Universidade do Minho
Escola de Economia e Gestão

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The Balanced Scorecard and Bureaucracy in the Hospital Environment: A Portuguese Case Study

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Tese de Doutoramento
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e do
Professor Doutor Russell Craig

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Finally, I dedicate this thesis to my lovely kids, Tiago and Sofia, never forget that you were always on my mind and in my heart.

Statement of integrity

I hereby declare having conducted this academic work with integrity. I confirm that I have not used plagiarism or any form of undue use of information or falsification of results along the process leading to its elaboration.

I further declare that I have fully acknowledged the Code of Ethical Conduct of the University of Minho.

The Balanced Scorecard and Bureaucracy in the Hospital environment: A Portuguese Case Study

This thesis analyses the link between Management Accounting (MA) and bureaucracy. The connection between them has not yet been analysed in previous studies. The main purpose of the thesis is to demystify bureaucracy, and to verify and understand its actual presence in organizations that are managed according to a contemporary MA tool, the Balanced Scorecard (BSC).

The thesis is organized in four essays. The first essay presents a literature review that addresses the relationship between MA and bureaucracy. The essay concludes that developments in understanding bureaucracy are reflected in the evolution of MA tools and in the theoretical questioning of MA. The second essay presents the concept of neo-bureaucracy and highlights nine features that identify a contemporary bureaucratic order. The essay finds that the BSC is comprised of these nine features and that it adopts a neo-bureaucratic approach. The third essay reviews studies of the bureaucratic features of the operation of the BSC in hospitals and health care facilities. The essay also presents a qualitative case study of a Portuguese Local Health Unit (LHU) of a Public Sector Enterprise Health Care (PSEH) that implemented the BSC, evidencing full bureaucratic features. The fourth essay uses the metatheory of Thornton, Ocasio, and Lounsbury (2012), the Institutional Logic Perspective, to explain how the Portuguese PSEH context conducted to a neo-bureaucracy logic in its management. In this essay, three logics are identified: those of the state, the community and the profession, with the former logic dominant. Bureaucracy is still very present and valued in the PSEH, despite common prejudices against it.

This thesis contributes to a better understanding of bureaucracy by stressing its relationship with the development of MA. The thesis proposes that the BSC be interpreted as a neo-bureaucratic device; and that institutional logic metatheory is a valid way to explain the Portuguese PSEH context and the persistence of bureaucracy therein. This thesis helps to develop a more mature understanding of bureaucracy. The implication for managers is that instead of confronting bureaucratic practices, they should accept bureaucracy as a form of collaborative, flexible and enabling management.

Keywords: Balanced Scorecard, Bureaucracy, Health Care, Management Accounting.

O Balanced Scorecard e a Burocracia no Meio Hospitalar:

Estudo de Caso em Portugal

Esta tese discute a ligação entre a Contabilidade de Gestão (MA) e a burocracia. Esta ligação nunca foi analisada em estudos anteriores. O principal objetivo é desmistificar a burocracia, verificar e compreender a sua real presença em organizações geridas por uma ferramenta contemporânea, o Balanced Scorecard (BSC).

A tese está organizada em quatro ensaios. O primeiro ensaio apresenta uma revisão de literatura que aborda a relação entre a MA e a burocracia. O ensaio concluí que desenvolvimentos no entendimento da burocracia estão refletidos na evolução de ferramentas da MA e nas teorias que a questionam. O segundo ensaio apresenta o conceito de neo-burocracia e nove características que identificam uma ordem burocrática contemporânea. O ensaio verifica que o BSC encapsula estas nove características e que adota numa abordagem neo-burocrática. O terceiro ensaio revê estudos sobre as características burocráticas na implementação do BSC em hospitais e cuidados de saúde. O ensaio também apresenta um estudo de caso de uma Unidade Local de Saúde Portuguesa (LHU), pertencente ao Sector de Saúde Empresarial do Estado (PSEH), que implementou o BSC, evidenciando todas as características burocráticas. O quarto ensaio recorre à meta teoria de Thornton, Ocasio, and Lounsbury (2012), a Perspetiva da Lógica Institucional (ILP), para explicar como o contexto Português do PSEH conduziu a uma lógica neo-burocrática de gestão. Neste ensaio foram identificadas três lógicas: estado, comunidade e profissão; com a primeira lógica dominante. A burocracia continua muito presente e valorizada no contexto do PSEH, apesar dos seus preconceitos comuns.

Esta tese contribui para uma melhor compreensão da burocracia através da sua relação com a MA. Esta tese propõe que o BSC seja interpretado como ferramenta neo-burocrática e que a meta teoria da lógica institucional é uma forma válida para explicar o contexto Português do PSEH e a persistência da burocracia. Esta tese contribui para uma visão mais madura da burocracia. A implicação para os gestores é que em vez de confrontarem práticas burocráticas devem aceitar a burocracia como forma de gestão colaborativa, flexível e capacitadora.

Palavras-chave: Balanced Scorecard, Burocracia, Contabilidade de Gestão, Saúde.

Contents

List of Abbreviations

ABC	Activity-Based Costing
ABM	Activity Based Management
ACSS	Administração Central do Sistema de Saúde
APAH	Associação Portuguesa de Administradores Hospitalares
BI	Business Intelligence
BSC	Balanced Scorecard
CCM	Centro de Controlo e Monitorização
CCP	Código de Contratação Pública
DGS	Direção-Geral de Saúde
EGP	Estatuto do Gestor Público
FNAM	Federação Nacional dos Médicos
GDP	Gross Domestic Product
IFAC	International Federation of Accountants
ILP	Institutional Logic Perspective
INFARMED	Autoridade Nacional do Medicamento e Produtos de Saúde, I.P.
IT	Information Technology
LHU	Local Health Unit
MA	Management Accounting
MAS	Management Accounting Systems
NHS	National Health Service
NIS	New Institutional Sociology
NIT	New Institutional Theory
NPM	New Public Management
PSEH	Public Sector Enterprise Health Care
RHA	Regional Health Administration
ROI	Return on Investment
SEMA	Secretaria de Estado para a Modernização Administrativa
SIADAP	Sistema Integrado de Avaliação do Desempenho para a Administração Pública

SMA	Strategic Management Accounting
SPMS	Serviços Partilhados do Sistema de Saúde
TQM	Total Quality Management

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Introduction

Introduction

Context and Motivation

Despite the traditional demeaning of bureaucracy, it remains in contemporary society (Du Gay, 2005), showing a discrepancy between the contempt of bureaucracy and its declared presence in many domains (Styhre, 2007). The importance of bureaucracy has risen in social and managerial studies (Styhre, 2007), namely by discussing the value of terms like neo-bureaucracy (Hales, 2002) and post-bureaucracy (Heckscher & Donnellon, 1994). The concept has evolved from the originally expressed by Max Weber (1922) to the one of neo-bureaucracy (Farrell & Morris, 2003). Initiated in the 1990s, the New Public Management politics intended to diminish the bureaucratic constraints of public administration (Meyer et al., 2014) and started an ongoing debate about the presence, value and future of bureaucracy in the public sector (Kettl, 2000). The Portuguese context of the public sector health care system is under the constant managerial and political transformation (Rego et al., 2010). Therefore, this context is rich ground to investigate the reasons and the ways for the persistence of bureaucracy.

If we understand bureaucracy as a management method and Management Accounting (MA) as a support to management, both concepts should be related. This thesis aims at bringing together concepts that are set apart in literature, but whose related understanding could improve the comprehension of its historical developments. The study of the different understandings of bureaucracy along its history, as well as the polemics about its present and future, can have in the study of MA an original way to be addressed. This approach also conduces to a view of MA that underscores its instrumentality to a bureaucratic logic of management, beyond the questions of the deliverance of good information to the management. Driven by this relation, this thesis investigates the value and relevance of bureaucracy for its tacit presence in a contemporary management accounting tool (the Balanced Scorecard (BSC)) implemented in a Local Health Unit (LHU) belonging to the Public Sector Enterprise Health Care (PSEH). To support this investigation, the literature review develops an argument about the pertinence of the neo-bureaucracy concept and advances a scheme for interpreting BSC according to bureaucratic features. Furthermore, it is developed an overall institutional explanation for the presence of neo-bureaucracy in the management of the Portuguese PSEH, using the Institutional Logic Perspective (ILP) of Thornton et al., (2012).

