diseases in different municipalities. Concurrently with this change in the subsidy allocation system, the restrictions imposed on municipalities when contracting out health services were removed, allowing the municipalities to make contracting agreements on health service delivery not only with their own health care institutions—owned by themselves or together with several municipalities as municipal federations—but also with competing service providers, i.e. with public health institutions located in other areas and with private health suppliers (Linnakko & Back, 1994).

By increasing both the financial power of local authorities, and their freedom to contract out health care services, the government assigned to municipalities the role of health service purchase agents. This had the effect of delegating to municipalities responsibility for service development as well as financial control (Häkkinen, 1994, pp. 128–129). The consequent shift in the relative power of hospital institutions and local authorities, resulting from the transfer of financial capital from the state to the municipalities, was described by one leading physician as follows:

Previously the planning proceeded in a way that we presented what we were going to do—how many in-patient days, out-patient visits, surgical operations...we were going to perform—and these were the figures to which the municipalities were supposed to adapt themselves[...]. Now the situation is totally reversed[...]. The good side, I suppose, is that now the municipalities really know how much they pay for special health care and how much they pay for health care in total. When the money used to come partly from the municipalities, partly from the state, it didn't give an idea of the total expenditure.

In this (new) system the money comes only from one source. Of course, there is also the point, which can be seen as a weak point from the viewpoint of hospitals, that we have ended up being at the 'mercy' of municipalities[...]. You know, the (hospital) federations used to be blamed for being masters towards the municipalities, because we were quite independent during the old state subsidy system. We weren't dependent on municipalities... But now when the money comes from the municipalities the role has turned from that of master to hired man.

In their new role, local decision-makers were expected to have increased power as a result of the intensification of financial accountability required from health care providers through competitive tendering. Furthermore, municipalities were encouraged to place greater emphasis on economic calculation within hospitals via the application of internal markets, i.e. by allowing hospitals' clinical units to buy medical and administrative services from competing hospitals. This was supposed to implicate hospital service units within the market game and to spread the “calculative network”—the individuals so affected becoming the object of calculation, and in turn demanding calculation from those responsible to them—within, across and beyond the health sector (see Humphrey, Miller, & Scapens, 1993). Consequently, the image of hospitals as bureaucratic, provider-led institutions receiving appropriations from the public sector was replaced by the view of health service organizations as financially accountable business entities which cover their expenses by generating sales revenues from their services. The redefinition of the rules of the game, and the increased possibility of those possessing economic capital in the health care field to require accountability from those producing the services, were described by one hospital district manager as follows:

[...] Since the beginning of 1993, when the new State Subsidy Act came into force, the government ceased to send us money. Now

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*Quotation marks indicated by gesture from interviewee.
we have to invoice the municipalities[…] for all our expenditure[…] and the state subsidies allocated for health care go to the municipalities… in their bank accounts[…] This (pointing to the hospital price list) has been sent to all municipalities, to all Specialist Hospital Districts and to all health centres located in our Hospital District[…] We invoice twice a week based on the real consumption of our services[…] For the time being the municipalities are not obliged to buy a certain health service from a certain organization[…] Therefore, if our municipalities don’t buy from us we have to analyse very carefully why they don’t […] We have to justify our existence by being price competitive.

2.2. The Municipal Act, 1995

The subsequent revision of the Municipal Act, that came into force on the 1st of July, 1996, was in line with the revised State Subsidy Act. The new Municipal Act reinforced the increase in the autonomy of municipalities in their task of providing a variety of social, educational and recreational services for their populations. It also spoke of competitive tendering and the stimulation of entrepreneurial thinking and acting among public service employees as a way of obtaining “increased value for money” in the public sector. The revised Act laid emphasis not only on the municipalities’ freedom to reorganize their service production, but also on the possibilities for local authorities to set priorities in providing publicly financed services. The committee report expressed these aspirations in the following terms:

The administrative model based on traditional civil servant behaviour is exploring a new direction for service provision by utilizing business sector operational models. The municipality has to use all service providers, both public and private, in a flexible way. […] Each municipality has to have a large degree of autonomy to decide on its administration, economics and operations[…] There are remarkable regional and municipal differences in the need for municipal services.

Therefore, it is logical that municipalities begin to make choices with respect to the development and focus of service provision. A centrally managed system, based on standard solutions, does not work (Kunnallislakikomitea, 1993, pp. 152, 156).

More advanced financial reporting for the municipalities and their operational units was seen to be needed. Traditional public sector reports, though supplemented recently by a funds flow statement called the “finance statement”, were seen as providing insufficient information for management purposes. A more profound financial accounting reform was held to be required:

The budgets and financial statements of the municipalities, prepared according to contemporary regulations and recommendations, have not given information which would be clear enough to analyse the economics of the municipalities. […] The statement is[…] a finance statement which shows the balance of finance, not the balance of revenues and expenses. As an income statement it is defective because the acquisition costs of fixed assets are not shared between different periods by depreciation. The difference between the viewpoints of finance and income statements has not been understood well enough in the municipalities when the strength of their economies has been assessed. Loans have been misinterpreted to be the revenues of the financial year and investments the expenses (p. 272).

The requirements set for the new financial information by the committee were high. Equally high were the expectations for behavioural change as a result of the provision of restructured accounting data:

[…] The budget and the financial statement of the municipality should include statements which would give a clear account of both the incomes and the finance of the municipality. This would separate the balancing of annual revenues and expenses from financial decisions
concerning long-term investments of the municipality. Economic matters would be weighed more in municipal decision making. Decision-makers would have to find out what it costs to produce services, how the services are financed, and how different forms of financing influence the economic position of the municipality in the long run (p. 272).

The puzzle of how to bring the financial accounting of the public sector “on a modern level and on a sound theoretical basis” was worked out once again by copying private sector practices. The proposal of the committee was that the bookkeeping and financial statements of the municipalities would come within the scope of the Accounting Act from the beginning of 1997. According to the committee:

The Accounting Act would give a ready made, generally accepted and commonly known set of regulations which would guarantee comparability with other municipalities and economic entities. Supposedly, bookkeeping based on the Accounting Act is also better known among municipal decision-makers and citizens than the (contemporary) administrative bookkeeping system. […] The application of the Accounting Act would improve the information given by the financial statements. The municipality would receive an income statement which would show whether the periodic revenues of the municipality are sufficient to cover the depreciation caused by the deterioration of fixed assets. The income after the deduction of depreciation from the accounting period, based on income statements, would show the change in the equity capital of the municipality. The balance sheet, based on the Accounting Act, would allow an assessment of the self-sufficiency and indebtedness of the municipality by using the same accounting ratios as the other accountable entities (pp. 282–283).

The idea of self-contained business responsibility units, whose performance could be assessed in traditional balance sheet and income statement terms in “one single figure” (Miller, 1994), was strongly supported in the committee report. However, it ignored or overlooked the considerable conceptual and practical difficulties of income measurement, such as the classification, timing, and valuation problems of revenues, expenses, gains and losses. In Finland, as in many other countries which have reformed their public service provision, the shift from public sector accounting practices to private sector procedures and control techniques was thus promoted despite the simultaneously strengthening scepticism of the private sector towards the ability of financial statements to capture a “true and fair view” of any business concern’s results and financial position (Mayston, 1993).

Within only a few years, the rules of the Finnish health system were radically re-written. New methods of resource allocation, contractualisation, and competitive tendering, as well as altered practices of financial reporting, made up a complex process of transformation. In the next section, the implications of these changes for hospital financial reporting practices are examined in more detail.

3. Change in accounting and accountability—the prospect of reinforced financial control over health care providers

[…] Of course many hospitals and hospital doctors wonder now what this is all about. They work hard[…] they work enough, more than enough, and they don’t cheat at all… Well, that is ok then. Now it just has to be shown. It is better to show this to the purchasers so that it will be clear, that there won’t remain a seed of suspicion… because there has quite evidently been some suspicion that the hospitals are robbing the municipalities… (a health economist)

The official accounting systems employed in Finnish hospitals during the era of centralized governmental control were an explicit reflection of the prevalent resource allocation system. National
officials exercised tight financial control over health service units by setting strict limits for resource consumption not only at the level of clinical units, but also at the level of individual expense items based on the national five year plans and the budget proposals prepared by hospital financial departments. The main task of accounting systems was considered to be that they should help the hospital’s financial department to control the spending of resources during the budget period.

