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AN INSTITUTIONAL SOCIOLOGY PERSPECTIVE OF THE IMPLEMENTATION OF ACTIVITY BASED COSTING BY SPANISH HEALTH CARE INSTITUTIONS

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Abstract

According to institutional sociology, hospitals will respond to external environmental pressures and adopt Activity-Based-Costing (ABC). This theory overemphasizes conformity and fails to consider the advantages of organizational non-conformance. A conflict of interests between physicians and management leads to physician resistance to accepting ABC. This paper investigates the Spanish government's response to this resistance by creating new public foundation hospitals, and involves a case study of the Alcorcón foundation hospital. Population ecology is offered as an explanation for the emergence of new entities as a result of inert existing entities' resistance to reform.

Keywords: Activity based costing, ABC implementation, Health care, Institutional sociology, Spanish health care sector

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Introduction

During the 1980s, in many developed countries there was a movement to change the existing formulas for managing public institutions (Hood, 1995; Olsen et al., 1998; Olfas de Lima, 2001). This movement, termed New Public Management (NPM), was driven by significant changes in the environment, combined with globalization, and brought about a profound change of mentality among both customers and managers of public institutions (Hood, 1995; Lapsley, 1999). The customer, who until then had perceived two forms of receiving services – from the market and from a public administration – now held the public administration to the same discipline as the market. The revolution in management thinking for public administrators was the belief that they could achieve optimum levels of productivity and customer satisfaction.

One of the most important sectors to be affected by this NPM movement was the public health sector, which began to experience pressure to improve the management of health services (Ham, 1997; Ruef & Scott, 1998). Part of the response to this pressure was to introduce contemporary management practices, including improved costing systems (Preston 1992), such as Activity Based Costing (ABC). Cost control is arguably the most important issue facing the healthcare industry, which has been transformed from a fee-for-service model in which the healthcare provider could pass on cost increases, to a system of managed care in which the healthcare provider receives a fixed, predetermined fee for each medical service (Ferguson & Lapsley, 1989; Ruef & Scott, 1998). This change in the contractual relationship between healthcare providers and the funding entities has been the primary focus for introducing market discipline into healthcare management, one of the components of management reform (Hood, 1995). These market pressures would suggest that the success, or even survival, of healthcare providers, especially under capitated¹ systems such as Health Maintenance Organizations (HMOs), where the financial risk of providing healthcare services is shared between the healthcare provider and the HMO, depends upon two factors: appropriate utilization of resources (i.e. identification of resource consumption on a procedural basis) and control of costs per unit of service (Bergthold, 1990). The true advantages are the prospective and retrospective reviews of high volume procedures in order to assess resource utilization (Hood, 1995) and contracting with payors (Hussey and

¹ Capitation is a set amount of money received or paid out. It is based upon membership rather than services rendered and usually is expressed in terms of amount per member per month.

Holford, 1993). Typically, due to their weak cost measurement systems (CMSs), healthcare providers enter into negotiations and contracts with payors with no realistic knowledge of their costs (Long et al., 1983; Fowkes, 1985; Ryan et al., 1996; O'Connell & Feely, 1997; Reichert et al., 2001).

Most prominent organizational theories suggest that organizational diversity is due to adaptation, with adaptation theories suggesting that organizations respond to external environmental pressures. Institutional sociology posits that an organization's survival requires it to conform to institutional pressures (Covaleski & Dirsmith, 1988; Oliver, 1991; Carmona & Macías, 2001). It follows that hospitals would respond to various institutional pressures, since hospitals seek legitimacy in the view of those various institutions; thus, the adoption of contemporary management practices, including ABC, would not only provide the economic benefits of a more sophisticated CMS, but would also signal the hospital's intention to improve efficiency. In practice, however, implementation of the ABC model in hospitals has been very difficult (Cobb et al., 1993). While considerable attention has been given to the technical considerations necessary for successful implementation (Hussey and Holford, 1993; King et al., 1994; Rotch, 1995; Urrutia, 2001), less attention has been given to the issue of resistance to the pressures for implementation.

This paper expands on previous work regarding the impact of institutional forces on the adoption of management processes in hospitals. Specifically, it addresses the issue of resistance to institutional pressures in the highly institutionalized Spanish health care sector. Rather than passively responding to and complying with environmental demands, as suggested by the institutional perspective, a resource dependent perspective suggests that organizations will actively employ a range of strategic adaptation choices, including non-compliance (Oliver, 1991). Consequently, the successful deployment of New Public Management in the Spanish health care sector should consider that hospitals' responses to pressures to conform will depend on several factors, including why those pressures are being exerted, who is exerting them, what the pressures are, how they are being exerted, and where they occur (*op. cit.*). This paper explores these institutional factors in the Spanish health care sector in an attempt to provide insight into the predicted strategic responses of hospitals and the consequences of those responses.

Additionally, this study expands on the previous literature and responds to Marcon and Panozzo's (1998) call to go beyond English-speaking countries by examining the issue of implementation in a significantly different setting – a Latin as opposed to Anglo-American environment – and by focusing on costing systems as opposed to the control function, which has been the primary focus of previous studies.

The research method involved a qualitative intensive case study of the Alcorcón hospital over a one-year period. Data were gathered by means of a total of fifteen visits made to the hospital, including three semi-structured interviews with the CFO and Controller, totaling ten and a half hours. These interviews were conducted as in-depth qualitative exchanges on a specific set of topics. The remaining twelve visits totaled approximately 36 hours. Notes were taken in all fifteen visits. The objective of the initial interview with the CFO and Controller was to discuss and diagnose hospital cost accounting systems. We received documentation relating to the design of the ABC system as well as the operational plan, which included the organization chart and the portfolio of medical services offered. The objective of the second interview was to analyze the reasons why top management had decided to implement an ABC system, and discuss the potential problems identified in the literature (Hussey and Holford, 1993; King et al., 1994; Rotch, 1995), which centered

primarily on issues internal to the hospital. The objective of the third interview was to discuss potential sources of problems external to the hospital regarding relations with the tax authority, the hospital proprietor², and the consulting firm hired to assist in the design of the ABC system. Each of the remaining twelve visits to the hospital had the objective of verifying statements made by top management via observation and collaboration with medical personnel. Additionally, we made four visits, averaging one hour each, to three other hospitals in the area – Getafe Hospital, Puerta de Hierro Hospital, and Doce de Octubre Hospital – to identify both common and contrasting costing practices and procedures.