Purpose and Research Questions

The first essay consists of a literature review with the purpose to relate the understanding of bureaucracy and the MA. The research question explores whether the current perception of bureaucracy (whether it is positive or critical) is reflected in developments in MA.

Also based on a literature review, the purpose of the second essay is to define the concept of neo-bureaucracy and to present its contemporary pertinence. As a development of Weber's work, the essay establishes the set of nine features that define a bureaucratic order. The main research question explores the extent to which these bureaucratic features are present in the process of design and implementation of the BSC.

The third essay has two main objectives: to analyse the presence of the bureaucratic features in published studies on BSC in health care settings; and to develop a case study in a Local Health Unit (LHU) that implemented the BSC. The purpose is to evaluate empirically if the BSC in the LHU presents the set of features defining bureaucracy. The research question is: how the set of the nine defining features of bureaucracy were present in the BSC to manage the LHU?

The final essay seeks a theoretical explanation for the presence of the bureaucratic logic in the Portuguese PSEH, based on the ILP. It addresses the logics and relations between the relevant institutional orders in this context, to explain the resulting neo-bureaucratic logic. The essay aims to understand: the most relevant orders in the socio-cultural context of PSEH management; how are the institutional logics of these orders characterized in terms of bureaucracy; and if there is any dominant institutional logic.

Methodology

We support the two first essays in the literature review on bureaucracy and MA. In the first one, we have reviewed the literature on the features of each concept, as well as historical studies about their developments. According to delimited historical periods, the literature review of each concept was compared in search of the relationship between the understanding of bureaucracy and the development of MA. Exploring the work of Weber (1922) and more recent literature on bureaucracy (particularly Styhre, 2007), in the second essay a summarized conceptual matrix relating bureaucratic features and BSC was constructed.

The third essay begins with a literature review reporting the use of the BSC in hospitals and health care. The terms 'BSC and hospitals' and 'BSC and health' were searched on the website of *B-on* and this information was filtered from 124 papers. We start by highlighting the presence of bureaucratic features in previous studies. The nine bureaucratic features were searched in these papers, using the exact terms or synonyms or related terms that might point to the same characteristics. This essay also presents a qualitative case study. It was used an interpretative approach to collect data, which involved document analysis and interviews of key employees. Nine staff members were interviewed, selected on the grounds of their area of responsibility and rank in the hospital's management: a member of the board, the manager of the contracting office, the manager of the planning and control office, two service managers from the care support area, and four department managers from the hospital. The interviews were triangulated with several of the LHU's internal documents such as Annual Reports and Accounts; Annual Reports Internal Audit Service Activities; Code of Ethical Conduct; Internal Control Reports; Internal Regulation; Objectives, Indicators and Target Maps; Plan of Activities and Budgets; Program Contracts; Internal Communication of Irregularities Regulation; Reports on Corporate Governance; Sustainability Reports; Strategic Maps and Strategic Axes.

The fourth essay applies the ILP of Thornton et al. (2012) to the Portuguese PSEH. The essay uses as data the legislation on health care and public hospitals, managerial and sociological published papers, press articles and government documents on health care. The context of management in the Portuguese PSEH is studied. Firstly, we identify the relevant institutional orders in this context. The objective is to understand their relevance and to understand the presence of a bureaucratic logic in the management of a Portuguese PSHE. Each order is analysed according to categories related to bureaucracy - authority, control, procedural rules, and accountability.

Expected Contributions

The first essay draws attention to a fundamental link between bureaucracy and MA, a link that justifies the study of MA as a pertinent way of considering the presence of bureaucracy, and the MA as a fundamental instrument to a virtuous bureaucracy. It is expected to understand how the study of the features of MA tools is relevant for the study of bureaucracy.

In the second essay, that link is studied more closely, particularly in terms of a contemporary MA tool, the BSC. A new analytical perspective of the BSC as a bureaucratic tool is pointed out, putting forward a set of nine defining features of bureaucracy today (*systematization, rationality, authority, jurisdiction, professional qualification, knowledge, discipline, transparency,* and *accountability*), which will be helpful to future works on the subject.

In the third essay, two contributions are expected: firstly, a literature review of past studies on BSC in health care settings aims to highlight the presence of bureaucratic features in previous studies. Secondly, the scheme advanced in the second essay is applied in a case study of a Portuguese LHU belonging to the PSEH.

The last essay applies the ILP to the Portuguese context of PSEH contributing to understanding the institutional context that justifies the presence of neo-bureaucracy in management. It identifies three institutional logics (state, community, and profession) that establish the PSEH institutional logic. It is expected that this study will be useful to other similar studies in several Portuguese contexts aiming to identify the institutional logics and to better understand the behavioural reasons. Given the scarce use of ILP, this study contributes to the profusion of this metatheory in health care and management studies.

Along this work, we present reasons that will help to understand the value of bureaucracy and its contemporary presence as neo-bureaucracy, namely in the public sector health care system. We also expect to put forward the awareness of MA as instrumentally fundamental to the good bureaucracy.

Structure

The first essay investigates the relationship between bureaucracy and MA. In the literature about both concepts, touching points were found. The MA history was divided into four periods: classical (1700-1950), modern (1951-1980), post-modern (1981-1990) and contemporary (1991 onwards). We will try to understand, in each period, if the current understanding of bureaucracy is reflected in the developments of MA. We will aim at establishing a link between both concepts.

In the second essay, we will present the concept of neo-bureaucracy, applying it to the BSC. Following Weber's work on bureaucracy (1922) and its development by Styhre (2007), we will highlight a set of nine features to characterize a contemporary bureaucratic order. Analysing the BSC's formulation by Kaplan and Norton (1996), we will then apply these concepts to develop a theoretical understanding of the BSC as a neo-bureaucratic tool.

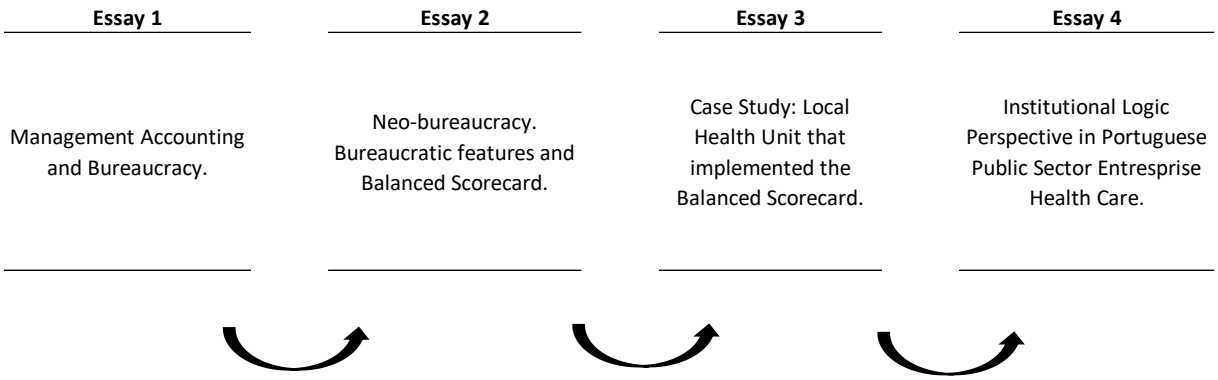
The third essay will start with an introductory review of published works about the BSC in health care, looking for the presence of the bureaucratic features defined in the second essay. Afterwards, we will proceed with a case study that methodologically investigates the presence of the set of bureaucratic features in the LHU after the implementation of the BSC, from 2015 to 2018. We will contend that the BSC in this LHU presents those features.

Finally, the fourth essay will bring a theoretical explanation for the bureaucracy in the Portuguese PSEH (as the LHU studied in the previous essay), that develops under a neo-bureaucratic logic. The essay will start with a brief evolution of the PSEH, and then analyses its bureaucratic context. Using the ILP, the essay explains how the bureaucratic logic in PSEH is a consequence of the dominance of the bureaucratic state logic, that interacts with community and profession logics.

The next figure will summarize the structure of the thesis:

Figure 1

Scheme of the thesis



Essay 1 – Understandings on Bureaucracy and Related Management Accounting Developments – A Research Note[1]

[1] An earlier version of this essay was presented at the *XXVIII Jornadas Luso Espanholas de Gestão Científica*, Guarda, Portugal, 2018, titled: *Contabilidade de Gestão e Burocracia – Relações Históricas e Contemporâneas*; and at *XVIIIth International Conference of the Accounting Teachers and Researchers Association of Spain (ASECUP)*, Madrid, Spain, 2018, titled *Contemporary Bureaucracy Thought in Management Accounting*.