As far as cost accounting was concerned, the operating costs incurred for an average in-patient day and an average out-patient visit were calculated in each of the health service institutions on a one year basis. As explained by one financial manager:

You see, the way hospitals used to operate was that the hospitals produced in-patient days [...] and out-patient visits [...] Those were the (two) basic products [...] When the annual expenditure (budget) for the municipal (hospital) federation was confirmed [...] one had to live with that. And when the term was over, the patient days were calculated as well as the out-patient visits, and the grants used were checked over, and by division the price of an in-patient day and the price of an out-patient visit were confirmed [...] The price of an in-patient day was the same irrespective of whether it was a question of a patient day which was related to e.g. varicotomy or heart surgery [...] the (calculated) cost was exactly the same [...] The aggregated cost calculations of an average in-patient day and an average out-patient visit were produced for the purposes of state subsidy applications. These cost calculations were used also for apportioning the share of operating costs which was to be financed by local authorities among those municipalities who owned and operated health care institutions in the form of municipal federations.

The rudimentary accounting techniques that existed during the planning allocation era of the Finnish health care system were attributed to the overriding influence of the state subsidy system. This subsidy system was seen as an extra-organizational influence that shaped hospital accounting practices (Hopwood, 1984). In response to a question as to why hospital cost accounting practices had, until recently, been lagging behind private sector systems, one financial manager commented:

This (showing a drawing of the state subsidy system during the planning allocation era) is the one which shaped practice [...] If you think about this (old system) [...] If one didn’t know this, one wouldn’t understand (the prevalent accounting systems).

Alongside the official accounting system, interviews with hospital representatives revealed a systematic gathering and storing of other operational and financial data. This accumulation of data was not explained in terms of its value for decision making purposes. Displaying information, and being able to explain operations in terms of information, were considered as important symbols of competence and efficacy. According to one leading physician:

Well, the municipalities have never followed anything else [...] (than) in-patient days, hospital occupancy rates, and out-patient visits [...] Those are the things the municipalities have been able to follow [...] When they have been following the operations of the hospitals they, the municipal “fathers”, have always started from the occupancy rate and compared that to (the occupancy rate of) their municipal hospitals, the old-age homes, whose rate is 110% [...] “How can it be 80% over here? You must operate inefficiently!” (they say) [...] You see, when these claims concerning inefficiency etc. are presented one has to be able to answer the nasty questions [...] and that is why, at least as far as I am concerned, one prepares one’s own follow-ups besides the operational plans and these official follow-ups.

Information storing was thus motivated by the potential post hoc accountability it offered, as well
as by the desire to demonstrate to the hospital’s external constituencies that the conditions for intelligent decision-making and proper management existed. A systematic “overproduction” of information was justified by the managers’ preference for having information that was not needed, rather than lacking information that might be needed (Feldman & March, 1981).

During the late 1980s and early 1990s, attempts to increase the cost-consciousness of health professionals and improve the ability of health care financiers to control the service providers resulted in hospitals being encouraged or pressurized to introduce substantial modifications in their official accounting practices. This included changes in budgeting, cost accounting and financial reporting. It is to these changes in practice that we now turn.

3.1. Results management—clinical units as cost centres

In Finland, as in numerous other countries, the intended transition to a market based resource allocation in health service production was preceded by a Management By Objectives (MBO) programme. In hospitals, MBO programs—entitled Results Management5—were argued for in terms of the complexity and variety of the health professionals’ work, and the dignity and maturity of health providers in taking responsibility for their work goals, an accentuated version of the legitimation of professional autonomy in other public sector organizations, such as schools and universities (Raelin, 1985, pp. 210–211; Dirsmith & Jablonsky, 1979; Hofstede, 1981). The introduction of Results Management was an explicit attempt to improve the coordination of operational and financial planning within health service organizations by incorporating health professionals into the management processes, thereby altering the relative power exercised by economic and professional capital. As explained by one financial manager:

[...] The purpose (of the Results Management initiative) was to change the whole operational culture[...] From the clinical point of view the issue had been the separation of financial and operational power... Previously this was organized in such a way that the chief physician of each clinical unit was responsible for the operations in his unit while the financial manager was responsible for the economics—he prepared the budgets. The budgeting was quite centralized... When these persons were making the plans—like the five-year-plan—there might have been some proposals in the operational plans but then in the financial ones there was no mention of the resources required. So the plans were not in balance because they were made in different places.

The Results Management initiative also strengthened the accountability for resources in clinical units by tying medical professionals into networks of calculation via the budgeting process (Miller & Rose, 1991, p. 133). This reorganization of budgeting procedures gave increased financial autonomy and accountability to medical professionals. It was seen to offer the possibility of constructing and extending spheres of discretion and choice within clinical units, while also helping to ensure that professionals’ actions were taken in accordance with broader economic, financial and social objectives (Humphrey et al., 1993). The role of clinical units and clinical service units as cost centres was emphasized, and the responsibility of preparing budgets was passed to the cost centre level. As described by one financial manager:

In 1993, when our administration was reorganized and profit centres formed, a remarkable amount of administrative decision making power was delegated to the profit centres. Related to this was a change in management practices and a change in the whole administrative culture, also economic planning and control was transferred to the profit

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5According to Carroll, Tosi, & Henry (1973, p. 3) organizations have implemented the ideas of MBO using variously terms like “management by results”, “goals management”, “work planning and review”, “goals and controls” etc. which all are based on the same idea, despite the differences in terminology.
So the change was made and the profit centres were made responsible for the budgeting... the financial department gives some help if needed, of course... We give as much help as they want and need but they do the preparation over there, where there is a leading nurse or ward sister who takes care of it... It was quite a process of learning for them of course.

The Results Management ideology introduced new ways of thinking and talking in health care settings. Clinical units were re-named “profit centres”, and the chief physicians of these units were called “profit centre managers”. Also, the rearranged management structures and new accounting systems were expected to create a new notion of accountability—the right of health care financiers to hold professionals accountable for their actions not only in medical, but also in financial terms (Roberts & Scapens, 1985). The change in ways of thinking and talking presaged a shift in the relative distribution of economic and professional capital in the field of Finnish health care. Yet despite the introduction of the concepts of “profit centre” and “profit centre manager” in hospital organizations, no financial performance of the profit centres was calculated as a consequence of the Results Management programs. Until the transition to the market based resource allocation, the “results” of the profit centres were assessed on the basis of operational indicators only, created by the representatives of the clinical units themselves. The value of professional capital thus remained largely unaltered.

3.2. Market forces—from cost to profit centres

One of the objectives of introducing market forces in the field of Finnish health care was to place pressure on hospitals to replace their traditional cost accounting and financial reporting with private sector accounting methods. The strengthened financial power of local authorities as fund holders, and their opportunity, in the role of purchase agents, to require “value for money” by imposing competition among health providers, was believed to intensify the interest of municipal representatives in claiming detailed price information for various services. From 1993 on, instead of sharing their expenses between the municipalities based on average in-patient day and out-patient visit costs, hospitals were expected to cover their costs by charging municipalities on a “true” costs basis. The ensuing change in cost accounting practices in one central hospital was described by the hospital district manager as follows:

...Quite a remarkable transformation has occurred... say in the 1990s, from 1991 onwards... in other words, the path that we have started to calculate very strictly, how much different things cost in health care... because previously there wasn’t such a thing (as cost accounting). They were all just lump sums...

According to one financial manager:

...The problem at that time (during the old state subsidy system) was that we knew, based on our own accounting systems, how much costs a certain clinical or out-patient unit caused, but we really didn’t know the cost of e.g. an appendix removal or bypass surgery... The costs were calculated based on the cost of an average in-patient day... but that didn’t really describe... So, a development process was started in the whole hospital and the renewal of accounting systems was a part of the process. The aim was to find out the treatment costs of a single patient.

Based on the assumption of the efficient functioning of market forces—including the presumption of economically rational behaviour on the part of purchase agents—competition was expected eventually to force all health care providers to employ cost-based service pricing. The imperative of setting up appropriate cost accounting systems within those hospital organizations wishing to survive was described by one health economist as follows:

...Actually pricing itself is quite easy... But if there is no cost accounting behind the pricing, then you are in trouble...
(some hospitals) have not realized the trap of pricing their services based on average costs[...] Now, when all the money is in the municipalities at the beginning of the game... no municipality is so stupid that, if it gets a lower offer from somewhere else... Let’s imagine a situation; a normal childbirth isn’t one of the most expensive operations. Now if it is priced based on in-patient days (number of in-patient days multiplied by the cost of hospital’s average in-patient day) it will obviously become much more expensive than its real production costs are[...] So when the average pricing method is used[...] one pays for some treatments more than the real costs would be[...]. If the buyer wants to speculate with this he or she can... For example, if the university hospital sells its specialist services by using average pricing, based on average (in-patient day) costs... (e.g.) heart transplant which takes approximately 10 days[...] the purchaser gets the treatment, I would say, at a third (of the real costs)... Well, now if one municipality decides to buy heart transplants from where they are the cheapest... much cheaper than the real production costs, but decides for example not to buy childbirths from the same hospital and starts to buy them instead from the local hospital... in a way this changes the structure... Well, you understand what the result will be.