A qualitative methodology is appropriate when the research aim is to understand a complex process (Blumer, 1969), with the interview considered an accepted method within qualitative research for the purpose of building theory (Holstein & Gubrium, 1995). Advocates of qualitative methods stress the richness of qualitative arguments on the big picture and the appealing explanations of how processes, chronological facts and causal links occur (Miles & Huberman, 1994). Specifically, a case study approach was adopted as it is apt for ‘why’ and ‘how’ questions (Yin, 2003), thus enabling the researchers to make sense of events, iterate theory with empirics, and generate ideas for future research (Patton, 1987).

This paper is organized in three parts. The first part briefly discusses institutional sociology theory, including criticisms. It then discusses institutional sociology in the context of management accounting and hospitals, followed by a discussion of the Spanish health care sector from an institutional and resource dependent perspective, including the strategic responses to institutional pressures, specifically the resistance of health sector civil servants and hostility to economic reforms. This part concludes with a review of studies of ABC applications to hospitals, identifying key issues regarding implementation of ABC in hospitals. The second part first describes the Spanish health care sector, followed by a discussion of the Alcorcón foundation hospital. The third part contains a discussion of the authors’ observations and conclusions regarding the penetration of ABC in Spanish health care organizations.

Institutional sociology, the health care sector and ABC

Market-based theories view organizations as sites for economic transacting (Scott, 1995, 2001; Baxter & Chua, 2003) and suggest that behavior is directed towards improving internal technical efficiency due to market pressures, thus emphasizing rational decision making. In contrast, institutional sociology emphasizes cultural, normative and cognitive factors and suggests that organizations need to appear legitimate, and that behavior may be directed more toward environmental acceptance than technical efficiency (op. cit.). While both of these pressures produce an *isomorphism* (a process which forces one member in a population to resemble other members which face the same set of environmental conditions or pressures (DiMaggio, 1988)), institutional sociology posits that organizations react and ultimately conform to institutional pressures in order to achieve legitimacy, institutional support and stability. This isomorphism can be either *competitive isomorphism* (e.g. Hannan & Freeman, 1977) or *institutional isomorphism* (DiMaggio & Powell, 1983), of which there are three core mechanisms: mimetic, normative and coercive forces. It should be noted that legitimacy (the focus of institutional sociology) is not necessarily gained at the expense of efficiency (the focus of market-based theories), and vice versa. The authors take the position that rational behavior aimed at improved efficiency and effectiveness can coexist with

² Instituto Nacional de Salud (INSALUD).

isomorphic behavior aimed at gaining legitimacy. Furthermore, increasingly in private and public organizations, legitimacy depends on being perceived as a ‘modern’ organization, demonstrating efficiency and rationality (Lapsley, 2001).

While institutional sociology has been studied in many settings, there is a general lack of studies focusing on the actual process of change as opposed to the result (Dacin et al., 2002; Scott 2001), particularly regarding this issue of resistance to change. Institutional sociology has been criticized for its lack of attention to the role of organizational self-interests and active agency in these responses (Covaleski & Dirsmith, 1988; DiMaggio, 1988). Likewise, institutional sociology emphasizes the survival value of conformity and generally fails to consider the advantages of non-compliance and the ability of the organization to maintain autonomy over decision making. In its focus on isomorphism, institutional sociology has deemphasized both the ability of organizations to defy external demands and the benefits of doing so (Oliver, 1991).

Institutional sociology - Management processes and hospitals

In the health care sector, there is a fundamental conflict of interest between physicians and management, resulting primarily from their different socialization experiences and resulting set of values. The medical profession is the dominant socialization agent for physicians (Derber & Schwartz, 1991; Lurie, 1981), with two important consequences. First, physicians are oriented towards effective clinical care for individual patients (Alexander et al., 1986); and secondly, the profession operates as the primary control mechanism (Mintzberg, 1979), due to the fact that physicians are “dominant professionals” who control the core clinical processes (Friedson, 1975). The management group is oriented towards efficient and effective use of economic resources for all patient groups, as well as the overall needs of the hospital (Alexander et al., 1986). This conflict in orientation is compounded by the fact that the core hospital processes depend on the expertise of the physicians, thus granting them a significant degree of autonomy (Barley & Tolbert, 1991; Derber & Schwartz, 1991; Zucker, 1991) and shielding them from formal bureaucratic controls (Mechanic, 1976). Consequently, physicians have a great deal of authority over hospital resources – their decision making commits up to 70-80% of hospital resources (Flood & Scott, 1987; Hillman et al., 1986) – but essentially no responsibility for the economic consequences of their decisions (Young & Saltman, 1985; Werner et al., 1987; Burns et al., 1993).