Understandings on Bureaucracy and Related Management Accounting Developments - A Research Note

Abstract

There is historical evidence of the existence of bureaucracy and Management Accounting (MA) since ancient civilizations. Both concepts (bureaucracy and MA) have formal and historical correspondences. This paper consists of a literature review and follows a historical evolution of MA in four periods: classical, modern, post-modern and contemporary. In each period, the aim is to link the evolving understandings on bureaucracy to changes in MA. We found evidence that developments in the understanding of bureaucracy, as part of the evolution of the social context, are reflected in the practice and thinking of MA. In the classical period, the revival of MA corresponds to a prevailing positive understanding of bureaucracy. In the modern period, theoretical elaborations of MA assimilated the post-bureaucracy posture. In the post-modern period, changes in MA practice accompanied anti-bureaucratic criticism. In the contemporary period, management accounting practices enhance bureaucratic order. The study of the MA can be a way to achieve a fair understanding of the presence of bureaucracy.

Keywords: Bureaucracy, History, Management Accounting.

1. Introduction

Although bureaucracy is a symbol of modernity (Kallinikos, 2004), there is evidence that bureaucracy has existed for thousands of years (De Landa, 2000). Bureaucracy is evident from about 3000 B.C. in ancient Egypt (which grounded its power and work capacity in an ingenious bureaucratic constitution). It is also evident in the 1100 B.C. Chinese empire (with its protocols and formalisms); and in the Prussian government in the first quarter of the eighteenth century (the first great example of modern administrative machinery) (Von Mises, 1944; Garston, 1993 and Crooks & Parsons, 2016). Similarly, management accounting (MA) is widely regarded to have existed in Sumerian, ancient Egypt and ancient China (Ovunda, 2015; Alexander, 2002). Therefore, there is historical evidence of the coexistence of MA and bureaucracy in the administrative mechanisms of ancient China and Egypt. Besides, looking at the current time, MA calls upon tools that embody neo-bureaucracy. This includes soft bureaucracy, where procedures are used to support rather than control (Kärreman & Alvesson, 2004), and learning bureaucracy, where learning-oriented characteristics of the organization's "formal" systems are combined with the distinctive characteristics of its "informal" systems (Adler, 1992).

This essay is a literature review that investigates the relationship between the evolving understanding of bureaucracy and developments in MA in four periods of MA history. It is studied how, in each period, the prevailing views on bureaucracy is reflected in the developments of MA. More than the real presence of bureaucracy, the aim is to understand if the fact that the bureaucracy is praised or criticized has consequences on MA. This investigation is in line with the critical accounting historians that analyse the relationship between accounting and society to understand how accounting developed in practice (Miller et al., 1991).

As opposed to financial accounting, which provides economic information from the perspective of external users, MA focuses mainly on the needs of internal managers of an organisation (Hopper et al., 2007). MA consists of a set of procedures to provide management with the information to support the decision process, measuring the employee's performance and the efficiency of the organization. Bureaucracy is regarded to be an organizational method centred on the formal rigor of rational rule in which the key guiding principles are reason, control, and formalism. Bureaucracy is linked so closely to MA that the way bureaucracy is understood always has reflections in MA. If this argument holds, as the understanding of bureaucracy evolves the MA somehow changes. Thus, according to the main periods of MA history, the developments in MA are related to the prevailing views on bureaucracy. Four main periods are proposed in MA history, based on previous works of the International Federation of Accountants (IFAC)

(Abdel-Kader & Luther, 2006), Kamal (2015) and Ovunda (2015): classical (1700-1950), modern (1951-1980), post-modern (1981-1990) and contemporary (1991- current time). In the classical period, the revival of MA corresponds to a prevailing positive understanding of bureaucracy, as epitomized in Taylorism. In the modern period, theoretical elaborations of MA assimilated the rise of post-bureaucracy posture that criticized bureaucracy. In the 1980s, changes in MA practice accompanied anti-bureaucratic criticism, particularly concerned with the workforce management. Contemporary management practices enhance bureaucratic order (Salaman, 2005) as bureaucratic rules and procedures are now rehabilitated to be an answer to contemporary challenges (Callon, 2002).

To the best of the author's knowledge, a study of the type presented here has not been reported in the MA or accounting history literature. The pertinence of the present study arises from drawing attention to the relationship between both bureaucracy and MA, mainly how bureaucracy, as part of the social context, influences MA. The exposed relation suggests that an innovative and better way to understand the real presence of bureaucracy in an organization emerges from studying its MA system. On another level, it suggests that the study of bureaucracy understandings is important to contextualize MA developments.

This essay is structured in five sections. In the following section, a historical review of MA is presented according to four identified periods. Thereafter, the research method is presented. In the fourth section, after an introductory discussion of the relationship between both concepts, the understanding of bureaucracy is related to the developments of MA in each period identified. Thereafter, conclusions, limitations, and suggestions for further research are offered.

2. A Brief Perspective of Management Accounting History

2.1. Classical period of management accounting (1700-1950)

Before the Industrial Revolution (about 1760 onwards), there were already examples of sophisticated MA practices (such as a cost and accounting systems integration in a Silk Factory company, in Portugal, in 1745 (Carvalho et al., 2007)). However, the Industrial Revolution prompted such an economic and social breakdown, related to mass production and the development of large corporations, that forcibly changed MA (Johnson & Kaplan, 1987a). A new form of management led to the emergence of a new category of employees – managers (Chandler, 1977) - who, for the performance of their duties, required information provided by MA. Many MA innovations appeared: a Scottish foundry allocated overhead costs among several departments in 1759 (Fleischman & Parker, 1990). In the early nineteenth century, the direct labour and overhead costs of produced goods were calculated (Chandler, 1977). Techniques were developed in the late nineteenth and early twentieth century to analyse productivity and contributions to profits (Kamal, 2015) and to evaluate the performance of subordinate managers (Johnson & Kaplan, 1987a). In 1850, the American company Lyman Mills defined the criteria for cost allocation (Johnson, 1972).

The last quarter of the nineteenth century stands out for accounting innovations, namely because of the development of large corporations (Chandler, 1977). In the late nineteenth century, Taylor adopted an approach, known as Scientific Management (Taylor, 1911), that purposed to optimize mass production through the partition of work into simple tasks. These standardized tasks were easily perceived by the worker and controlled by a central office that conducted constant performance analyses, searched for variances, and provided payment for individual performance (Cooper, 2000). In 1887, one of the first books on cost accounting, written by Emile Garcke & John Manger Fells, elaborated on the concept of marginal cost (Parker, 1969). In 1889, Von Wiser explored the concept of opportunity cost in the paper "On the relation of cost to value".

In the early twentieth century, the Dupont company started measuring capital productivity and developed the Return on Investment (ROI) measure; General Motors pioneered the multidivisional organization (Johnson & Kaplan, 1987a). In this period, concepts such as transfer costs, flexible budgets, departmental evaluation, standard cost, and variance analysis were developed (Ovunda, 2015). The evolution was such that, around 1910, the cost for collection of so much information became unmanageable, questioning the cost/benefit relationship of accounting systems (Kaplan & Atkinson,

1998). The Great Depression of 1929 led to new political regulations, stressing the importance of financial information that centred the management's attention on financial issues. From these years up to the 1950s, MA stagnated as the major concerns were related to financial accounting (Johnson & Kaplan, 1987a).

The evolution of accounting in this classical period was initially marked by the need to control costs and support prices (Wyatt, 2002), but not by the need to support operational factory management (Loft, 1995). However, the emergence of large corporations with complex business (such as textiles and railways) required more efficient and useful information for management. This gave new relevance to MA. This empirical evolution, simultaneous with the development of Scientific Management (Littler, 1978), is a consequence of the new market and production conditions that were very much determined by an engineering mentality, as epitomised by Taylorism. For example, the break-even point is an enginery concept (Ovunda, 2015); Taylor, also an engineer, developed procedures for productive process efficiency such as time/cost measurement and standardization of every task. This evolution was paradigmatic of the understanding of companies as a closed system, centred in the principles of efficiency and control, and more concerned with the production than with the market and other factors external to the companies.