The detailed pricing of health service activities, such as different surgical operations, laboratory tests, and x-ray examinations, was introduced with the aim of enabling municipal politicians to evaluate the profits gained by contracting out various health services. It was also part of a much wider attempt to introduce private sector financial control mechanisms into publicly funded health care settings. The possibility of giving monetary value to the output of health service production—previously reported by means of various operational measures—and the potential to compare the value of the output of the accounting entity chosen (e.g. a clinical unit) with the resources it consumed, created from this point on genuine profit centres. Accounting numbers were expected to make visible the operational inefficiencies within health institutions, to contribute to the financiers’ ability to intervene in the complex reality of hospital life in the name of better management (Roberts & Scapens, 1985; Hopwood, 1984, p. 173; Chua, 1995), and thereby increase the value of economic capital vis-à-vis professional capital. Further, by shifting the terms of calculation and performance measurement from professional to economic—from medical to financial—financial information systems were to provide a common language for policy makers, hospital management, and clinicians, building up extended information transfer and discourse between health care financiers and producers:

[...] We (health economists) regard pricing, cost accounting as well as purchasing and selling, as such, as almost nothing... I don’t think that those are very significant issues except in the sense that they are brought to different parties involved in this process... In fact, they force the parties to come closer to each other... Earlier they were able to operate apart from each other—I mean without knowing about each other—and there was some kind of... Now, along with the (renewed) financial flows, in a way extended information flows are forced to... so that ordinary kinds of barter transactions will be created and the purchasers and sellers must, in most of the cases, be on better terms with each other than people who have nothing to do with each other. Perhaps at this stage the understanding that they are parties to the same process—actually on the same side of the fence—will increase. But still the money-service-exchange-relationship keeps them brisk. It is a kind of break away from the planned economy.

The strong appeal of the reforms in the Finnish health sector was based on the potential attributed to accounting for moulding the underlying codes of health care providers, for promoting economic values and rationales in health care organizations, and for enhancing the ability of health financiers to employ their economic capital. The extension of
financial reporting within highly professionalised health institutions, in which the use of accounting had traditionally been modest, was expected to mobilise new organizational practices and contribute to purposeful cultural change in the management of health care (see Hopwood, 1989; Dent, 1991; Preston, 1991). The international experience of health system reform suggests, however, that efforts to alter the functioning of the institutions and individuals involved in health provision, by revising the rules of the game, has uncertain effects and unpredictable implications (see e.g. Bartlett & Le Grand, 1993). The ability of Finnish local authorities to require increased financial accountability from health professionals, and to exercise strengthened control over service providers, are addressed next.

4. The implications of revised rules—is there competition?

[...] They (the municipalities) have not understood the change in the rules of this game... Now the game is played with two different sets of rules...[...] If they were clear to take the role of the owner and see the hospitals as a production capacity which they own, like the electric power stations for example[...] It is always the task of the owner to control the size of the basic investment... that is something they have to get under control, but after they have decided on the size of the investment, the number of employees and what those are supposed to do[...] then they (the municipalities) should maintain the production incentive cruelly by using the price mechanism. [...] But this relationship has not worked[...] As I said, the rules have changed but they don’t know the new rules and they don’t know how to play the game. But it would be so much easier to play by the new rules, if only they wanted to... if they understood... (interview with a health economist, spring 1995)

This excerpt from a health economist’s commentary on the game played in the field of health care reflects the difficulties experienced in reorganizing the governance of the Finnish health sector, and redistributing power and control within it. Despite the significant changes in the rules of the game, the play appears to continue with only slight modifications in its nature. Hospital management and health care professionals echo this sentiment. A hospital district manager, speaking at a university hospital strategy seminar in October 1995, summarised the changes as follows:

[...] We have made some minor changes each year in our strategic plan but no major reforms have been made to the original one, the one which was developed as a consequence of the Results Management process[...] As you know very well, quite remarkable changes in the operational environment have taken place and all the expectations haven’t been fulfilled that were anticipated and expected to happen. The board of directors (of the Hospital District) has, in their seminar at the end of this summer, discussed this and came to the same conclusion; it is time for a more profound reform. We have to go through these principles—the whole strategic plan... How does it correspond with the time in which we are living[...] First, to remind you about the issues that were within sight at the time we made our strategic choices... These (referring to a slide) were the issues on which the contemporary strategic plan was based, and still is[...] Economic growth was one starting point... Almost anything was seen to be possible. The market economy had prevailed over the planned economy, and some neoliberalist ideals were strengthening[...] there was an ecstasy of freedom... In 1988[...] we started the development process which later continued with the Results Management process having a major impact on these (organizational) structures and we started to learn strategic planning... A lot of weight was laid on the municipalities' state subsidy renewal, the removal of restrictions concerning buying and selling, and on the belief that once the state subsidies are allocated to the municipalities
there will be a clear distinction between purchasers and producers. We also believed, at that stage quite firmly, that there will be a competitive health market, some more firmly than others, of course... We believed in competition, its possibilities and its inevitability all in all. If you remember, it was said that everything is going to change in 1993... these kinds of refrains were used... We also believed in quite remarkable operational and economic autonomy. Also, in those meetings we were talking about living with sales income as well as about purely demand driven operations, about free competition etc. Now if we think what has happened... obviously one can say that there are no competitive health markets in this country. According to the studies only about 10% of the area of secondary health care has been subject to competition... It (competition) has its role in these plans, and it also has to have a role in the future, but the question remains whether our main strategy... should be based on competition or on some other issues... Living with one’s sales revenue, demand driven control system (reading the expected changes listed in his slide)... This (pointing the text) is the reality. This is what we hear all the time... budgetary control... The municipalities set the frames... They have noticed that the only way to control these operations is to rely on budgetary control... There is no other basis for the control of these operations than to set different kinds of (expenditure) constraints... And, anyway, in their role as the owners, they (the municipal decision-makers) seem to have the desire to control...

Attempts to introduce competition in the field of health care have proven problematic not only in Finland, but also in other countries experimenting with market based allocation of health resources (Bartlett & Le Grand, 1993). Increased economic rationality and system-wide cost savings have not followed directly and unproblematically, as envisaged by many health economists, hospital managers, and health professionals. To the disappointment of those hospital managers and health professionals who saw the introduction of competition in the health care system as an opportunity to be rewarded as leaders in market-driven modes of resource allocation (see Cochrane, 1993; Ezzamel & Willmott, 1993), Finnish municipal politicians have continued to focus their attention on the ultimate resource constraints. They have been accused of managing the health system primarily by means of budgetary control, without utilizing the possibilities created by the 1993 Act for improving the efficiency of the system via competitive tendering.

At a hospital level, the tight budgetary control exercised by local authorities over expenditure on patients from within their catchment area, coupled with a financial incentive to attract patients from outside, has led to a clear distinction being made between two different sources of revenues: on the one hand, the revenues generated by providing health care for the citizens of the municipalities which form a common Specialist Hospital District, and which also own jointly the hospital in question; and, on the other hand, the revenues generated by servicing patients from other Health Districts, the latter type of income hereafter called the external sales revenue. While patients from the Health District’s catchment area are required to be serviced within the limits of the hospital’s preset expenditure budget, the ‘customers’ who contribute to the sales revenues from other Health Districts are allowed to incur costs beyond the hospital’s expenditure budget, in so far as the increase in costs can be financed by a corresponding increase in external sales revenues.

4.1. Competition among central hospitals

The health professionals interviewed explained the near absence of competition between central hospitals primarily by reference to a lack of the necessary preconditions for competition to exist. The long distances between publicly operated hospitals in this sparsely populated country, and the small number of private hospitals (due to the extensive coverage of public health care), were seen to place central hospitals in the position of regional monopolies. The lack of locally competing health
service suppliers, and the high travelling costs incurred through the contracting out of patient cases, were considered to leave little potential for most municipalities to implement competition which would bring real economic savings. As one chief physician stated:

[...] Though it was recently reported in the newspaper that district hospital X has been operating very efficiently, it is still difficult to imagine that municipality Y... even if it is allowed... would start to send patients to X. Thinking economically, it doesn’t work... Those things should be considered quite carefully.