There are two major trends which have intensified this conflict. Physicians are increasingly becoming salaried employees of the hospital, as well as becoming integrated into the management structure as managers and board members (Abernathy & Stoelwinder, 1990). Secondly, the significant change in funding in the health care sector via the introduction of prospective payment schemes (PPSs) has transferred the economic risk of providing health care services from the funding entity to the hospital³. In response to these PPSs, hospitals are now seeking to develop sophisticated budgeting and costing systems (Comerford & Abernathy, 1999). These costing systems are based on product costing

³ PPSs reimburse the health care provider a predetermined amount for standard treatment critical path protocols of medical conditions. These treatments are classified as DRGs (diagnosis related groups) and the hospital case-mix is the mix of DRGs. The actual treatment received depends upon several factors, including the severity of the patient’s condition, etc., hence it must be noted that the DRG reflects an average standard cost and does not have a direct relationship to the costs incurred for a specific patient. DRGs have the effect of clustering patients and are the final level cost objects in a healthcare organization.

concepts which originated in the manufacturing sector and focus on accurately capturing resource consumption, thus allowing for a determination of the profitability of the various product lines (Chua & Degeling, 1991; Preston, 1992).

A number of studies have employed an institutional sociology framework to examine hospitals' responses to the pressures to adopt more sophisticated management planning and control tools (Abernathy & Chua, 1996). Despite the fact that several of these studies (op. cit.) sought to address the three fundamental criticisms of institutional sociology – that it neglects issues of power and interest; that it assumes that practices adopted to secure legitimacy are only symbolic and always decoupled from actual internal systems (Carruthers, 1995; Mouritsen, 1994; Chua, 1995); and that it provides only limited insight into institutionalism as a process as opposed to as an achieved state (DiMaggio, 1988) – there remains a lack of studies in management accounting literature exploring the resistance to institutional change.

Institutional sociology - Strategic responses to new public management in the Spanish health care sector

While organizational choice is possible within the context of environmental constraints, institutional sociology has tended to focus on the passive imitation of organizational structures, activities and routines in order to achieve stability and survival. A resource dependence perspective diverges and argues that organizational stability and survival are achieved via the exercise of power, control or negotiation of interdependencies. Strategic responses to environmental pressures can range from acquiescence to compromise, to avoidance, to defiance, and to manipulation, in order of increasingly active agency (Oliver, 1991).

Many organizations are often confronted with inconsistencies between institutional expectations and internal objectives; specifically in the health care sector, institutional expectations are based on New Public Management, while the internal objectives of physicians center on maintaining autonomy over decision making (Lapsley, 1997). In broad terms, the response of physicians will be either in the spirit of conforming through tactics such as pacifying and bargaining, or in the spirit of defiance, with tactics ranging from dismissal and manipulative control (Oliver, 1991).

It is useful to consider the scope conditions under which organizations are both willing and able to conform; an organization's willingness to conform is bounded by skepticism, political self-interest and control, whereas its ability to conform is bounded by its capacity, conflict and awareness (op. cit.). Responses to these pressures to conform will depend on the circumstances surrounding these pressures, e.g., why pressure is being exerted, by whom is it being exerted, what pressures are actually being exerted, how those pressures are being exerted, and in what environmental context they are being exerted. In the health care sector, the pressure is by the funding agencies to achieve economic efficiency. However, there is organizational skepticism about the legitimacy of this objective among clinically trained physicians, who see this objective in conflict with their clinical objectives of providing health care. This is compounded by the non-profit nature of the hospital (Lapsley, 1994) and the fact that physicians tend not to be subject to formal bureaucratic controls (Mechanic, 1976). And finally, compliance would generally be perceived by physicians as a loss of discretion and autonomy (Jones & Dewing, 1997; Doolin, 1999; Cosialls i Pardo, 2000; Kurunmaki et al., 2003). These argue for an unwillingness to conform to institutional

pressures, to which it should be added that the ability to conform may be limited by a lack of capacity due to an absence of managerial training on the part of physicians.

Organizations can be perceived as structures for accomplishing collective actions as well as repositories of corporate resources. As such they require two fundamental competencies – reliability and accountability – to obtain public legitimacy and social support. Reliability refers to the degree of variance of performance, and accountability refers to organizations accounting rationally for their actions. Reliability generally requires that organizations continually reproduce their structure, which is primarily accomplished through processes of institutionalization and the creation of highly structured routines (Hannan & Freeman, 1984). However, while institutionalism gives organizations the necessary taken-for-granted character, implying organizational purposes, it also tends to create structural inertia. The factors contributing to structural inertia can be both internal and external. Internal factors often include internal politics, which are likely to arise when different internal groups are pursuing different objectives, as is the case within hospitals.

ABC applications to hospitals

Studies of ABC applications (Hussey and Holford, 1993; King et al., 1994; Rotch, 1995; Urrutia, 2001) to hospitals have focused primarily on the technical considerations necessary for a successful implementation. Despite their technical orientation, several of their conclusions are related to the fundamental conflict of interest between physicians and management noted in the previous section and potential conflict regarding collaboration of the physicians in their role as clinical department directors. Hussey and Holford (1993) noted that there must be a significant change in the attitude of hospital administrators, who initially rejected the ABC model on the basis that the health care sector was fundamentally different from those sectors in which the ABC model had been implemented. King et al. (1994) found that, in the hospitals investigated, the clinical department directors did not believe that a more sophisticated treatment of costs was necessary and consequently were suspicious and not supportive of the implementation. These authors stressed the need to educate clinical department directors regarding the need for and benefits of the ABC model. This conclusion was supported by Urrutia's study (2001) of the Spanish health care sector.

Data collection was identified as another area of potential conflict. There must be recognition of the total dependence, regarding data collection, on the owners of the data (Hussey and Holford, 1993); physicians are the primary proprietors of data within the hospital and the implementation team must understand that they must negotiate with these proprietors, as opposed to making demands upon them, regarding both the quantity and method of data collection. The design of the ABC model necessitates the adaptation of a horizontal process view of the hospital, based upon the hospital's operating processes, which contrasts with the typical vertical view of the hospital organization, based upon specialized functional divisions or departments (op. cit.). Due to the technical complexities of health care work, the designer of the ABC model must rely on the physicians to capture the intricacies of the hospital's operating processes (King et al., 1994; Lapsley, 1996)⁴. Furthermore, in

⁴ Each DRG has an operating process which is comprised of the protocols for the related activities, tasks, and operations. The only way to understand the hospital operating processes is via the descriptions and specifications of these protocols. However, there is no common language regarding these protocols. The ABC model requires standardized protocols, but the lack of a common language contributes significantly to the inability to develop these standardized protocols, hence there is a vicious circle.

situations where there is a general policy of cost reduction, generating this information may cause problems in relations between hospital personnel and management, with the possibility that hospital personnel may suspect that, after implementation of the ABC model, management may use the model for objectives other than those originally identified, such as to analyze under-utilization of productive capacity (King et al., 1994).