2.2. Modern period of management accounting (1951-1980)

In the modern period, MA started stressing the idea that numbers were used by people to make decisions, that accounting information could influence behaviour while covering a much broader range of topics rather than focus on full costing of cost accounting (Anthony, 1989). There is an emphasis on the behavioural aspects of MA, valuing the importance of the communication and motivation aspects of cost measurement. As such, it questions about the cost constructions that are most likely to induce people to take the action that management desires (Horngren, Datar, & Rajan, 2012). According to Flamholtz (1992), the behavioural accounting (a formulation of accounting measurements that, as they affect, can be affected by human behaviour) question the view of a rational and neutral accounting.

The focus of MA changed to one of providing support to planning through simple managerial costing to support decision-making, the statistical estimation of costs, cash-flow discounting techniques and cost discrimination (Parker, 1969). Companies began to be treated as an open system, creating conditions for the development of MA (Buble, 2015). Studies on MA now resorted to economic fundamentals, such as decision theory and the assumption of perfect rationality (Abdel-Kader & Luther, 2006). If before the

1950s, the development of MA had been empirically based (Bromwich & Scapens, 2016), thereafter it became linked to economic theory and it started to incorporate contributions from sociology, psychology, and organizational theory. It was developed the human resource accounting, which accounts for people as organizational resources (Flamholtz, 1992). In the 1950s and 1960s, the accounting and management literature adopted a normative approach. In the 1970s, a descriptive approach initiated and MA studies began to consider two theories: Agency Theory, focused on the influence of accounting information on decision making (Hofstede & Kinard, 1970), and Contingency Theory, focused on external aspects, both legal and cultural, in the decision process (Otley, 1978).

In the modern period, quality management was a prominent development in the 1950s, opportunity cost budgeting in the 1960s, and just-in-time production in the 1970s (Kamal, 2015). Nonetheless, these theoretical developments did not influence MA practices until the 1980s (Johnson & Kaplan, 1987a). Rather than gathering cost management information, most manufacturers still used cost accounting information. One of the reasons for this was that the managers had been mostly exposed to costing methods presented in university cost accounting courses focused on training students for careers in public accounting (Johnson & Kaplan, 1987b).

2.3. Post-modern period of management accounting (1981-1990)

MA practice remained unchanged from the first quarter of the twentieth century until the 1980s. It was unfit to the new economic reality because the information provided was too late, too aggregated and too distorted to be relevant for managers planning and control decisions (Johnson & Kaplan, 1987a). MA information was still centred in the existing financial accounting information systems, not achieving, though, in giving unbiased and holistic information that reflects the technology, products and complex processes. In addition to that, it does not succeed in integrating them in a highly competitive operative environment (Baines & Langfield-Smith, 2003). The 1980s required cost models adjusted to a competitive environment changed by new production procedures and in which the customer has an undisputed relevance – it was the time when enterprises initiated overseas relocations, of growing automation and the computer revolution (Abdel-Kader & Luther, 2006). As such, new management models started to consider the environment and cultural context in their development (Amat et al., 1994). Post-modern approaches viewed organizational boundaries with some scepticism, seeking to incorporate customers within the organization (Waldo, 1971). Consequently, a degree of uncertainty was considered a part of a management model (Birnberg, 2000). It appears the concept of Strategic Management Accounting (SMA)

by Simmonds (1981) that was differentiated from the concept of MA because of its greater focus on the comparison of the business with its competitors.

The MA studies renewed an empirical approach. It was proposed to re-name *cost accounting* as *cost management* (Abdel-Kader & Luther, 2006). Activity-Based Costing (ABC) (Cooper & kaplan, 1991) and Benchmarking (Henczel, 2002) were developed, quality management was improved, through the Total Quality Management (TQM), towards a more accurate relation of accounting with quality (Ishikawa, 1985). These approaches brought MA closer to the actual needs of organizations and enhanced the importance of information systems (Ashton et al., 1995), reflected a renewed concern for measurement and control. These alternative MA tools imply the establishment of new goals and patterns, a concern for continuous improvement, and to consider knowledge and teamwork as manageable organizational values (Kamal, 2015). MA was now more concerned about efficiency gains to survive in a competitive market, evolving from a previous concern centred in reducing wastes (Abdel-Kader & Luther, 2006).

2.4. Contemporary management accounting (1991-to present)

In the 1990s, a new economic-social order began with the exponential development of Information Technologies (IT) (Burns & Scapens, 2000). This forced companies to organize their work according to processes (Hammer & Champy, 1993) and for managers to look beyond internal processes and consider the surrounding environment (Drucker, 2002). According to IFAC (Abdel-Kader & Luther, 2006), the purpose of MA began to be the creation of value through good decisions, rather than a focus on control issues. MA wishes to have a major role in organizational management and, as such, contemporary management accountants should (proactively) be involved in leadership, strategic management, operational alignment and long-life learning and improvement (Zainuddin & Sulaiman, 2016). The concept of SMA was developed in tools like the Balanced Scorecard (BSC) (Kaplan & Norton, 1992) that attended to the external aspects of the business operations (Smith, 2005) and moved away from simply monetary concerns and closer to multi-dimensional business matters (Ma & Tayles, 2009). This strategic approach retrieved from the work of Anthony (1965) and meant that MA is integrated into the process of decision-making, adjustment of the goals of the company and the necessary resources and policies.

In the twenty-first century, the competitive marketplace is more complex, requires efficiency and predictive analytic capability. These circumstances led to a MA that was focused on organizational objectives (Boer, 2000), on the motivation of workers, and on the evolving demands of clients. The concern for workers and clients reinforced the interest in motivational theory in MA (Cokins, 2014).

Overall, MA should foster a form of integrated management, take advantage of new IT, and align internal and external factors of organizations with a strategic emphasis. The effective strategic management accountant required high levels of communication skills and the ability to empathize with others (Coad, 1996). This is evidenced in the development of contemporary SMA tools such as the BSC (Kaplan & Norton, 1992), Activity-Based Management (ABM) (Kaplan & Cooper, 1998) and Value Chain Costing (Porter, 1998). These tools care for new interrelationships of accounting with other disciplines like strategy, marketing, and human resources management. Some other authors see marketing as the more relevant orientation for SMA (see, for example, Foster & Gupta, 1994; Roslender & Hart, 2002; Roslender, 1995; Roslender, 1996). Cravens & Guilding (2001) identified fourteen new techniques of SMA. However, the strategic approach on MA is questioned, as management accountants make little use of strategic management in their work (Cooper, 1996; Parker, 2002) and, while special attention is given to the internal affairs of the business, sight is the loss of the external opportunities and potential business threats (Chapman, 2005; Innes et al., 2000). It was also found that the adoption of SMA tools was not guaranteed since many managers viewed them as costly, time-consuming and complicated.

A recent understanding presents MA as an interpretative model of reality (Quattrone, 2015) in which alternative organizational policies pop-up within an organizational dialogue, resulting from an evaluation of MA data. The openness that this view of MA implies requires the collaboration of workers, searching for different perspectives and an increase of dialogue based on the information produced.

In sum: the classical period of MA was centred initially on accounting for the cost determination and efficiency of processes. In the modern period, MA evolved into support management planning and decision-making. In the post-modern period, MA aimed to reduce wastes and increase efficiency with a view centred in the market and consumer demands. In the contemporary period, MA aimed at value creation. MA is central in organizations, as a constituent of management itself and not an adjunct. Despite different interpretations throughout history, MA proposes a representation of reality but does not constitute a truth by itself (Quattrone, 2016). MA is not the mere collection and treatment of information. It is a way of influencing behaviours, generating questions and stimulating research paths dealing with uncertainty. By taking advantage of technological innovation, MA becomes a human and social construction in its virtuosities and limits.

3. Research Method

This essay is based on a literature review. The main objective is to investigate the relationship between the evolving understanding of bureaucracy, praised or criticized, and the developments in MA.

We aim to answer the following research question: are the prevailing views on bureaucracy reflected in the developments of MA, and if so, in what way?

First, as a way to validate this study we began with a brief relation between bureaucracy and MA concepts and correspondences between theories on the emergence of MA and bureaucracy.

Then, to answer the research question, we follow the four main periods identified in the previews section to characterized MA: classical (1700-1950), modern (1951-1980), post-modern (1981-1990) and contemporary (1991 onwards). So, for each period we began to identify the prevailing understanding of bureaucracy and then relate it to MA. We conclude each period with a summary table.