Viewing the potential for competition between central hospitals from the standpoint of sales opportunities, another chief physician referred not only to patient transportation costs, but also to consumer preferences:

[...] It is quite impossible (to attract patients from other Health Districts). They are seriously ill patients whose transportation is expensive and difficult... and the relatives want to be nearby... Actually, for reasons of humanity... and then because of transportation, it is difficult.

Another factor held to have limited the effectiveness of competition-based resource allocation between central hospitals was the restricted access of health service purchasers to reliable information on the costs and quality of services offered by the competing health service providers. The limited knowledge of local politicians about technologies and conditions of health service production, the heterogeneous pricing techniques applied by different hospitals, and difficulties in assessing the quality of health service output, were all regarded as contributing to the “information asymmetry” between purchasers and providers which health economists have repeatedly drawn attention to. The resulting difficulties experienced by local authorities in seeking to curtail health care spending through competition reinforces the extensive professional capital of health care providers.

Comparing hospitals in terms of cost efficiency and quality of services was difficult not only for nonprofessionals, but also for medical experts. As one chief physician remarked:

[...] The idea was that we would be able to compare the efficiency of different hospitals and perhaps—thinking optimistically—that the municipalities might begin to buy services from where they are cheap and of high quality. But since all the patronage by the state disappeared simultaneously, no-one gives guidance anymore—not to mention about regulations—of how accounting should be developed. All the hospitals I know price their products in such different ways that they are by no means comparable. The municipalities can’t do it... When you look at the prices here (pointing at a pile of price lists on his bookshelf)... even we are not able to say which institutions are cheap and which are expensive. So in this form it doesn’t work[...]. More rules should be given us on how to do the pricing because there seem to be twenty different ways to do it... Some include some costs while others don’t... You can’t compare these. [...] If we could create some kinds of price groups... the next question would be: how should quality be considered... Which is at least as important[...] although it is even more difficult than getting monetary measures comparable... and that has to be done, of course, at that stage where these (hospitals) are made to compare... (a chief physician)

The third factor viewed by hospital representatives as having seriously undermined a competition-based reallocation of resources between central hospitals was the strong influence of local politics on health care decision making. The municipal politicians, in their dual role of purchase agents and owners of health care organizations, were seen as having little motivation to set up competition between hospital institutions based solely on economic incentives. Contrary to the basic idea of market based resource redistribution, it was thought that local decision-makers never fully accepted the idea of health care
institutions as independent accounting entities which would be assessed on the basis of their financial efficiency. Instead, wider concerns relating to regional politics (such as the economic influence of transferring the labour-intensive health industry to other areas, and the subsequent loss of local tax income) as well as various kinds of non-financial issues (such as the perception of a town as a regional centre), were seen to have been taken into account when decisions were made concerning the arrangements of health service delivery in municipalities (see also Hääkkinen, 1998). According to the manager of one hospital district:

[...] The municipalities accept slightly higher payments in some cases because the regionality is considered, and because having these kinds of services gives some kind of profile to this town, the impacts of which are seen somewhere else... and then, of course, because of labour policy...

The significance of labour policy was emphasized by one profit centre manager as follows:

[...] Let’s say that clinic X[...] would be closed down in this hospital. It is self-evident to every municipal decision maker, who can count 1+1, that it is a direct transfer of income to municipality Y... At the same time so many jobs will disappear from here... Yes, they can count that much and everyone is holding on to their own.

Local politics was thought likely to prevent the anticipated reduction of overcapacity that would result from competition. The threat of hospital closures was seen to encourage municipal politicians to make further investments in their own institutions, hoping to secure the survival of the local health care providers:

[...] All the more because in this province there are two central hospitals[...]. In a thinly populated area[...] we are two very similar “houses”, about the same size and similar functions[...] It is foreseeable that some day one of us will have to be reduced to the level of a district hospital, and that is why I believe that the municipal decision makers have a strong urge to keep their institutions capable of functioning, so that it (their hospital) would be the one which remains. This “house” is the biggest employer in this town.

The politicization of health care resource allocation was strongly criticized by several of the chief physicians interviewed. Although it was considered important to include a wide variety of issues in decisions concerning the delivery of health services, the politicization of health care management was considered detrimental to the executive function. The simultaneous operation of decision-makers in the overlapping fields of politics and health care, and the local politicians’ strong desire to maximise their symbolic capital in the political field, were considered by a number of chief physicians to have resulted in the financial mismanagement of health institutions.6

As characterized by a chief physician of one central hospital:

(The management of hospitals) would require rational financial management. And I don’t believe in the rationality of politicians, any more in financial than in other issues. First, sensible financial management is made a political issue, after which the results (of the decision making processes) are totally unpredictable.

The perceived failure of market forces to have brought about a more efficient allocation of resources between central hospitals belonging to different Hospital Districts was mirrored at the level of health care providers belonging to the same Hospital District, and jointly owned by the same group of municipalities:

6See also Oakes et al. (1998) who regard Bourdieu’s work as useful in understanding the behaviour of actors in the field of cultural production. The behaviour of individuals acting in a specific field may sometimes appear contradictory, but starts making sense when the actors are recognized as operating within, or moving between, several fields in which differential capital and positions are available.
We have discussed quite a lot about competition in our profit centres. We do have such units which already sell something and which would have the potential to sell (more). Typically clinical chemistry... also microbiology... because these are the units which have the apparatuses processing the samples. In other words, they don't have to increase their workforce a lot to be able to process a significantly higher number of samples. And, for example, the prices of our clinical chemistry are (already) so low that to anyone else from outside, it would be profitable to buy these services. But they don't buy (them)... Not even the ones from this area (Health District). Instead, there is a wish to preserve small laboratories over there in the municipalities, as well as to do all kinds of other things themselves... not even to mention that some other Health Districts would buy something from us... It is out of the question because in every place the following question would be: what shall be done to those people who take care of these tasks for the time being. So, right now competition is more a theory than practice.7

The internal markets within hospital institutions were also perceived to not be functioning in the desired way, producing practical effects only in exceptional cases. A reason for this was given by a chief physician of one clinical service unit as follows:

In principle it (buying some of the services from outside the central hospital) would be possible within the rules of the hospital, but no one has even considered anything like that... There are plenty of issues... From the private sector one would get these services cheaper, no doubt[...] But sending the samples and waiting for results takes some time...

Then there are these special services[...] in the case of which we give the results within five minutes... those are the kinds of services that the private sector cannot provide, plus, of course, the personal contacts, so that whenever these physicians phone me we can discuss these things... So those are the things they are prepared to pay for although they would, most evidently, get some specific samples cheaper somewhere else.

The statement of this chief physician received implicit support in a discussion with a profit centre manager of a surgical unit, the main user of various service departments:

Researcher: “Over here in your budget (reference was made to a budget sheet of the prevailing year which the profit centre manager had on his desk for the purposes of preparing a budget for the coming year) you have highlighted the expenses (of the clinical service units) allocated to your unit. Is it possible to have an influence on these costs?”

Profit centre manager: “No[...] I haven’t thought through those allocations very carefully. I have just taken into account how much money is transferred to other units. In our budget the allocations are a bit more than a half... Of course we need laboratory, X-ray, operating theatre, intensive care and so on, and I have relied on their (the clinical service units’) ability to count how much money they are going to use. They have a specific system by which to allocate (invoice) those...”

The changes in the rules of the game, which were designed to encourage health professionals to play the market game within and between hospitals, were thus ignored by many health professionals who continued working with each other according to respect for each other’s professional capital. The difficulty of creating purchaser—provider relationships between health service professionals has been expressed by Bartlett & Le Grand (1993, p. 21) in the context of an attempt to create health service purchasing organizations in the UK:

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7During the budgeting process for the year 1996 a preliminary decision was made in this Hospital District to centralize all laboratory services in the Health District’s central hospital. However, the preconditions for the agreement were as follows: (1) the quality of service has to be preserved or improved, (2) the costs of the services must decline and (3) none of the prevailing civil servants will be given notice to leave.
There will be a relatively small number of people dealing with each other, a large proportion of whom may well have been erstwhile colleagues under the old system. In these circumstances it will be difficult to construct or maintain the distance that a market or bargaining process requires.