Finally, several studies identified the need for information systems that were capable of capturing the different medical resources, which are utilized in every DRG, and that considered product diversification by including a classification of patients, i.e. a case-mix (Hussey and Holford, 1993; Rotch, 1995; Urrutia, 2001). A description of the traditional hospital cost system is provided in the Appendix.

The Spanish health care sector and the Alcorcón foundation hospital

Article 43 of the Spanish constitution of 1978 establishes the right to health care as a general right. In 1978, the *Instituto Nacional de la Salud* (INSALUD), a government agency under the Ministry of Health, was created to oversee the administration and management of Spanish health care services. INSALUD continued to exercise this role until 2002, when it lost its executive powers and became a support agency. In 1986, a law⁵ was enacted regarding the transfer of health service responsibilities and resources from the national agency, INSALUD, to Spain's 17 autonomous communities. This transfer began in 1981 with the autonomous communities of Catalonia, the Basque Country, Galicia, Canaries, Valencia, Navarra and Andalusia.

The politicians who govern the public health system have the greatest impact on INSALUD (Núñez Feijóo, 1998). The Popular Party (*Partido Popular; PP*) took over from the Socialist Spanish Workers Party (*Partido Socialista de Obreros Españolas PSOE*) in 1996 and installed a new management group in INSALUD, with a mandate to identify problems in the health care sector, quantify those problems, and identify possible solutions (Ley 15/1997; Núñez Feijóo, 2000). The management group found high levels of inefficiency, including de-capitalization and deterioration of hospital equipment, due to underinvestment in previous years, and a centralized bureaucratic organizational model, lacking management tools and with an overemphasis on controlling expenses rather than managing costs. Furthermore, there was a complete lack of valid measurement tools, combined with obsolete health care information systems. The health care infrastructure, in all the autonomous communities except Catalonia, the Basque Country, Galicia, Canaries, Valencia, Navarra and Andalusia⁶, was also de-capitalized as a result of an overemphasis on controlling expenses (Núñez Feijóo, 1998).

⁵ Redrafted text of the General Social Security Law, and in the third Transitory Provision of Act 14/1986, April 25, 1986.

⁶ In 1996, INSALUD was responsible for the health needs of 14 million people and had at its disposal an extraordinary amount of human and material resources, including 81 hospitals, with 37,133 beds; 95 specialty centers; 994 health centers; 1,083 primary care teams; and over 132,000 employees. Furthermore, the organization had another 108 subsidized centers, with 21,916 beds. INSALUD's total budget was approximately 1.5 billion pesetas (0.9 billion euros) and covered 10 autonomous communities, plus Ceuta and Melilla, in total covering 27 provinces (INSALUD Annual Report 1998).

The pretext that INSALUD would transfer hospitals to the autonomous communities in the short to medium term effectively excluded a long-term perspective. Along with the uncertainty regarding the transfers, the autonomous communities were not prepared, in terms of organizational structures, to receive and administer the hospitals; in other words, it would take time to develop the necessary infrastructure. This lack of a long-term focus resulted in a “residual” or “minimalist” management approach for an indefinite period of time; in effect, hospitals controlled only a few marginal aspects of the resources, as INSALUD continued to employ the personnel and own the infrastructure resources; and without a long-term perspective that was not going to change. This management approach resulted in a deterioration of health care services administration and a loss of motivation on the part of physicians, due to a lack of initiative and a clear set of objectives for the health system (Nuñez Feijóo, 1999). For these reasons, the management group implemented both structural and cultural changes in the organization, which led to the preparation of a general strategic plan, the first general planning document in the organization’s 20-year history (Nuñez Feijóo, 1998).

These reforms were not limited merely to improving the management of health care services, but also were directed toward setting new trends of organizational behavior that would promote strategic change within the organization; specifically, to consolidate the health care system and make it more flexible (González González, 2002). These desired changes were driven by the need to achieve a higher level of quality in the administration of health care services and also to facilitate the transfer of hospital management from INSALUD to the autonomous communities, which was concluded in 2002 (Uribe Ladrón de Cegama, 2002).

Concurrent with these reforms, as detailed in the INSALUD Strategic Plan (*Plan Estratégico del INSALUD*) (1997; 15), was the implementation of various actions designed to promote the involvement of physicians in the hospital management structure and increase the motivation of physicians to internalize this new managerial focus, which has been a common approach to the application of New Public Management to the health care sector (Abernathy & Stoelwinder, 1990). These actions were on the whole unsuccessful, due, among other things, to the physicians’ lack of managerial training, and usually resulted in the medical director becoming isolated from the clinical group (Repullo Labrador and Oteo Ochoa, 1999).

As described in the INSALUD Strategic Plan (1997), political responsibility for avoiding deficits in any fiscal year during the legislative term was enhanced in 1998 through the acquisition of resources from the “Financial Agreement of 01/98” (*acuerdo de financiación 98/01*), as well as through changes in the financing arrangements that allowed savings by a hospital to be subsequently reinvested in the hospital rather than having to be returned to INSALUD. This political responsibility for the economics of the system, combined with a no deficit policy, facilitated the development of new relations with the hospitals, culminating in the introduction of prospective payment schemes (PPSs), which transferred the economic risk of providing health care services from INSALUD to the hospital. In contrast to the prior method of financing, where hospitals were reimbursed for the costs incurred in providing health care services, now the hospitals had to negotiate prospective payments, which were essentially standard prices for treatments as defined by DRGs.