4. Bureaucracy and Management Accounting

4.1. Relating concepts of bureaucracy and MA

The conceptual understanding of bureaucracy that appeared in the twentieth century, prompted by Max Weber's work (1922), still influences the modern conception of bureaucracy and stimulates the formation of the vast literature in this particular field of research (Aucoin, 1995). Max Weber considered bureaucracy as the main component in the rationalization of the world and the most important of all social practices. After his work, bureaucracy started to be identified with the public service spirit. Bureaucracy was considered the ideal type of legal realm because it was based on rationality, control, authority, knowledge, hierarchy, formal communication and the importance of documentation, free labour relations, impersonality, and accountability. Each worker had a precise notion of the functions for which he was accountable. A former feature in Weber's conception that no longer is considered in the present concept of bureaucracy is the permanent character of jobs. Currently, no civil servant expects to hold a permanent job in governmental departments. In spite of the common particularities, bureaucracy is not considered a uniform way of management, because organizations are diverse and develop differently (Du Gay, 2005). It can be summarized as a management method, applicable to public and private entities, that seeks to control the inherent uncertainty of the human factor; it represents a formalization of practices; and anchors an organization in written rules and formalisms (Stinchcombe, 1959). It is an administrative system strictly enforced by rules and established through rational-legal authority (Gerth & Mills, 1946). Since bureaucratic organizations are defined as based on records (Maniha, 1975), developments of bureaucracy are associated with the improvement of technologies to save, share and reproduce the information (so-called discourse networks (Styhre, 2007)). Contemporary bureaucracy is very concerned with how to collect and store information, to circulate it efficiently, and to allow easy access (Cervantes et al., 2018).

MA is an integral part of the planning and control function in an organization (Anthony, 1965) and not merely a bookkeeping function. The management accounting system is an important part of an information system (communicating accounting information) and is also used for motivation purposes since it provides information about performance. It supports an operational control assuring that specific tasks are carried out effectively and efficiently (Anthony, 1965).

An immediate correspondence between the two concepts can be found in Weber (1922) when, in his seminal work on bureaucracy, it refers to the need to clarify functions to be performed and to establish a

disciplinary order of control for an impartial evaluation of performance. The control and accountability issues represent a fundamental link between both concepts. The bureaucracy demands an objective control feature on which depends the accountability of every person's performance. We find that MA is an information system integral to the control function in the organization that communicates the tasks involved, the respective goals, and the performance achieved. Therefore, the bureaucracy, in its search for objective control and accountability, is dependent on the MA and its capacity to generate relevant information. In the line of Weber, which sets the importance of documentation to bureaucracy, Maniha (1975) stresses the importance of an organization to save records, which depends on the capacity of the MA to produce and deliver information.

4.2. Correspondences between theories on the emergence of MA and bureaucracy

Several theories explain the emergence of MA as a discipline. Some theories justify MA because it supplies the information needed to optimize resources in the new manufacturing complexity of the Industrial Revolution (Edwards et al., 1995). Other theories justify MA by the emergence of large corporations (Chandler, 1977; Johnson & Kaplan, 1987a). Some present MA as a form of exploitation and social domination (Neimark & Tinker, 1986). Some view MA as a result of a willingness to control costs to identify human responsibilities (Hoskin & Macve, 1988).

These different perspectives can be divided into two main categories, one economic (Chandler, 1977; Johnson & Kaplan, 1987a; Edwards et al., 1995); the other one social (Neimark & Tinker, 1986; Hoskin & Macve, 1988). The supporters of the latter try to depict MA as a social theory and observe it according to the social, economic and cultural environments (Murai, 1999).

The social perspective presents an immediate and clear link between bureaucracy and MA. The theories of MA based on social reasons meet the critical understanding of bureaucracy as a domination and control form that inhibits the individual (Ferguson, 1984; Martin et al., 1998). By coining the term *Iron Cage*, Weber addressed the risks of social domination of the bureaucracy. An understanding is found also in the social theory of MA.

4.3. The evolution of the understandings on bureaucracy and historical changes in MA

There are correspondences between the social emergence of MA theories and bureaucracy. Besides comparing both concepts, bureaucracy is related to MA because it is dependent on the information

system that MA constructs. Justified on these *a priori* correspondences, this essay proceeds to study the historical relationship between the evolution of the views on bureaucracy and MA.

4.3.1. The classical period (1700-1950)

By the late nineteenth century, bureaucratic forms began to spread from government to other large-scale institutions (Beetham, 1996). A particular reason for the rise of bureaucracy was the security it created in labour relations through written bureaucratic rules (Weber, 1922).

The Taylorism (also known as Scientific Management) appears in this period. Although Taylorism and Weber's bureaucracy are distinctive concepts, the former centres on the efficient worker's performance, and the later, on building a systematic view of an organization. Both aim at a more efficient way to manage organizations (Grey, 2005; Littler, 1978). Taylorism was presented as a rational process with control and performance measuring, allowing personal accountability and objective rewards. Thus, Taylorism translates principles of the bureaucracy later claimed by Weber.

Taylorism tries to measure every variable in the work process, to identify standards and to control any variance: the aim is an individual reward according to performance (Cooper, 2000). From this control obsession comes the understanding of Taylorism as the bureaucratization of the control structure (Littler, 1978), since there is a strict definition of functions and expected consequences by the employer. There is the bureaucratic sense of hierarchical authority, accountability, and formal communication with the definition of task and impersonality - tasks are defined regardless of the worker's personality. MA responded to the new demands of information that arose from Taylorism and its bureaucratic traits, MA defined standards to help monitor labour and material efficiencies (Kamal, 2015). For operation control, MA resorted to analysis of differences between actual and standard costs (Johnson & Kaplan, 1987a).

Organizational concerns for non-financial information, such as worker performance, go back to the first half of the nineteenth century in the textile industry (Kamal, 2015) but the development of Scientific Management, in the late nineteenth century, intensified these concerns. Although initially focused on costs, due to accountability and control demands, MA concerns of the classical period went beyond cost expressing new bureaucratic demands.

Under a bureaucratic context of control instigated by Taylorism, concern for the division of labour and accountability required information to evaluate performance and to keep records for deviation analysis.

Thus, in this classical period, the uprising of bureaucracy converted the attention of MA to the rigorous control of labour and work efficiency.

The critic of bureaucracy because of the disregard of the human factor in the organizations (Guillén, 1994), with the moral and social danger of an utilitarian view that depersonalizes the workers (Weber, 1922) was already latent and grew after the Great Depression (Von Mises, 1944).

In sum, in the classical period, the revival of MA encompassed the spread of bureaucratic organization, epitomized in Taylorism, where concerns for control and discipline were central. The prevailing positive understanding on bureaucracy as an organizational method determined the evolution of the MA in a way that responded to the new bureaucratic demands. Table 1 summarizes the relationship between the current understandings on bureaucracy and related MA developments.

Table 1

Current Understandings on Bureaucracy and Related MA Developments, in the Classic Period

Current understandings on bureaucracy	Related MA developments
Bureaucracy is praised as a management method that confers formal rigor to management through the objective to control performances and goals and accountability.	Increased attention given to processes and techniques of measuring individual and organizational performances for control and accountability reasons.

4.3.2. The modern period (1951-1980)

In the modern period, theoretical criticisms against bureaucracy arose. The charge is essential that bureaucracies are self-serving and more concerned making the lives of bureaucrats easier rather than serving the clientele (Marini, 1971). The post-bureaucracy concept emerged (Maniha, 1975) in a social criticism context. These expressed a reaction against the disrespect of the workforce on the ground that it was considered as a mere economic resource. Bureaucracy was seen as dysfunctional (Du Gay, 2005). This was because it decoupled formal rules and reality (Grey, 2005) and lacked formal rationality (Crozier, 1965) since bureaucrats, as individuals have their own prejudices and preferences. Merton et al. (1952) criticized Weber's concept of bureaucracy by observing that it does not consider the important role of the informal relationships that exist in any human organization. It was addressed the 'goal-displacement' problem, a phenomenon where following the rules becomes the point, rather than the actual point of the rule (Merton, 1940). Also, it appeared the first purely economic insights on bureaucracy, as when Downs

(1965) argues that bureaucrats are motivated by their self-interests. The bureaucrats try to enhance their position within the institution they work in (Downs, 1965; Niskanen, 1971) and not to maximize the profit of the organization. And the concept of the budget-maximizing model for bureaucracy appeared (Niskanen, 1971). In the same line, Williamson (1964) developed the idea that managers do not have a neutral attitude toward all classes of expenses. According to the public choice theory, bureaucrats are now expected to maximize their utility levels either exploiting their monetary gains or enjoying higher status in the organization (Buchanan & Tullock, 1965).