4.2. Competition between university hospitals

As with the central hospitals, the five university hospitals in Finland are owned and operated by the municipal federations forming Specialist Hospital Districts. Prior to the reforms, these hospitals were subject to the same resource allocation system—based on the centralized five-year-planning scheme—as the central hospitals. As a result of the 1992 revised State Subsidy Act, these university hospitals were also required to start financing their operations by generating sales revenues.8

Despite this apparent similarity between central and university hospitals, the conditions for competition-based resource allocation were regarded as being met more closely in university health services. This was seen to be due in part to the less significant influence of local politics in university level health service purchasing decisions. Only five out of twenty-one Specialist Hospital Districts own a university hospital, and most Hospital Districts have therefore traditionally acquired the necessary university level services from “outside”. In the new competitive situation, the extensive capacity of university hospitals—each of which had, during the planning allocation era, been geared to serving the needs of a specified geographical area of approximately one million inhabitants—together with the consequently high fixed costs of these hospitals, were seen to put them under sustained pressure to retain their customers from diverse Specialist Hospital Districts. The importance of external sales revenues to the university hospital was emphasized in one strategy seminar by the hospital manager as follows:

[...] Keeping it (the external sales revenues) on the list of items on which we have to put special emphasis is important because[...] part of our capacity was intended for sale to outsiders from the very beginning. We have a special responsibility as a university hospital in this part of Finland, so we have had to build up our capacity. It has not only been our right but also our responsibility. In the current situation I still consider it as our responsibility, but the buyers are not obliged to buy unless we are competitive, and unless we are able to develop our operations in such a way that we are able to survive also in markets other than our own District. It (the external sales revenues) is quite a remarkable part of our income, 145 million marks, and it is also where a certain latitude has come from... which has been very important for us, not only from the point of view of the hospital and its resources, but also from the standpoint of the fixed costs for our owner municipalities. This is the ‘dividend’, and it is important from the viewpoint of the owners.

Another factor held to contribute to the impact of competitive tendering on university hospitals was the arrangement by which the external sales revenues of these hospitals, which forms a substantial part of their financing, started flowing through the clinical budgets of central hospitals. As a result of the re-arranged state subsidy system, the chief physicians in central hospitals were, for the first time, required to cover the expenses of patient referrals to university hospitals from their clinical budgets. In contrast to the physicians operating in health centres, who incur no financial penalties by referring patients to the central hospitals, central hospital chief physicians came to be seen as the real purchase agents of university health services.

Finally, not only was the distraction of local politics considered to be less, and information asymmetry of minor significance (due to medical specialists, rather than political decision makers, being in the role of health service purchase agents), government plans to reduce the number of Medical Faculties in Finland formed an additional factor in

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8Some minor finance for the purposes of medical teaching and research is distributed directly by the state.
creating the basis for competitive tendering between university hospitals. This was a topic raised frequently in coffee-break discussions. If realised, the plans would result in the downsizing of one university hospital to the status of a central hospital.

However, even allowing for the greater impact on the services provided by the university hospitals, experiences reported by health economists, hospital management and health professionals, revealed competition having touched only a minority of all hospital services. The main factor limiting competition between university hospitals was considered to be the diverse pricing techniques applied by different university hospitals, as reported by two central hospital chief physicians:

 [...] You cannot possibly compare these (prices) over here for the time being... We have so small a number of patient cases and the cost accounting is really difficult...

Have you seen the price-list of X (a university hospital)? [...] Those prices are built up in a way that it is absolutely impossible (to compare the prices)... Even for myself it is quite impossible to estimate, based on those, what something will cost[...]

Competition was thus a narrowly circumscribed phenomenon, even in university hospitals. Where price comparability was possible, quality control readily visible, and competitive pressure came form the private sector, competition-based resource allocation was possible. This was the case, for instance, with the major and expensive operation of open heart surgery:

 [...] (Competition is possible) only in areas which are not taken care of everywhere, for example, the case of university hospitals... and heart surgery, as the most typical example... An expensive large operation where the private sector is also competing. There you can see the competition. [...] If we think about open heart surgery, it is a very unambiguous operation. There are world-wide quality systems. It is known approximately what the mortality rate should be in those operations, what the rate of serious complications should be... In this way they (the hospitals) can be quite strictly compared... (a central hospital chief physician)

Competitive tendering in the area of open heart surgery was referred to by the central hospital chief physician, representing a purchaser of services, in one meeting as follows:

We are moving more and more towards the practice of buying these, i.e. bypass surgery, as packages[...]. It is the same package price[...], independently of whether it is five (cure) days or seven, it is 44 000 mk. We are discussing these (prices) with X (university hospital) from where[...] we received the price discounts last year[...] and if we get these cheaper from somewhere else we aren’t absolutely tied to X.

The realisation of competition in specific treatments only was considered to be problematic, however, because of the possibility for cross-subsidisation between the various services provided by the university hospitals:

 [...] Take for example the private sector... Let’s say a hospital, which does only that (open heart surgery)[...]. Then the price must be right sooner or later, otherwise the hospital folds up... But then a university hospital, which does them too, can perform those with marginal resources and also sell them (with marginal prices) when that suits its purposes.

Attempts to alter the balance of power and control within the field of Finnish health care thus reveal the inability of market forces, as given form in the 1992 Act, to diminish substantially the professional capital of health care providers. Health care financiers were seen to have been given insufficient tools to effect a reallocation of resources. As one central hospital leading physician remarked:

Previously, operational measures were followed in different hospitals and Health Districts and these were compared with
operational expenses but that wasn’t at all successful... In the neighbouring hospital they did twice as many operations in each of the speciality areas as in our hospital, because the operation was considered quite differently... As far as outpatient visits were concerned the neighbouring hospital recorded each x-ray examination and laboratory visit as an outpatient visit[...] “Look! In that hospital there is this much outpatient visits and you have this little... How do you explain this?” were the comments (of the municipal representatives). Then they thought that monetary measures, i.e. the pricing of the services, would help with this... But you know that the cost of a service and the price of it are two completely different things... You can use whatever (prices) you wish[...] So neither a professional nor a “municipal father” is able to draw any conclusions concerning the economic efficiency of the hospital operations based on mere product prices.

Despite this strong scepticism about the ability of performance indicators or market mechanisms to reveal the differential efficiency of competing health providers, and thus to increase the relative value of financial capital possessed by the local authorities, the changes in the rules of the game were none the less considered to have produced significant effects, in the form of a furthering of economic reasoning within health institutions. However, the extent to which the new accounting practices and symbols became embedded in, and succeeded in moulding organizational practises and altering intra-organizational relations of power, varied considerably in the different health care settings studied.9 Referring to Hopwood, it can be argued as follows (1984, p. 185):

The consequences of accounting are multiple, often conflicting and far from automatic. Although accounting can have very real consequences, those consequences are created in the specific contexts in which it is made to operate. The effects of accounting are determined by the uses that are made of it, the organizational and social roles which it is made to serve, the ways in which it intersects with other organisational and social processes and practices, and the resistance which its use engenders. Rather than being either a unitary or automatic phenomenon, accounting comes to function in a variety of very different ways in very different settings. And it is those ways and settings which influence the effects that it comes to have.

This variation in the organizational uses of accounting information, and its implications for the balance of control, is now examined in the two contexts of university and central hospitals.

5. Economic argumentation in health care institutions

August 28th, 1995, in the negotiating room of a university hospital:

The core members of the surgery unit, as well as members of the hospital management group, were gathered in the negotiating room of the hospital administration building. The purpose of the annual meetings between the hospital management group and profit centre representatives was to have a look at the operational and economic situation of each profit centre, and to discuss the opportunities and objectives for the coming year. The meeting had started by a review of operations and economics for the present year, after which budget limits for the coming year were discussed: Financial manager: “[...] From an economic point of view your opportunities should be much better than last year... Simultaneously, this (referring to the relative increase in the resources of surgery unit) has repercussions on the whole chain of operations; anaesthetic etc. These are the units to which quite a lot of money has been transferred... and the money has had to be taken away from somewhere else, of course.” Chief

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9See Preston, Cooper, & Coombs (1992) who investigate the management budgeting initiative in the UK hospital system.
physician: “But isn’t this the most profitable part in this (hospital). . .” Financial manager: “Yes. This (pointing at the budget figures on the paper in front of him) shows where the management group has set the focus of the operations. . . The surgical function is considered the one which supports the whole ‘house’. . .”

August 31st, 1995, in the office of a leading physician in a central hospital:

Related to the budget preparation process in the central hospital, the leading physician had invited the chief physician and the ward sister of the surgery unit to his office. The purpose of the meeting was to find means of adjusting the expense budget proposals of different profit centres to the hospital expenditure frame set by the local authorities. At the beginning of the meeting the chief physician, a profit centre manager, commented cheerfully: “Are you aware of how profitable the surgery unit is? I accidentally got this (a slide in his hand) from the Health District’s office. . .” Leading physician: “And what is it supposed to show to me?” Chief physician: “Here are our incomes and here the expenditures. . . So, now we can raise our voice when calling for resources. . . While the others mainly spend money. . . Actually (reading the slide more carefully), while all the others mainly spend, we mainly generate revenues. . . I mean, the revenues exceed the expenditure in our unit and nowhere else. . . Look, the expenses of our operations are less than 30 million and our revenues are more than 60 million! So, this is the case. . .”