Public foundation hospitals

The Alcorcón foundation hospital was created by INSALUD on December 18, 1996 and effectively began operations in 1998 (Foundation Hospital Alcorcón, 2003). It began operations with an ABC system in place, although not operational until 2000 (Urrutia, 2001)⁷. It also began operations with a TQM program, thus facilitating the vertical process perspective necessary to configure an ABC system (op. cit.). The Alcorcón foundation hospital provides public health care services to a population of approximately 220,000 people and specializes in Allergology and Nephrology, serving approximately 400,000 people (Foundation Hospital Alcorcón, 2003).

An intensive case study (Urrutia, 2001) of the design of the ABC system in the Alcorcón foundation hospital, involving fifteen visits to the hospital over a one-year period, was initiated with a series of interviews with the CFO and Controller. The CFO had prior experience with ABC design and implementation when serving as CFO of the Ministry of the Treasury's currency printing factory (*Fábrica Nacional de Moneda y Timbre*), where an ABC system was implemented in 1996. Consequently, the CFO was familiar with the requirements for ABC implementation and also with potential problems identified in the literature regarding ABC applications to hospitals (Hussey and Holford, 1993; King et al., 1994; Rotch, 1995). Also due to his prior successful experience, he championed the idea of implementing ABC in the Alcorcón foundation hospital. We received documentation regarding the design of the ABC system, and the subsequent twelve visits to the hospital were to verify statements made by top management via observation and collaboration with medical personnel, e.g., comparison and confirmation that there were no differences of opinion regarding statements by top management and the medical personnel.

In considering the minimum requirements for a successful implementation, three areas of potential problems were addressed in the second interview with the CFO and Controller, which involved the implementation team, the design of the ABC model, and the model's operating environment (Urrutia, 2001). Regarding the design of the ABC system, top management had decided that the implementation team had to be multi-disciplinary and needed to understand the hospital operating processes. They had also considered it necessary that there be a proper classification of costs and patients, as well as a cost accumulation process that included the proper selection of cost drivers. Top management was aware of the absolute need for collaboration by the physicians. A subsequent visit to the hospital involved three interviews with physicians from three of the 18 medical areas (image diagnosis, gynecology and cardiology) with the objective of determining potential resistance on their part. No potential resistance was detected. Reports representing output from the information system were collected at that time.

The third interview with the CFO and Controller involved a discussion of their presumptions regarding positive collaboration by the physicians, our interviews with the sample of physicians, and the conclusion that their presumptions were well founded, and that there did not appear to be a problem of potential resistance on the part of the physicians. Having effectively discarded the internal sources of problems, the discussion then focused on existing problems resulting from interaction with external parties such as the tax authority and INSALUD, as well as with the consulting firm assisting in the design of the ABC system.

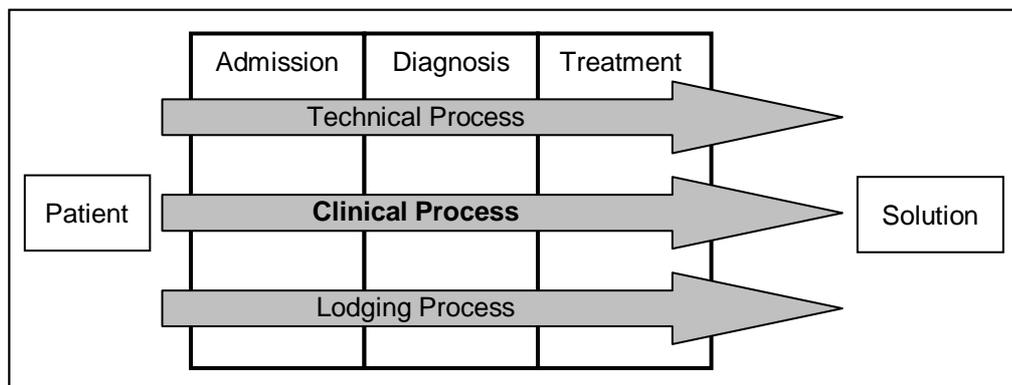
⁷ The ABC system was finalized in 2000. A costing system is not necessary to satisfy information requirements for interactions with the tax authority and INSALUD, hence the hospital could begin operations before the finalization of the ABC system.

Due to its legal status as a foundation hospital, several accounts were used that were not commonly used in the health care sector. The use of these accounts by the hospital had created confusion in dealing with both the tax authority and INSALUD and these issues were ultimately resolved. There were also some design-related difficulties due to the consulting firm, Cap Gemini's, incomplete understanding of the clinical processes, which led to several technical problems regarding the mapping of activities and documentation of the critical path protocols. These design issue were eventually resolved with the collaboration of the clinical personnel.

The objective of the subsequent visit to the hospital was to review the ABC system design documentation we had received from top management in the initial interview. The design of the system involved three stages: the cost classification stage, the process assignation stage, and the establishment of valuation criteria (full vs. direct costing, actual vs. normal costing, etc). In this visit we were also able to briefly interview the hospital director and verify that there were no differences of opinion between top management and the hospital director regarding the benefits of the ABC model.

The value chain of the clinical services that hospitals provide to patients is made up of three parallel processes and involves three business functions, as depicted below:

Figure 1. Hospital Value Chain



The clinical process is the core operating process, while the technical and lodging processes are support processes. In hospitals, patients are classified based upon diagnosis, i.e. what clinical process is necessary to treat the identified condition. These classifications are referred to as DRGs (diagnosis related groups) and the hospital case-mix is the mix of DRGs. A DRG is a classification of a standard treatment protocol or critical pathway for treating a particular medical condition. The DRG is determined by first identifying the pathology, and secondly identifying any complications within the pathology. Hence the DRG involves developing the expected sequence and timing of patient treatment processes and is intended to give the physician a concrete idea of the minimum cost procedure the average patient should receive to obtain effective treatment. The actual treatment received will depend upon several factors, including the severity of the patient's condition, etc., hence it must be noted that the DRG reflects an average standard cost and does not bear a direct relationship to the

costs actually incurred for any given patient. DRGs have the effect of clustering patients and are an intermediate-level cost object in a healthcare organization⁸.

