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Emerging pathways of *colonization* in healthcare from participative approaches to management accounting

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ABSTRACT

This paper analyses, through the Laughlin and Broadbent framework, the interaction between Management Accounting (MA) (as a design archetype) and clinicians' *interpretative schemes* in the change of healthcare organizations, started by reforms introduced by government. Unlike previous research, this paper focuses on the process of MA change and in particular (1) the role played by the government and internal actors in MA change and (2) the implication of MA change for clinicians' *interpretative scheme* and for organizational change. We found that the interaction between the government and internal actors determines MA change and that an i*ntegrative-interactive approach* to MA change can be developed. This approach is based on a collaboration between clinicians and controllers in the revision of MA tools. The *integrative-interactive approach* underlines a new change pathway of reciprocal *colonization*, where the *interpretative schemes* and the *design archetypes* influence each other in the organizational change triggered by the government.
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1. Introduction

In the introduction of managerial principles in healthcare, the role played by Management Accounting (MA) is of the utmost importance. Because New Public Management (NPM) reforms required that clinicians become managers and control the costs of their processes (Hood, 1995), healthcare organizations have progressively implemented MA tools to *colonize* clinicians' core values along the path of managerialism to achieve the objectives of reformers (Kurunmaki, 2004; Jacobs, 1995; Broadbent, Laughlin, & Read, 1991; Broadbent, 1992; Broadbent & Laughlin, 1997; Laughlin, Broadbent, & Shearn, 1992, Laughlin, Broadbent, & Willig-Atherton, 1994). Within the stream of research on *colonization* in healthcare, this paper addresses the need identified by Oakes and Berry (2009, p. 344) to provide studies concerning accounting *colonization* .

The primary aim of this research is to investigate, through an empirical case, the process of *colonization* of clinicians' core values with a focus on the interaction of government, controllers and clinicians. To pursue this aim, we analysed the role of multiple actors (specifically governors, controllers and clinicians) interacting in the process of designing of MA tools, the way healthcare organizations manage the conflicts among these actors and the progressive process of *colonization* of the clinicians' core values driven by MA tools. We believe this is of interest, because previous studies (e.g., Agrizzi, 2008; Broadbent at al., 1991; Broadbent, 1992; Jacobs, 1995; Kurunmaki, Lapsley, & Melia, 2003; Laughlin et al., 1992, 1994; Oakes &

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Berry, 2009) mainly focused on the *result* of the process of *colonization* process with limited attention to how this process evolves and the roles of multiple actors in it.

The secondary aim of this research is to contribute to the theory of *colonization* that draws upon the Habermasian societal theory (Habermas, 1987), elaborated by Laughlin (1987, 1991), Broadbent and Laughlin (2005) and expanded by Oakes and Berry (2009), because a development is necessary to illustrate the complexity of *colonization* in practice. To clarify this motivation, we now briefly describe the current knowledge on *colonization* available in the literature and the problems we found unsolved when attempting to illustrate *colonization* in our empirical case.

The theory of *colonization* is described by Laughlin (1987, 1991) and Broadbent and Laughlin (2005). They consider two opposite outcomes of organizational change: *morphostasis* (first-order change) and *morphogenesis* (second-order change). The fundamental difference is that only *morphogenesis* determines the change in the core values of the organizations. In this frame, *colonization* is an example of *morphogenetic* change that occurs when MA invades and coercively changes clinicians' core values. Oakes and Berry (2009) still consider *colonization* as a phenomenon that occurs when MA changes the *interpretative scheme* (even without coercion). However, they address limitations of this approach. Their criticism of the theory of *colonization* is that accounting *colonization* is underpinned by dualisms. First, there is a form of dualism when the theory of *colonization* considers organizational elements (for example, MA and core values) as separate entities, whereas they are strictly interconnected. Second, dualism occurs when the theory of *colonization* considers a dichotomy between resistance to change or acceptance of change, whereas *colonization* is a continuum process where there can be intermediate results. Furthermore, the authors argue that there can be instances where behaviours create the impression that core values have changed, whereas organizational actors only comply with required behaviours without fundamental changes in their core values. Based on an empirical case in education, the authors individuate alternative *colonization* tracks (*discursive*, *pathological* and *coercive*) to overcome these criticisms.