These two statements by profit centre managers of a university and a central hospital reflect remarkably different contexts for financial argumentation. In the university hospital context, the statement of the chief physician is presented in a serious vein. In the central hospital context the physician presents the figures as a joke, prior to a serious discussion about the real issues, the operational facts, based on which his budget proposal could be justified. In the university hospital, the participants were discussing the income that had to be earned to maintain the hospital, whilst in the central hospital reference was made to “Donald Duck”-money, an expression widely used in this organization.

Comparable to the battles in the wider health sector field, the success of players in the hospital’s internal “budget games” depends on the distribution of various capitals in the intra-organizational field. One highly valued capital in this field is the competence of medical professionals to speak and argue in an appropriate manner. The linguistic competence of the speaker is, according to Bourdieu, determined not only by the speaker’s command of the languages in use, such as medical or accounting, but also by the speaker’s ability to take into account the context within which the argumentation takes place (Thompson, 1991, p. 18).

The distribution of this linguistic competence, and the varying extent and sway of economic reasoning in Finnish hospitals, can be illustrated by analysing the different ways in which accounting is introduced into negotiations between health professionals and managers. Following Bourdieu, a reconstruction of the field within which economic reasoning is produced and received is undertaken (Thompson, 1991, p. 28). Once again, the two contexts in which the employment of accounting reasoning is studied are university and central hospitals.

5.1. The sway of financial argumentation in university hospitals

The observation of a number of meetings in the university hospital studied revealed an explicit concern on the part of management with the organization’s ability to sustain a sufficient level of external sales revenue. At an organization-wide level, the concern with competitiveness was manifested by seminars arranged around issues of strategic planning10 and quality control, in which

10The colourful picture of a peacock and the text “Welcome to discuss the basis of success for our hospital” projected on the screen of the assembly hall at the beginning of one strategy seminar, was illustrative of the nature of these meetings.
operational efficiency and quality were repeatedly emphasized as the factors crucial for the viability of the hospital. The anxiety of management concerning the competitiveness and financial performance of the hospital was reflected in the lines of argumentation employed within this organization.

In these seminars, and more generally in negotiations with representatives of the university hospital management group, health professionals sought to produce appropriate expressions, to inform their proposals with economic rationality in order to make themselves heard and believed. Arguments based on either the potential of clinical units to increase their external revenues, or a threat to lose some of the existing income flows, were seen to have especially strong impact. Accordingly, the most skilful arguments, whether related to the financing of new human resources, medical equipment, or operational premises, were seen to be those that referred to the competitive situation, and that argued for investments in terms of economic rationality rather than in purely medical terms. The type of argumentation used can be illustrated by the following statements made by one chief physician in a meeting with the hospital management group:

[...] This (referring to a specialized treatment which was expected to be centralized in only one or two university hospitals) is the area in which we can crucially increase our earnings by switching over to cure rooms of three (instead of one) patients... The labour costs of nursing those patients would decrease about one third, perhaps 40%... Elsewhere in the world[...] they treat more than one person in the same room and this, of course, has a significant impact (on costs)... If we kept our price the same, this would bring a lot of surplus value to this “house”... [...] The whole strength of this enterprise of ours, and our competitive ability... compared to A (a competing university hospital)... is that our total volume is so high that we can... let’s say that our rubber band stretches... when we have the maximum amount of... patients... it stretches more easily than in the smaller units... This means that our ability to alter volume is higher than in the small units, and if we had our operational premises in order, our ability to alter volume would be even better... We would be able to treat patients in rooms of an appropriate size... [...] But we do still have a keen competitive situation... University hospital B tries hard[...] and university hospital C is tightly involved in competition... And now when we have reached quite a good position (in the market)... now if we are sold out some times (i.e. not able to supply services when required because of the lack of space) they (the competitors) get those (customers)... That shouldn’t be allowed to happen...

In several cases, arguments were supported by calculations, as in a negotiation about the continuation of a ward which had been established as a temporary solution to rapidly increased demand for services in one clinical unit:

[...] If we now move to the financial issues... I understood that in this meeting we were asked especially to discuss how much it costs to treat these—as I said from 40 to 80 patients—in our hospital in this new ward. Over there (referring to a slide in which his calculation was presented) you see the costs of the ward according to our estimate. This year the operating costs[...] are about 3 mmk[...] It was opened at the beginning of May[...] so, our estimate is that if it were to operate for the whole of next year some additional 2.4 mmk’s would be spent... All in all the operating costs would be about 5.4 mmk per year[...] Then I tried to estimate how much it might cost us if we were not to have this ward. If we start from the top (of his calculation); it would require us to change the current week ward Y to a seven-day ward so that we could take care of the patients[...] Consequently the operating costs of ward Y would increase about 2 mmk... For the time being it (the cost of ward Y) is about 3 mmk... The next line; if ward Y were to take the patients coming to it, it would not be able to cure other patients... so (as a result of
the closure of the temporary ward) the external revenues of our clinic would decrease by 5 mmk. (Further) via this clinic about 420 patients come from other Health Districts to be operated in the surgical unit, and these would no longer come[...] So in the worst case the external sales income of the surgical unit would decrease by 17.5 mmk. Additionally, around 180 patients of our own Health District, who are going to be operated on, are examined in this ward, plus we carry out about 300 treatments[...] The purchasing of those operations and examinations from other hospitals, by using the standard prices of our own hospital, would cost 9 mmk[...]. We know that our prices are the cheapest ones, so we wouldn’t get them at that price. Additionally, it is the only elective ward of ours in which the patients suffering from p, r and t are examined. According to the estimation of Mr B, our associate professor, the examination of those patients somewhere else would cost 2–4 mmk[...]. So transferring these patients (currently treated in the temporary ward) somewhere else would either increase the expenses or decrease the income which totals 35 mmk. Of course, one could sack some surgeons and some people from the intensive care unit (if the ward were to be closed)[...]. and we could get some savings accordingly[...] of course not all of it (35 mmk) though[...]. Hence, this is the magnitude of costs that we are talking about when we bring these two options (keeping the ward open or closing it) face to face[...].

According to the view of one chief physician, carefully prepared calculations had become a prerequisite for the justification of an investment proposal:

At least in our case, if we are going to get something (i.e. new equipment) we have to present very strict accounts; how many examinations we are going to conduct, what is the depreciation time, what will be the price per examination based on these assumptions, whether it (the price) is competitive[...] compared e.g. to the private sector or our previous prices, whether there will be an increase or decrease (in the prices)[...] as well as all the expenses related to it (the investment and the usage of the equipment)[...] they all have to be presented, in every single case[...] With this system we have so far—thank God—been able to justify our investment proposals.11

The explicit discussion of competitiveness, as well as the strong sway of economic reasoning, should not be seen as an inevitable consequence of the hospital’s altered external conditions, however. The emphasis placed on financial reasoning in this institution should also be seen as a result of the purposeful change towards a more business oriented organizational culture, promoted by the intra-organizational forces operating within the hospital since the 1980s. A profound cultural change had been instigated by means of the Results Management programme, and was followed later by the careful preparations for transition to the competition-based resource allocation system. According to the financial manager:

Actually this process got started from the intra-organizational issues[...]. when that extension (of the hospital) was completed[...]. At the time, the contemporary hospital management had thought over the question of how to move ahead—it wasn’t possible to continue in the same way—and then the objective became to change the whole operational culture.

Reflecting the strong support given by the prevailing hospital management to the profound cultural change process, substantial resources had been invested in employee training, information systems, and in the creation of employee reward procedures, all believed to facilitate the purposeful change of management culture throughout the

11 Compare this to the statement made by a representative of one Finnish central hospital in the 1980s: "Here, people look for capital to buy, no one thinks about whether it is economic to have it, even if we use it only a few times. No one has to prove it economically sensible to need something. If it can be proven as medically needed, it will be bought (Saltman, 1988)."
organization. In the new organizational culture, calculative rationality was shown to be highly appreciated, and the aim of seeking and using financial reasoning as a basis of decision making was considered to have a high symbolic value (Feldman & March, 1981). As a result, discussions between the hospital management group and profit centre representatives in the university hospital studied often centred on issues of demand, marketing, market share, pricing, service mix, threat of competition, production bottlenecks etc. Despite claims that only moderate competition had been introduced in the Finnish health sector, these discussions were much the same as would be found in any business organization.