These new understandings of bureaucracy had no reflection on the practice of MA in this period, as the practice remained mostly unchanged and dependent on financial information (Johnson & Kaplan, 1987b), highlighting the gap between academic research and practice (Scapens, 1994). However, criticism of bureaucracy can be related to some theoretical developments in MA as they addressed the cognitive limits of the rational system, considered the cultural environment, and no longer regarded the workforce as a mere resource without agency power. These are reflected in studies on MA conducted according to the Agency Theory, about the impact of accounting information on decision making (Hofstede & Kinard, 1970), and Contingency Theory, considering the influence of cultural and legal aspects on MA (Otley, 1978). The agency theory re-established the importance of incentives and self-interest in organizational thinking (Perrow, 1986). This represents the new understanding of the worker as a person who must be reckoned with as more than a material resource. This addresses one of the reasons for the bureaucracy criticism. Contingency theory underlies the influence of the environment on the organizational structure and leadership style. As such, rationality is contingent and, according to the circumstances, there are differences in organizational attributes such as the span of control, centralization of authority, and the formalization of rules and procedures (Woodward, 1958). The prejudice of bureaucracy in favour of rationality is questioned objectively. This is one of the current reasons bureaucracy is criticised.

After 1950, the theorization of MA underwent an impulse featuring an emphasis on functions of control and internal planning. At the same time, bureaucracy criticism pointed at the cognitive limits of any rationality purpose and at the social understanding of the individual value of each person. These reasons trended the bureaucracy criticism are found in some of the theoretical developments of MA, like the behaviourist approach in management studies, incorporating the agency theory. Some theoretical developments of MA in this period echoed the criticism on bureaucracy as the reasons behind such criticism also motivated those developments. The evolving critical view of bureaucracy was reflected in

the developments of MA. Table 2 summarizes the relationship between the current understandings on bureaucracy and related MA developments.

Table 2

Current Understandings on Bureaucracy and Related MA Developments, in the Modern Period

Current understandings on bureaucracy	Related MA developments
Bureaucracy receives a wave of criticism. For social reasons, as it devalues the worker as a mere resource. For inefficiency reasons, as bureaucracy tends to privilege the bureaucrats in detriment of the organizations, failing the rational rigor. For dysfunctional reasons, as it prioritizes formality over the reality. It appears the concept of post-bureaucracy that envisages the end of bureaucracy.	Theoretical studies, through the use of the Agency Theory and the Contingency Theory, that recognize the workers as more than a mere resource, whose subjectivity is acknowledged by management, and the limits of the rational prejudice central to the original concept of bureaucracy.

4.3.3. The post-modern period (1981-1990)

In the 1980s, a bureaucratic organization was presented as technically incapable to deal with economic, technological and cultural transformations, due to its rigidity and social illegitimacy (Du Gay, 2005). The success was not achievable in rigid and bureaucratic structures (Peters, 1992). Bureaucracy was devalued and considered a rationalist myth that persisted only for isomorphic reasons and not for its efficiency or technical value (DiMaggio & Powell, 1983). Some argued that bureaucracy defuses responsibility and makes accountability harder (Bauman, 1989). The cultural aspect emerges as essential to bring integrity to the enterprise (Heydebrand, 1989). Organizations were considered to become more adaptive, to avoid hierarchies, emphasize informal relationships and collaborative spirit, being presented as "*heterarchies*" (Sölvell & Zander, 1995) in opposition to hierarchies. Theories of post-bureaucracy emerged, as a horizontal structure where employee empowerment is achieved through decentralised power (Clegg et al., 2016). This theory emerged due to the breakdown of traditional models of bureaucracy that entailed authoritative leadership and hierarchical organisational structures (Johnson et al., 2009). Organisation theorists described and proscribed a transition from bureaucracy to post-bureaucracy involving a declining emphasis on formalised internal organisational structures and control mechanisms (Cooke, 1990). Scholars, such as Handy (1989), Drucker (1993) and Giddens (1999), stated that managers rejected classic bureaucratic structures. Johnson et al. (2009) determined the post-

bureaucracy's legitimacy through an analysis of employee autonomy and research showed a tendency for organisations to make greater use of mechanisms to promote responsible autonomy.

One of the major MA tools developed in this period, TQM, focuses on business processes, values team structures, adopts an empowering view of the workforce (Daily & Bishop, 2003) and aims to develop a learning environment (Sohal & Morrison, 1995). TQM meant the establishment of rules and standards to control and assure compliance. Because of its quasi-regulatory approach, formalised procedures and prescriptive criteria, critics coined terms such as "The Audit Society" (Power, 1999). Therefore, quality management was often seen through sceptical eyes as a bureaucratic approach because it demands a huge amount of documentation and an increase in bureaucracy (Hill & Wilkinson, 1995). Another important contemporary tool, ABC, has similarities with TQM: in the importance given to a formal, centralized and mechanistic structure (Gosselin, 1997) in which rules, procedures and policies are formalized; and in the relevance given to team-work (Zhang et al., 2015). Benchmarking, another MA development of the period, enforces measurement and standards control and highlights the value of personnel commitment and interdepartmental communication (Asrofah et al., 2010; Henczel, 2002). Its concern to ensure compliance with legislation and best practice was translated into fundamental bureaucratic codes of conduct (Ackroyd & Thompson, 1999).

The deprecation of bureaucracy in this period for lack of organizational flexibility and its disregard of employee individuality was translated into a new organizational culture with the development of learning capacities that are present in the new MA tools. Appropriate information becomes available to support managers and employees at all levels and, in many cases, help empower employees (Abdel-Kader & Luther, 2006). The evolution of MA translated the anti-bureaucratic posture of the period in a way that acknowledges the importance and value of the workforce. As such, MA attempted to involve personnel in its development, avoiding imposed rules and considering personal knowledge in the procedures and policies followed. This post-modern period of MA corresponds to a period of strong criticism of bureaucracy. MA practice has evolved according to the wave of anti-bureaucratic sentiment. The workforce is now more valued and is deemed essential for the success of MA. It is no longer viewed as a simple resource at the manager's disposal. The relationship between management and employees has a new equilibrium: the employee role is considered a key feature for any success. During this period, there was a need to foster a flexibility that was capable of enduring economic, technological, and cultural uncertainty through the development of learning capacities. In addition, MA maintained bureaucratic traits linked with control and accountability by constructing a formal set of rules for the organization and a

sense of top managements' authority. MA recognized the need for flexibility and continuous improvement achieved by rational processes of control supported by objective measures and accountability.

Even if criticized, bureaucracy persisted and MA developments testify such persistence. However, the critical view of the bureaucracy of this period reflected how MA tools were developed to address the reasons for such criticism. Table 3 summarizes the relationship between the current understandings on bureaucracy and related MA developments.

Table 3

Current Understandings on Bureaucracy and Related MA Developments, in the Post-modern Period

Current understandings on bureaucracy	Related MA developments
Increase of the arguments for a post-bureaucratic organizational model as the criticism of bureaucracy is intensified. Presented as a rationalist myth, it is seen incapable to deal with the new socio-economic environment, and there is a demand for more organizational flexibility and personal autonomy.	Major MA tools address the problem of organizational flexibility and disregard for employee individuality fostering an organizational culture that involves the personal and giving new relevance to the learning capacities in the organizations.