In the empirical case presented in this paper, we embrace the assumptions of Oakes and Berry's (2009) theory, but our findings show a reciprocal influence between MA archetypes and clinicians' core values, which is not considered by the authors. In fact, Oakes and Berry (2009), although attempting to overcome dualism, do not sufficiently consider the interconnections among organizational elements resulting from the interaction between controlling and controlled actors, and do not foresee the possibility of a reciprocal influence between MA and core values. Thus, we argue that *colonization* can be further enriched with respect to the issue of dualism to explain the variety of *colonization* in practice. In fact, MA concerns the role and interaction of the multiple actors affected by MA information. According to Chapman, Cooper and Miller (2009), Hopwood (1972) and Simons (1991), these multiple actors are in conflict when determining MA criteria, such as the type of performance measures to be implemented (Scott, 1995).

The contribution of this research, supported by empirical evidence, is an extension of previous models of *colonization* with the identification of a new pathway of organizational change, namely, *reciprocal colonization*. The main feature of *reciprocal colonization* is a reciprocal influence between MA and clinicians' core values. This occurs by means of an *integrative-interactive approach* to MA change, that is a collaborative interaction between clinicians and controllers aiming to revise MA tools. Our research shows that the *integrative-interactive approach* has allowed the clinical culture to influence the design of MA tools, which now are more clinically oriented than in the past. However, our research also shows that the main effects of the *integrative- interactive approach* have been a reduction of the conflicts surrounding MA implementation and a more effective *colonization* of clinicians' core values. At the end this approach has been successful from the point of view of the government and controllers, as it has contributed to the process of making clinicians more governable and has helped to achieve the objectives of the government. In effect, despite a more clinically oriented design of MA tools, the goals are still defined by the government and sponsored by controllers according to their prevailing managerial culture inspired by NPM.

Given this, we also argue that the *integrative-interactive approach* is meaningful within Foucault's *governmentality* framework (1979). In this perspective, the *integrative–interactive approach* and the resulting *reciprocal colonization* can be considered as an "indirect mechanism of rule" (Miller & Rose 1990; Armstrong, 1994). In our research, the regional government and controllers have developed this mechanism to make clinicians more "governable" and to shape their conduct to achieve the objectives they consider desirable (Miller & O'Leary, 1987; McKinlay & Pezet, 2010). This highlights the circumstance that, even if several studies have shown the positive effect of using participative approaches to MA change (Burns & Scapens, 2000; Broadbent, Jacobs, & Laughlin, 2001; Hassan, 2005), participation can play an ambiguous role. In our case, for example, professionals are involved in MA decisions and perceive that MA is furthering their interests. In reality, MA only promotes the interests of the government in the NPM vein.

The research was developed in an Italian region (Tuscany) where, over the last ten years, the government and MA tools have strongly embraced the process of *colonizing* the core values of clinicians in accordance with the NPM approach (Hood, 1995). Thus, the regional government in Tuscany has attempted to change healthcare organizations by introducing an intense flow of reforms and managerial tools that have represented a breakthrough in governance and evaluation systems (Brown, Vainieri, Bonini, Nuti, & Calnan, 2012). The result is that today Tuscany has one of the highest quality and most efficient health services of all Italian regions (CEIS-CREA, 2013; Nuti, Seghieri, Vainieri, & Zett, 2012).

The most important *colonizing* attempt was the introduction of a new Regional Performance Measurement System (RPMS) in 2005. This system evaluates and compares the performance of activities across healthcare providers (Nuti, Vainieri, & Bonini, 2010). The results of the RPMS was made public, and this created pressure on healthcare organizations to fulfil the regional goals and defend their reputations (Brown et al., 2012). Furthermore, the RPMS was linked to a monetary reward system for hospital CEOs, which had placed additional pressure on organizations.

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