5.2. Financial argumentation in central hospitals

In principle, the introduction of market forces in Finnish health care created an equal opportunity for central hospitals to increase their production volume by attracting patients from competing Health Districts. However, the perceived failure of quasi-markets at central hospital level meant that these hospitals typically failed to generate supplementary revenues. The possibilities for generating additional revenue were considered especially limited in small central hospitals, as reported by one leading physician:

Previously it was the case that speciality areas... actually the hospital as a whole at that time[...] was responsible for its costs and also its (medical) outcomes, the development of which were followed by means of operational measures[...]. But now the situation has changed in such a way that the costs are adhered to... those cannot be exceeded... and then, besides these operational measures, the revenues are assessed. But we cannot— even though it would be possible for us to increase sales—we cannot increase costs... except in the situation where we sell to x, y, z (listing municipalities belonging to other Health Districts). But that is unrealistic when almost all the hospitals around us are bigger than we are, and at least as well equipped, perhaps even better equipped[...]

The special nature of the “business” between central hospitals—representing non-profit organizations with varying output levels, yet fixed expenditure limits—and municipalities was described by one central hospital chief physician as follows:

This is not a type of business in which the more you sell the more money you get. Instead, the more they (the municipalities forming the Hospital District) buy, the lower we have to set the prices, because we have an (expenditure) ceiling, that is definite!

Central hospitals were expected to match annual invoicing with expenditure limits, by means of price adjustments. The complicated process of fitting total invoicing with a total expenditure ceiling—determined by the municipalities—was explained by one central hospital manager:

[...]. And now if you look at that (an accounting report in which the accumulated sales revenues were shown alongside budgeted revenues, equal to the expenditure frame)... Two months... 17% (pointing to a figure of accumulated sales revenues of two months in proportion to the budgeted revenues for the whole year). If this goes through evenly (the whole year) it (the invoicing) will be enough, more than enough. And then we, the board of directors—you know it is not our principle to make profit—we assess these prices[...] and over there (in the meeting) we discuss whether to lower some prices for the future... In this way the accuracy (of pricing) is continuously improved.

If any surplus were to arise at the end of the financial year, because of “miscalculated” prices, the hospitals would be expected to return their profits to the municipalities:

You have heard that we—I mean our hospital federation—returned 15 mmk to the municipalities. It is our profit which we are refunding them without getting any benefit, whether for the purposes of buying equipment or hiring more staff... We would be able to sell...
more but the municipalities cannot afford it[...]. The costs have been fixed (a leading physician).

The combination of a purchaser-provider split between municipalities and health care institutions on the one hand, and an expenditure ceiling for health care institutions on the other, was seen to cause serious dilemmas for central hospitals. There was strong criticism, particularly by representatives of those clinics that had a significant increase in the volume of patients. As stated by one chief physician:

The issue... which I have just talked about today... is that the amount of in-patient days are increasing and more and more patients are treated, and the financial people... both the manager of the district and other businessmen say: “There is no problem, just lower the prices, it is nice for the municipalities”... But there is the problem, it gives some kind of a hint that there is slack over here... (Ironically:) “Just lower the prices and downsize the budget more and more”... However, it is damned hard work for the time being what the people do over there[...]. Every day there is a question of people’s lives in these operations... There should be something else in these things than just to lower the price and to put more people on the line than it can take[...]

In conditions where competition was seen to be lacking, the practice of invoicing by central hospitals was strongly challenged:

[...] Let’s say that e.g. municipality X reserved 100 million per year for us (under the old system)... Now that we have transferred to a very strict invoicing system they still tell us that we shall be given 100 million, and now we have to fit the invoices at the end of the year so that the (total) sum will be 100 million... I don’t understand this kind of trading at all (a chief physician).

To health care professionals in central hospitals, the practice of cost accounting for the purposes of service invoicing appeared a frustrating and time-consuming game played with fake money. At the same time as continuous cuts in clinical budgets were being made, expenditure to promote market forces was seen as something on which almost not enough money, or time, could be spent (Humphrey et al., 1993). In discussions concerning hospital accounting practices, the accountability of accounting systems designed to support market based resource allocation—the unrealized dream of health economists—was strongly questioned:

Well, I haven’t thought very carefully whether it (the allocation of administration costs to different units on direct labour cost basis) is fair for us or not. The fact is that those costs have to be allocated anyway and independently of the basis of allocation I shall most likely get about the same pot. [...] Now that we know that the total amount stays constant... someone else would be charged by the share of ours (if the allocation basis was changed) and yet, the total sum of money which is charged from the municipalities would stay the same[...] So this intra-organizational play by which we share these sums with one another and in which we transfer them to each other in different orders... again I ask: What is the surplus value achieved? Because the municipalities have to be charged a definite sum... Actually it is more appropriate to say that municipalities have now promised to give us a certain sum of money. If we think how the most remarkable savings—at least in the short term—could be attained... Now that the municipalities have let us know that we are going to get the same amount of money (for the next year) as for this year... so they would send the money over here at the beginning of the year and then we would run this system without sending any bills to anyone, to each other or to municipalities[...] I guess twenty or thirty years of labour would be saved if those damn bills were not sent from one place to another... And when we think now that municipalities are receiving a long list of differently priced in-patient days etc... If we
think about how much work it causes for them to go through those[. . .] All in all it may well be that one hundred people employ themselves for the whole year just circulating those pieces of paper. Anyway, we have been told that this much money will be given. What sense does this make? I don’t know. (a chief physician)

Despite this scepticism or hostility towards the idea of competition and the practice of service invoicing, financial argumentation nonetheless began to permeate discussions about resources within central hospitals. There was a difference, however, in the form this took, and the negotiating contexts in which it arose, between university and central hospitals. While financial argumentation in university hospitals was focused mainly on spending-to-raise-revenue proposals, i.e. on investments which were expected to generate new external income flows or to secure prevailing sources of revenue, financial argumentation in central hospitals was concentrated on the possibilities of reducing the purchasing of services from university hospitals by treating increasingly demanding patient cases in central hospitals. This gave central hospitals a reason to invest in new equipment and employees. Financial arguments supporting spending-to-save proposals—with reference to the consequent cuts in expenditure on university hospital services—were seen to provide powerful support for these investments, alongside more traditional arguments, such as the need to maintain equipment levels to a standard appropriate for a central hospital:

[. . .] The first argument is that it (the investment) is economically profitable in the current economic situation. In other words, we have some patients who we send to X or Y (university hospitals) to be treated or examined. And now if we show that when we acquire this kind of apparatus it becomes cheaper to do the examination here than to send the patients... then it is logical, to my mind. . . of course it is then worth acquiring (the apparatus) here. Another thing is that medicine is still developing enormously quickly[. . .] So in order to be able to maintain a certain level, we have to buy this new expensive equipment although the price of the examinations will become very expensive with it[. . .] We have there (referring to the investment proposal list of the hospital) equipment A. I wonder what the acquisition cost is... several million marks... and there will be a limited amount of examinations, but for this to be called a central hospital this equipment has to be acquired... Those are the two most important arguments to my mind. (a chief physician)

The permeation of financial argumentation into resource allocation discussions, notwithstanding the different form this took in university and central hospitals, can be seen as the acquisition by medical practitioners of a new linguistic competence. This does not mean that accounting information had come to be regarded as objective or “true”. Indeed, the increased use and power of financial argumentation in both university and central hospitals went hand in hand with a perception on the part of both hospital management and medical professionals that accounting information provides only a partial view of reality. Awareness of the wide variety of possibilities for manipulating accounting information to accord legitimacy and rationality to past and future actions was expressed in several discussions. The calculations presented by one party were often contested by other interested parties, both medical professionals and hospital management, with reference to the biasing, gaming and filtering of information (see Birnberg, Turopolec, & Young, 1983). The medical professionals’ temptation to utilize information systems for their own ends was seen to be especially intense in the existing circumstances of diminishing resources. The overall distrust of financial calculations was evident in statements like the following:

[. . .] I am sure there is no sense in that (investment proposed by one clinical unit). In figures it may appear reasonable for the time being but in the longer term there is no sense because, as I see it, the apparatus doesn’t do
it (the examination) cheaper over there in the corner of that clinic than in the corner of service unit X. The question is how the costs are divided between the variables... The same apparatus does the same examination... it must cost the same. [...] Recently Y started to do examination Z by themselves[...] according to their figures it was cheaper for them to do so than to buy it from us, because we invoiced them more (than their estimated costs). Now they do those (examinations) themselves, but the fact is that having acquired the similar apparatuses they are worse at (doing) it... they do it slower... their costs become higher, but by using their accounting methods the cost seemed to be one third of the price we invoice... (a chief physician)

The consequences of accounting thus varied according to the different contexts of university and central hospitals. But financial argumentation had become a part of the linguistic competence of medical professionals in both settings.