4.3.4. The contemporary (1991-to current age)

The problematic of bureaucracy receives denser attention in this period, with diverse studies on the subject and contributions that dispute the value of the concept of post-bureaucracy. Empirical studies in Western civilization still evidence the presence of classical bureaucratic organizations (Thompson & Alvesson, 2005) and, due to the discrepancy between the contempt for bureaucracy and its real presence in organizations (Styhre, 2007), the concept of post-bureaucracy is contested by the concept of neo-bureaucracy (Farrell & Morris, 2003). A study showed that bureaucratic and post-bureaucratic characteristics co-exist in most workplaces analysed (Bolin & Harenstam, 2008). We are in a transitional period in which much bureaucracy remains while more complete mechanisms of network relations are under construction (Edgell et al., 2015). What seems to subvert bureaucratic nature may prove to be a set of buzzwords - cooperation, continuous learning, charismatic leadership – that, sometimes insidiously, lead to an organization more controlled and taken by a sense of insecurity (Ogbonna & Wilkinson, 2003). The development of IT affected organizations that engaged in a dynamic process of changing (Alsharari, 2019). New organizational models arose, such as networks, virtual organization or learning organizations

(Senge, 1990), characterized by new forms of control and discipline. Milward and Provan (2000) found that those networks that develop long-term relationships mimic the stability of bureaucracy perform. This is the time of the neo-bureaucracy (Hales, 2002), where forms of bureaucratic control are updated (Clegg & Courpasson, 2004) to instigate a cultural, collaborative and safe environment. The idea of neo-bureaucracy means a new bureaucratic approach such as 'soft' bureaucracy (Kärreman & Alvesson, 2004) or 'enabling' bureaucracy (Adler & Borys, 1996) that justifies bureaucratic rules as a support, instead of control; and a 'learning' bureaucracy (Adler, 1993) that seeks to maintain the capacity of flexibility and change in organizations. Such bureaucracy builds an order where an apparent absence of rules favours the exercise of power (Robertson & Swan, 2003). Bureaucracy's understanding as a way of emotional control (Martin et al., 1998) should be dispelled. So, self-control is promoted (Du Gay 2005; Floyd & Woolridge 1994), reputational control is encouraged and success is measured by the judgment of others (Clegg & Courpasson, 2004).

Many attempts of 'de-bureaucratization' were simply attempting to repair badly managed bureaucracies and modify them for the modern age (Heckscher & Donnellon, 1994). In reality, post-bureaucracy is simply a call for the re-invention of the bureaucracy, as elements of flexibility and increased autonomy can help organisations to increase their innovative capacity and to compete for competitive advantage. Several authors share this view: Salaman (2005) considers sophisticated bureaucratic traits that are still present in rules derived from a central authority and are exemplified in the operation of call-centres. Hales (2002) perceives that there is an adaptation of bureaucracy to contemporary social values, not the disappearing of the bureaucratic order. According to Iedema (2003), post-bureaucratic rhetoric persists that hides a hierarchical bureaucracy. Heckscher (1994) displayed post-bureaucracy as an extension of the bureaucracy model, transforming classic organisational hierarchy into an interactive system allowing two-way communication and rejecting the use of power. Thompson and Alvesson (2005) suggested that post-bureaucracy was simply a means for legitimising organisational change and marketing of new ideas rather than an empirical indicator of change. In the book *The Bureaucratic Experience,* Hummel (2008) even argues that bureaucracy is even getting worse in spite of all efforts exerted by the theorists of quality management. The presence of bureaucracy in organizations is ambivalent: on one hand, it continues Weber´s bureaucratic formal definition of functions and control performance; on the other, there is a non-coercive posture. This posture seeks to motivate workers, by allowing them an active voice in organizational politics, countering the negative perception of bureaucracy because there is still the questioning of the moral justification of bureaucracy (Parker & Bradley, 2004).

Other authors, beyond the recognition of contemporary bureaucracy, also started advocating it. Feldman (2000), for example, suggests new ways to streamline bureaucracy towards innovation and creativity such as through leadership and artificial intelligence. Craig (1995) argues that bureaucratic predictability and logic are very important in dealing with the unstable process of innovation. Du Gay (2005) regards bureaucracy as valuable for the social and work security and constructing a stable organizational identity, counteracting the arbitrary power. Goodsell (2004) suggests bureaucracy as a condition of liberty instead of rigidity. At the public sector level, Alesina and Tabellini (2007) stated that bureaucrats are preferable to politicians in technical tasks for which ability is more important than effort. Also, it revealed the fact that bureaucrats are anticipated to perform better than politicians if the criteria for good performance can be easily described and are stable over time (Alesina & Tabellini, 2008). In the public sector, with the New Public Management, it might be necessary to adopt a more nuanced understanding of bureaucracy (Considine & Lewis, 1999) "which acknowledges the possibility that there has been a shift in the public sector from one form of bureaucracy associated with political control, to a form more directly linked to mechanisms of control" (Parker & Bradley, 2004, p. 211). Modern democratic governance requires a supporting bureaucratic apparatus because only an active and efficient bureaucracy can generate the surplus capacity to absorb the high decision and transaction costs inherent in democracy (Meier, 1997; Suleiman, 2003). The emphasis on the post-bureaucratic client-centred organizations is only possible when the social construction of the client population is positive; if not, bureaucracies should be kept separate from clientele and their mission to manage, and perhaps to subjugate, clientele (Schneider & Ingram, 1997).

In the contemporary period, bureaucracy was again advocated as a valid organizational method under the term 'neo-bureaucracy.' The contemporary MA, with a strategic posture, testifies to such presence. The technological developments fostered new MA tools and enabled real centralization of power (Hill et al., 2000) as an efficient way to create standardized systems of central control. The aggregation of information achieved by these systems provided better analyses of reality and conditions to control the whole organization, in an updated way. The sophisticated MA systems attempt to perpetuate a bureaucratic system of task definition, with rigorous performance evaluation. The MA stresses the need to monitor and assess results through processes of rigorous measurement and control that imply control processes and accountability. Following this idea, research has shown the high importance of the control function in the contemporary process of management (Cambalikova & Misun, 2017) to the point that entities in the Western world have discovered advantages on the strong bureaucratic control typical of the

Eastern world (Misun, 2017). The purpose of operational alignment, which is fundamental to contemporary MA (Zainuddin & Sulaiman, 2016), is a valid reason for the maintenance of bureaucratic features such as hierarchy, rules, procedures, and formalization. Such features are linked to organizational challenges with the purpose to align the interests of individuals and organizations (Buble, 2015). The success of a MA system demands close support from the top management and the involvement of managers and employees. Its maintenance requires constant organizational monitoring to assess the management accounting system's effectiveness (Strumickas & Valanciene, 2010). A bureaucratic hierarchy is recognized in these demands. This expresses a neo-bureaucratic posture personified in behaviour of the top management, but also in the involvement of every employee.

In the implementation and adaptation of contemporary MA systems, such as the BSC or the ABM, it is evident the concern for job motivation and involvement of employees. These systems develop a collaborative and integrative regime that involves employees in the definition of policies, tasks, and objectives. Also, they establish procedures to clarify functions, metrics and measurement standards, meaning real bureaucratic control (Ferner, 2000). Contemporary MA tools assert the formalization of practices. They expound the bureaucratic traits of control, accountability, formalism, and reason. Additionally, these tools have a positive approach to employees that, notwithstanding the presence of the hierarchical authority, value them as collaborators, not just as employees. Therefore, by maintaining bureaucratic traits, contemporary MA tools follow design and policies that may classify them as neo-bureaucratic.

According to the recent understanding of MA as an interpretative model of reality (Quattrone, 2015), the formative process of MA is very important, because an old-fashioned bureaucratic process with a rigid and imposing hierarchy could restrict the perspectives of analysis. It is important to the success of any MA system an inclusive organizational regime as is intended by the new bureaucracy.

A study of organizations and their MA systems in this period showed the pervading presence of bureaucracy, corresponding to a rehabilitation of the concept of bureaucracy. The MA subsumed the longing bureaucracy critics regarding the importance of the workforce and the need for flexibility, proceeding with the MA developments in the previous period, but also highlighted the importance of traditional bureaucratic values. The modern tools of MA restored the bureaucratic values of the control, authority, and formalization of procedures for its importance for strategic guidance in a period of socio-economic complexity. By considering the readings on bureaucracy and MA in this period, a case can be made that the features of recent MA corroborate the argument of the contemporary presence of

bureaucracy, and discredit the idea of post-bureaucracy. Also, it is argued that the new defence of bureaucracy for its predictability, sense of security and developed sense of leadership is reflected in the new MA tools. Contemporary MA expresses the neo-bureaucratic posture. Table 4 summarizes the relationship between the current understandings on bureaucracy and related MA developments.