The Alcorcón foundation hospital initially designed the ABC system to capture four clinical processes – hernia, childbirth delivery, orthopedic surgery, and cataracts; the model would subsequently be expanded to include more clinical processes. We reviewed the four clinical process descriptions as well the critical path protocol descriptions, which were codified as DRGs. Each clinical process contained several DRGs and we examined one DRG from each clinical process. The following is a partial illustration of the documentation for the clinical process for a hernia, of which there are three possible DRGs. The first four protocol stages are diagnostic and the fifth is a treatment stage.

Figure 2. Critical Process Description for Hernia

Stage of Protocol:	DRG types:	DRG Codes		
		300	315	320
Epidemiology				
Description and diagnostic problems				
Physical exploration				
Complementary tests				
Treatment program and follow-up				

The mapping of the clinical processes had been identified as a difficult problem by the CFO and Controller. This involved creating a hierarchy, using the clinical process, the business function process, the macro activity, and the task or micro activity. We reviewed the methodology employed to codify the different tasks and activities, and also the documentation. Costs were accumulated in cost pools at the task or micro activity level and coded at that level. These activities could then be rolled up into the next level – macro activities, which could then be rolled up to the next level – business function processes, which could then be rolled up into the DRG, as illustrated below.

Figure 3. Mapping of DRG 300 of the Clinical Process Hernia

	Clinical process: Hernia						DRG: 300		
Business function process	11 Admissions			12 Diagnostics			13 Treatment		
Activity (macro)	111	112	112	121	122	123	131	132	133
Task (micro activity)	1111	1121	1121	1211	1221	1231	1311	1321	1331
	1112	1122	1122	1212	1222	1232	1312	1322	1332

⁸ Managing a DRG environment is similar to managing a multi-product firm, where product-line management requires an accountability structure which assigns responsibility for “product lines” to those who control the production process (Comerford & Abernathy, 1999). Historically, hospital accounting systems have been designed and used primarily to report to external parties, e.g. government and other third party payers (see the Appendix for a description of traditional hospital cost accounting systems). There was little demand for the accounting system to serve as a management planning and control tool, as there were few incentives to control costs.

Regarding the routings in the critical path protocols, each physician generally had his own idea of what the route should be, which was a major concern expressed by the CFO and Controller. Consequently, a routing document was developed for each clinical process, which would generally involve several DRGs, and is illustrated below. We reviewed these documents, which served primarily as a point of reference for physicians, rather than as a control mechanism. Also note that the protocol and the DRG provide redundant information since they refer to the same thing.

Figure 4. Routing Document for the Clinical Process Hernia

Clinical process: Hernia		Protocol:		DRG:	
Cost Center:	Category:	Day:	Pre-hospital	Day 1	Day 2
External visits	Physician		1211		
Administrative	Secretaries		1111		
Hospitalization	Physician		1221	1221	
	Nursing		1231	1231	
Surgery	Physician		1311		
	Nursing		1321		

The ABC system provided reported costs for three objects – the tasks or micro activities, the DRGs and the patients. In concluding the review and evaluation of the ABC system, we reviewed the cost documents for these cost objects. The following is an illustration of the cost document for the intermediate products, i.e., the micro activities.

Figure 5. Micro Activity Cost Document

Cost Center	Medicine	Hospitalization	
Intermediate products	1211	1221	...
Costs:			
Materials			
Pharma products			
Sanitary ..			
Personnel			
Physicians			
Nursing			
Hospital Overhead			
External services			
Depreciation, ...			
Total			
Number of units			
Cost per unit			

The cost document for DRGs utilizes the codes established in the clinical process description documents, and is illustrated below.

Figure 6. DRG Cost Document

Clinical process:		Protocol No.:	DRG code:	
Operation name:		Operation code:		
Location within hospital:			Day:	
Cost center in which operation is performed:				
Resources Utilized:		Type	Quantity	Day
	Human			
	Technology			
	Materials			

The documentation for the final cost object in the ABC system is presented below.

Figure 7. Patient Cost Document

Patient data			
Clinical process:		DRG code:	Protocol No.:
	Admission	Diagnosis	Treatment
Administrative process			
Medical process			
Lodging process			
Technical process			
Cost per activity			
			Cost per patient

The design and development of the Alcorcón foundation hospital incorporated an ABC system, as this was perceived by the CFO and Controller to be the optimal cost measurement system. As the CFO pointed out in the first interview, the government in power intended the Alcorcón foundation hospital to serve as a model for existing and future hospitals. The Alcorcón hospital has been ranked as one of the top four general hospitals in three out of the past four years by the Iasist association, the Spanish affiliate of Solucient International⁹. The CFO's prior experience with ABC design and implementation issues, not least of which was the absolute necessity of collaboration on the part of the clinical personnel, was fundamental to the ultimately successful implementation at the Alcorcón foundation hospital.

Discussion

Responding to the expectations and expressed preferences of both citizens and physicians, INSALUD began a modernization process, which included the creation of public

⁹ Solucient International is the organizing company for the Top 100 Hospitals in the United States. Iasist has organized a similar benchmarking of top hospitals in Spain. For further information on the ranking results, see <http://www.diariomedico.com/grandeshist/top202004.pdf>

foundation hospitals¹⁰. The creation of self-managed public foundation hospitals, combined with the steps taken to progressively introduce a management culture in traditional hospitals, was directed towards creating a profound change that would facilitate and promote the search for new progressive forms of management, seeking to create effective clinical practice with an efficient utilization of resources (Ferrándiz Manjavacas, 1999).