6. Accounting and institutional action

I cannot say just now where in Europe or where in the world they may have succeeded in this (reform of health care)[...] The processes, of course, are quite slow. You can always build a house... even a hospital within ten years, if you are lucky, but just try to change the way of thinking of the employees. (a health economist)

The requirement that health professionals translate their therapeutic activities into cash equivalents, and transform the terms of calculation from medical to financial, was considered by those interviewed in both central and university hospitals as having changed the form of argumentation in health organizations. In the process, health professionals were urged to think about their activities in new ways, and according to changed norms (Rose & Miller, 1992). Requests by fund holders for more detailed cost information were seen by health care providers to have emphasized their accountability to municipal decision makers, and to have reinforced their notion of being under control (Roberts & Scapens, 1985; Ansari & Euske, 1987). This altered sense of accountability was described by the manager of one hospital district as follows:

To have only one master—the 16 municipalities which own us—requires us to respond more sensitively... meaning we must continuously search for more economic ways of doing things. Every day... every week when we are sending invoices (to municipalities) worth millions of marks we receive feedback from some direction like: “What on earth is costing this.”

While municipal representatives were seen to be requesting increased financial accountability from hospital management, the management was, in turn, seen to have responded by placing increased financial pressure on health professionals. Clinical units were required to find out the costs of their operations, and economic justifications were demanded for their investment proposals. According to one central hospital financial manager, the reforms had the effect of making health professionals calculable and calculating (Humphrey et al., 1993):

[...] Despite that (referring to her view of lacking conditions for the efficient functioning of competitive markets in health care), it makes sense for us to find out the costs[...]

Our hospital manager says often that when he started to talk to the doctors about the costs of some operations the doctors were asking “What... what costs?” I mean that those who do the operations, they have to know (the costs)... It’s no use if we over here in the administration are busy with pricing (their operations)... The whole idea is to influence the costs, and the costs are incurred where the operations are done[...]. In that respect it (cost accounting) is not unnecessary. I do agree that we shouldn’t go so far that our
educated doctors should become so busy with pricing that they spend all their time on accounting, but they have to take an interest in the matter, and they have to participate in it to the extent that they know the cost implications when making the decisions... and this has gone through really.

An increased awareness of costs, facilitated by the new and more detailed cost accounting systems, was evident to all health professionals interviewed at both university and central hospitals. Further, the improved cost consciousness—the economic judgement of health care operations—was regarded as having implications for the clinical decision making processes. As described by one central hospital chief physician:

[...] As far as cost accounting is concerned, the clear advantage is that now we really have to check how much money each operation requires... and the spending of money can be decreased... at least marginally as you can see (pointing to the operational and financial measures showing increased cost efficiency in his unit)... We can reduce expenses by considering whether everything is really necessary.

The impact of enhanced knowledge of costs on operational choices in one university hospital service unit was expressed by the chief physician of this unit as follows:

A good indication that we have continuously made calculations and debated our operations can be seen in our article that will be published in the American Journal of X, which considers the examination methods of Y; which is the most economical way... So these things should all the time be considered also from that (economic) point of view, not only from the medical viewpoint... and, yes, this is what we have tried to do[... ] I think, as far as the attitudes of the staff is concerned, that the impact of the whole costing project has furthered it (cost consciousness) enormously. One knows exactly whether it is reasonable to do this or that, or whether we should use that one, since it’s more economical.

Yet despite the widespread perception that the cost consciousness of health care professionals had increased substantially, hospital representatives often found it difficult to isolate either the impacts of Results Management programs, or the effects of an attempt to set up market forces in health care, from the wider social pressures for increased cost efficiency in the public sector. As reported by an administrative chief nurse of one central hospital:

[...] That we would have behaved somehow differently in this organization because of some competition or because of some market economy which would have come and swept us along[...] It may be somewhere there in the background but this is due to other developments... There are many things which have had their influences simultaneously.

Accordingly, some hospital representatives saw the economic recession as an important contributing factor—if not a precondition—for the successful implementation of market oriented health system reforms, and for the achievement of the changed ways of thinking and acting of health professionals:

[...] It (accounting) started to be taken seriously because of the lack of money. The lack of money and the economic decline furthered quite remarkably the transition to pricing and profit-oriented thinking. (a leading physician of a central hospital)

7. Conclusions

Neo-liberal ideals, according to which markets should replace planning as regulators of economic activity in the public sector, gained widespread acceptance by political decision makers across a broad international arena from the mid 1970s on. This shift in rationalities of government was accompanied by a profound reorganization in the governing principles of public sector organizations
in numerous developed countries. This paper has examined one of the settings in which this change in ways of thinking, talking and acting occurred. On the basis of interviews and observations in three Finnish hospitals, the hopes, and some of the effects, of these reforms have been addressed. The implications of these reforms for university and central hospitals, and the more tangible effects produced in the former, have been analysed. The focus has been on power relationships in the field of health care, and attempts to diminish the occupational self-control of health care provider institutions by shifting power from health professionals to health care financiers through the introduction of market forces. This attempt to redistribute power and control in the health care field has been analysed by using the notions of field and capital drawn from Pierre Bourdieu.

The process of marketisation encountered limits, however. The view of those involved with health service production was that conditions favourable to competition were absent, due in large part to the small number of service providers. Also, local authorities were reluctant to set up competition for political reasons, and there were difficulties in creating purchaser-provider relationships between health service professionals. A further problem was the limited and unreliable nature of information provided to those responsible for service purchasing. Contrary to the aspirations of health care reformers, the monetarisation of health service transactions through the price mechanism was regarded as having failed to reveal unambiguous differences in health service providers’ cost efficiency or quality. As a result, political decision makers were unable to augment the value of their financial capital, and unable to challenge the professional capital of the medical professionals.

None the less the process of marketisation had consequences. Although many of those wishing to benefit from the reforms were disappointed by the apparent failure of market mechanisms to create conditions for competition, and although the reforms did not result in a radical redistribution of resources between existing health providers, a profound change was seen to have occurred in the organizational life of health institutions. Economic reasoning—although employed differently in the university and central hospitals studied—had come to play an increasingly pervasive role, especially in the intra-hospital games for resource distribution. Economic reasoning influenced the argumentation used, the decisions made, and the actions taken by health professionals. Ways of thinking, talking, and acting within health care settings had altered. Cost accounting—initially fabricated as a response to extra-organizational pressures—had established its position in hospital life:

[...] I am definite that yes, this (cost accounting) has come to stay... It is, of course, another thing if we want to discuss how our costs will be shared among the municipalities... those can be shared just like one wants to, but independently of that, this kind of management accounting will stay with us... Yes, we have to know what things cost... (a financial manager)

Yet the potential for a gradual transition towards market based control mechanisms in the health sector had not been completely buried either. Future progress was thought to depend primarily on the development of accounting practices. In order to make visible the inefficiencies within operational processes of health care, and to provide a basis for valid comparisons between competing health service producers, increasingly standardized, relevant, and accurate cost information for service purchasers was held to be required:

I don’t believe, in this sector, in the overall power of free competition... What I believe is that if we somehow were able to make the (hospital) accounting systems comparable in this country, we would be able to compare these “houses” with each other. Then the municipalities, which own us... if we were clearly more expensive than the other similar kind of “houses”... then not in the sense that they would start buying the services from outside, but that they, as the owners, would let us know that first we have to explain very
carefully why our services are more expensive and after that take care that our prices will become competitive... And if the current managers are not able to achieve that, then the managers would be changed... that the people would be changed until it succeeds... (a central hospital chief physician)

Optimism that this further development in cost accounting could be accomplished was evident:

The specification of the rules of the game according to market mechanism principles has indeed brought a certain kind of[...] competition in citations. Yes. Our units and our decision-makers, the municipal directors, they do follow the products and their prices nationally... Only because there are no national guidelines, making the comparisons is so difficult that I wouldn’t recommend the task to non-professionals... [...But there is the potential and challenge for accountants to provide, in cooperation with (medical) experts, comparable packages[... ] (an administrative leading nurse of a Hospital District)

Struggles for the redistribution of power and control in the Finnish health care field thus continue. Accounting practices and economic reasoning are now an integral part of them.

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