One of the main premises underlying the search for new efficient and effective management models was the free enterprise model, emphasizing the competitive (albeit non-profit) organization as opposed to the bureaucratic organization. Hence it was essential that these centers operate as separate legal entities, independent of the health institutions on which they are dependent. That way, these centers will be submitted to a juridical system with less administrative bureaucracy without losing their public entity nature, i.e. the mission of providing health care services (Martín Martín & Maneul-Keenoy, 1998). The relationship between the public foundation hospitals and INSALUD (and the Health Ministry) at the time of the creation of the first public foundation hospitals can be described as follows. INSALUD was both the owner and financing entity of the public foundation hospitals, as was the case with all hospitals in Spain until the transfer mandated in 1986 was completed in 2002, at which time the autonomous communities took over the role of owner and financing entity. However, whereas traditional hospital employees are civil servants, employed by the Health Ministry, and operate under contracts subject to administrative law, which governs all transactions involving government agencies, including employment conditions, the employees of public foundation hospitals are employees of the hospital itself and operate under contracts subject to labor law. This difference in employment agreements gives foundation hospitals the ability, among other things, to utilize different incentive programs. These new public foundation hospitals were designed from the beginning to offer state-of-the-art medical facilities, combined with a contemporary managerial culture, in a bid to attract the best physicians from traditional hospitals (Núñez Feijóo, 1999). Hence, those physicians who were critical of the inert bureaucratic nature of traditional hospitals were free to migrate to the better equipped and better managed public foundation hospitals, but in doing so would forfeit their civil service status.

Furthermore, according to the terms of the financial agreement of 1998, the public foundation hospitals could retain any favorable budget surplus, which could be invested in improvements, new installations etc., a situation significantly different from traditional hospitals, in which positive budget surpluses were remitted to INSALUD. In contrast to this new system, the traditional public health care organizations lack spending autonomy and so have serious difficulty introducing incentive systems designed to create a more competitive organization focused on achieving better results.

The fundamental conflict of interest between physicians and management, resulting primarily from their different socialization experiences (Derber & Schwartz, 1991; Lurie, 1981) and resultant value sets, is compounded by the hyper-bureaucratic nature of the Spanish health care sector, where physicians are civil servants employed by the state rather than the hospital itself. The design and implementation of an ABC system absolutely requires cooperation and input from the physicians (Hussey and Holford, 1993; King et al., 1994), who as “dominant professionals” both know and control the core clinical processes (Friedson, 1975). However, these physicians have viewed the attempt to introduce more

¹⁰ Ley 15/1997. This law established the creation of the new public foundation hospitals. Two foundation hospitals were created, Alcorcón Foundation Hospital in Madrid and Manacor Foundation Hospital in Palma, Majorca.

sophisticated costing systems such as ABC as effectively leading to a loss of their autonomy and so have been unwilling to give in to these institutional pressures.

When faced with this resistance, it could be argued that the Spanish government opted for a strategy of creating new hospitals with a managerial culture rather than trying to change the culture of the traditional hospitals, which are taken-for-granted institutions (Ruef & Scott, 1998); successful operation of these new hospitals would serve as a model for both existing and future hospitals. Rather than attempting to explain this emerging organizational diversity via adaptation theories, we suggest utilizing population ecology theory, which challenges the adaptation view and argues that observed changes in organizations reflect changes in the population, in which new organizations emerge to replace highly inert organizations, as opposed to changes in organizations due to adaptive behavior (Hannan & Freeman, 1984). There are two significant aspects to population ecology which should be emphasized. The first raises the fundamental question of whether observed diversity is due to adaptation or to selection and replacement. The second is that population ecology takes the population as its unit of measure, as opposed to the individual organization.

Population ecology argues that the selection processes tend to favor organizations with high levels of structural inertia, such as traditional Spanish hospitals.

“...for wide classes of organizations there are very strong inertial pressures on structure arising from both internal arrangements (for example, internal politics) and the environment (for example, public legitimatization of organizational activity). To claim otherwise is to ignore the most obvious feature of organizational life” (Hannan & Freeman, 1977: p. 957).

The creation of new organizations designed specifically to take advantage of some new set of opportunities is one of the most important kinds of threats to existing organizations (Hannan & Freeman, 1984) and may be seen as a rational response from the Spanish government to the resistance of physicians to conform to New Public Management pressures.

Conclusion

The health care sector has been under pressure to reform the management of health care services due, among other things, to the transformation from a fee-for-service model to a system of prospective payments. Effectively, this has transferred the economic risk of providing health care services from the funding entity to the hospital. It has become imperative that hospitals have both prospective and retrospective reviews of high volume clinical procedures in order to assess resource utilization and for contracting with payors, thus favoring the introduction of improved costing systems such as ABC.

Organizational theories such as institutional sociology suggest that the observed diversity amongst organizations is due to adaptation, specifically that organizations have an isomorphic response to environmental pressures in order to ensure their legitimacy and survival (Covaleski & Dirsmith, 1988). This would suggest that hospitals conform to pressures to implement a managerial culture by implementing improved costing systems such as ABC. However, the institutional sociology literature has been criticized for a lack of studies focusing on the actual process of change as opposed to the result (op. cit.; DiMaggio, 1988). For instance, it has overlooked the advantages of non-compliance by political players,

amongst other things in an attempt to maintain autonomy over decision making (Oliver, 1991; Scott, 2001).

The relationship between physicians and hospital managers is highly conflict-laden, due mainly to the different socialization experiences and value sets of the two groups (Derber & Schwartz, 1991; Lurie, 1981). Physicians are “dominant professionals” who control the core clinical processes (Friedson, 1975) and whose decisions commit up to 70-80% of hospital resources (Flood & Scott, 1978; Hillman et al., 1987), yet have essentially no responsibility for the economic consequences of their decisions (Young & Saltman, 1985; Weiner et al., 1987; Burns et al., 1993). The inconsistencies between the institutional expectations shared by management and the internal clinical objectives of the physicians, combined with the skepticism of physicians regarding the legitimacy of the institutional objectives, suggest the high probability that physicians will adopt a strategic response of non-compliance. This probability is augmented by the general absence of managerial training and education among physicians.

In investigating the implementation of ABC systems in Spanish hospitals, we found only one successful case, the Alcorcón hospital, a new foundation hospital (Urrutia, 2001). Given the hyper-bureaucratic nature of the Spanish health care sector and the resistance by state-employed physicians to conform to pressures to improve costing systems, it could be argued that the Spanish government, rather than trying to change the culture of traditional hospitals, opted to create new foundation hospitals imbued with a managerial culture. Rather than view the emergence of these new hospitals as an adaptive response to institutional pressures, it can be viewed per population ecology theory (Hannan & Freeman, 1984) as the emergence of new more efficient organizations that, eventually, will supplant the highly inert traditional hospitals within the Spanish health care provider population.

Successful design, implementation and subsequent operation of an ABC system in a hospital absolutely necessitates the full collaboration of the clinical personnel. As evidenced in the case of the Alcorcón foundation hospital, the consulting group encountered difficulty modeling the clinical processes due to their incomplete understanding of these processes, thus supporting King et al.’s (1994) argument that the collaboration of the physicians was absolutely vital for the design of the ABC model. These activity mapping issues were successfully resolved with the full collaboration of the physicians, thus allowing the ABC project to proceed to successful implementation.

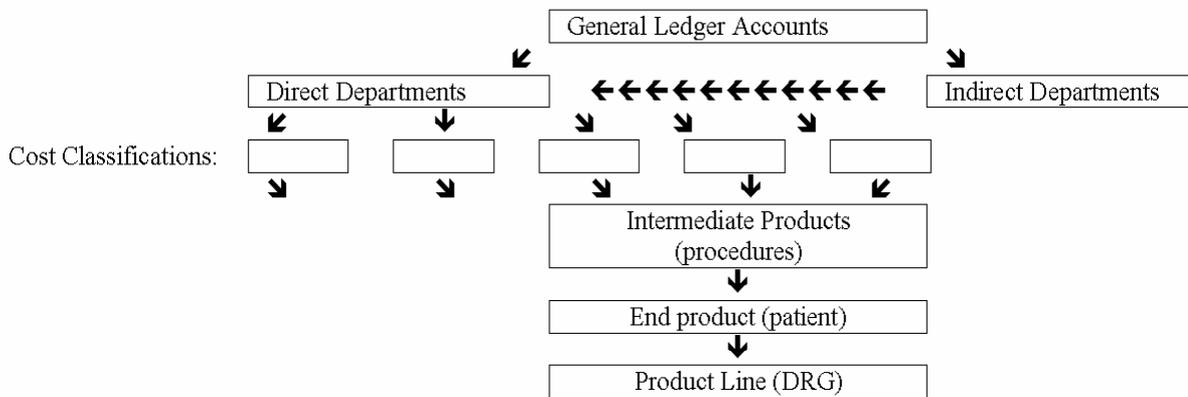
This paper contributes to the institutional sociology literature by addressing one of its primary criticisms: that it is static and deterministic (Dacin et al., 2002; Scott, 2001). It does that by exploring the institutional factors in the Spanish health care sector in an attempt to provide insights into the internal political conflict between physicians and hospital management and the predicted strategic responses of hospitals, as well as the subsequent response by the Spanish government. This paper also expands on the previous literature by examining implementation in a significantly different setting than previous studies – a Latin as opposed to Anglo-American environment – and by focusing on costing systems as opposed to control systems, the primary focus of previous studies.

As with most empirical research, including case studies, there are potential limitations. The case study was limited to one hospital in the Spanish health care sector, hence limiting the ability to generalize conclusions and suggesting that further research needs to examine other hospitals. A second potential limitation in the reference to population

ecology theory is the use of the hospital as the unit of measure as opposed to the population. This again argues for further research examining other hospitals.

Appendix

The traditional cost system for hospitals works in the following manner. Costs are accumulated in departments, which are designed as either direct or indirect. A direct department is revenue producing; i.e., it creates services and procedures that can be traced to a specific patient. Indirect departments are non-revenue producing and all costs are fixed. All indirect department costs are allocated to the direct departments using the step-down method. Then all direct department costs (variable and fixed) are assigned to a number of different intermediate products (stand-alone medical services and procedures) based on a ratio-of-costs-to-charges (RCC) or a Relative Value Unit (RVU) approach, both of which indicate the relative amount of resources used by that intermediate product. The RCC is a *top-down approach* which focuses on aggregate information and makes broad assumptions that may not reflect the actual costs of a particular procedure. The RVU is a *bottom-up approach* which focuses on the actual costs of a procedure. The summation of RVUs for a department is 1. The RVU approach allows costs to be captured without having to actually measure every single operation (activity) performed to complete the procedure. Hence the total cost of an intermediate product is determined by multiplying this ratio by total cost of the department. The actual unit cost of the intermediate product is then determined by dividing the total cost of the intermediate product by the actual volume of the intermediate product. Later, the cost per patient is determined by accumulating the per unit intermediate product costs attributable to the patient. This is graphically depicted below:



There are two fundamental problems with this approach. The first is the origin of the RVUs. This is especially a problem in Spain, since these amounts are obtained by simply using RVU amounts published by the Health Care Financing Administration (HCFA); amounts which are developed in U.S. hospitals. The second problem is that the per unit intermediate cost is determined by using actual volume and not some measure of capacity.

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