Table 4

Current Understandings on Bureaucracy and Related MA Developments, in the Contemporary Period

Current understandings on bureaucracy	Related MA developments
The concept of post-bureaucracy is contested on practical grounds; and bureaucracy is once again praised, by some, as a management method. It appears the concept of neo-bureaucracy that rehabilitates and updates the notion of control and authority in an adaptation to contemporary social values.	MA contemporary tools, as strategic tools, envisage a systematic view of the organizations in which the bureaucratic features of control, formalization of procedures and authority, presented as leadership, are rehabilitated as important assets to the good management.

5. Conclusion

This essay has addressed the relationships between bureaucracy and MA. It aimed at the relationships between the evolving views on bureaucracy and the developments of MA. It introduces a new understanding of the evolution of MA based on the evolving understandings of bureaucracy. An immediate correspondence between the two concepts is first presented: the control and accountability features of bureaucracy demand the information system of MA. A bureaucratic order presumes the pre-existence of an MA system to support its control and accountability demands through the ability to save and treat relevant information. Secondly, social theories that explain the emergence of MA as a form of exploitation and social domination, or because of a willingness to control costs to identify human responsibilities, meet with the critical understanding of bureaucracy as a domination and control form that inhibits the individual. These social theories call on the bureaucratic features of control and accountability. Considering these *a priori* correspondences, we proposed to relate the evolving understandings of bureaucracy with developments in MA.

Following previous research in the evolution of MA, four pivotal periods were considered (classical, modern, post-modern and contemporary) to relate the understanding of bureaucracy and MA.

In the classical period, the prevailing positive understanding of bureaucracy that was epitomized in Taylorism determined developments in MA. These were centred mainly on questions of control and discipline. MA reflected an overtly positive view on bureaucracy, developing tools centred in the objective of measurement, control, and accountability of performances.

In the modern and post-modern periods, MA developments beyond control issues reflected the increasing criticism of bureaucracy. In the modern period, this happened only in theoretical studies that resourced to the Agency Theory and the Contingency Theory. In the post-modern period, newly developed MA tools reflected the criticism of bureaucracy in their design. They subsumed a new understanding of the relations between management and employees, thereby reinforcing the workforce value in the design and implementation of the new MA tools. However, these new tools did not mean a real break with the bureaucracy for, despite the reasons for bureaucracy criticism were addressed in their development, they maintained fundamental bureaucratic traits, namely the hierarchic control and formalism. The new MA tools did not mean a break with the bureaucracy but did reflect in their design the prevailing criticism of bureaucracy in this period.

The contemporary period is characterized by the rehabilitation of bureaucracy as neo-bureaucracy. After a period of pressing critic of bureaucracy with the upsurge of a post-bureaucratic order, there was

the rehabilitation of the concept as neo-bureaucracy and this was reflected in contemporary MA tools (such as ABM, BSC, TQM). These tools, in their design, openly develop and value the sense of control, predictability, leadership, and collaboration that the advocates of neo-bureaucracy praise.

The readings on bureaucracy and MA indicate that how the bureaucracy is perceived has consequences on how MA evolves. MA is not equivalent to bureaucracy. Nor is every development in MA related to bureaucracy. However, a case can be made that the changing understandings of bureaucracy are related to the developments of theoretical studies in MA and to the way new tools are designed or updated. From these readings, it can be also adding that the study of the features of MA tools is very relevant for the study of the real presence of bureaucracy. In the contemporary period, arouse the dispute between an idea of post-bureaucratic organizations and an idea of neo-bureaucratic organizations. The readings on the contemporary MA tools corroborate the idea of neo-bureaucracy and dismiss the idea of post-bureaucratic organizations.

The a *priori* correspondences between the studied concepts and the relationship between the evolving understandings of bureaucracy and developments in MA suggest that a good way to understand the bureaucracy in an organization is to study its MA system. Future research should use case studies of MA systems to evaluate the degree to which bureaucracy is incorporated in MA systems. Another interesting research should explore how the practice of MA affects the social perception of bureaucracy.

Essay 2 - The Presence of Bureaucracy in the Balanced Scorecard[2]

[2] An earlier version of this essay was presented at the 1st Workshop in Economics and Business Administration, Braga, Portugal, 2018, titled: *Management Accounting and Bureaucracy in Contemporary Organization*; and was published in, 2019, in the Spanish Accounting Review 22(2): 218–24, titled *The Presence of Bureaucracy in the Balanced Scorecard* (WoS Indexed Journal).

The Presence of Bureaucracy in the Balanced Scorecard

Abstract

Despite being pilloried widely bureaucratic processes are present in many organizations as a form of neo-bureaucracy. In this essay, we analyse whether a technique used in Management Accounting Systems (MAS), known as the Balanced Scorecard (BSC), represents a bureaucratic order. We propose the following set of concepts to identify a bureaucratic order: authority, jurisdiction, professional qualifications, knowledge, rationality, discipline, accountability, systematization, and transparency. We discuss the presence of such a set of concepts in the design and implementation of the BSC and conclude that the BSC is an example of a neo-bureaucratic order. This essay also underlines another important finding, the value of bureaucracy in attaining good MAS. The theme we explore is overlooked in the accounting literature. This essay can be a starting point for further research.

Keywords: Balanced Scorecard, Bureaucracy, Evolution, Management Accounting, Organizations.

1. Introduction

This essay focuses on the relationship between the concept of bureaucracy and the operation of Management Accounting Systems (MAS). We understand bureaucracy to be a management method that aims to control human uncertainty through rules and formal procedures. We regard MAS to be a set of processes that provides accurate, reliable, relevant, and timely information to facilitate sound decision-making by management. We argue that a component of many MAS, the Balanced Scorecard (BSC), incorporates bureaucratic principles that are beneficial to the satisfactory overall operation of MAS.

Mere mention of the word "bureaucracy" usually elicits a negative response. This attitude is something that is difficult to change, particularly given the many failed promises of politicians to cut "red tape" and to "de-bureaucratise" (Jones et al., 2005). The discrepancy between the widespread contempt for bureaucracy and the continued presence of bureaucracy in various domains (Styhre, 2007) is mildly perplexing. This has prompted us to enquire whether the phenomenon of bureaucracy exists in contemporary organizations – and, in the current instance, whether it exists in the BSC.

We begin by critically reviewing literature about bureaucracy. Our purpose in doing so is to highlight the relationship between bureaucracy and a specific MAS technique, the BSC. We then identify a set of nine concepts that define organizational bureaucracy, before analysing whether these defining concepts are present in the BSC. The work of Weber (1922) and Styhre (2007) is invoked to propose nine concepts that define a bureaucratic organization. These are *rationality, systematization, authority, jurisdiction, professional qualifications, knowledge, discipline, accountability*, and *transparency*. We explore whether there are relationships between the design and implementation of the BSC and these nine concepts. We find that the BSC embodies bureaucratic concepts in seeking to provide accurate and relevant financial and non-financial measures to facilitate decision making in organizations.

To the best of our knowledge, this is the first study to explore the link between MAS and bureaucracy. We contribute by proposing an extended set of nine concepts to identify bureaucracy in contemporary organizations, and by drawing attention to the existence of bureaucracy in the BSC.

The following section reviews the evolution of the literature on bureaucracy, seeking to understand its main concepts. Next, we present the research method of this study; discuss the presence of bureaucracy in the BSC; and offer conclusions, limitations and suggestions for further research.

2. Literature Review: Bureaucracy Over Time

Bureaucracy is a management method originally characterized as possessing the features of rationalization, division of labour, and the institution of rules and regulations defined by an organization's guiding authority. According to this view, bureaucracy represents a process of formalizing practices and anchoring them in organization-specific rules and formal procedures (Stinchcombe, 1959). In a bureaucracy, people are regarded to be instruments of labour (Guillén, 1994). Furthermore, bureaucracies give much attention to maximizing control of the uncertainty inherent in human behaviour.

Bureaucracy has increased in importance because of the development of technologies that facilitate recording, sharing, and reproducing information. For some observers, bureaucracy is an organizational form that epitomises modernity (Kallinikos, 2004). Over time, bureaucracy has changed such that it is now more likely to embrace an interdisciplinary perspective. This has been prompted by emerging technological opportunities and cultural changes (Garston, 1993). There has also been a greater commitment more recently to elaborating procedures and decision-making by involving workers and fostering teamwork and peer-review (Thompson, 1993).

When observing bureaucracy, we must be careful not to consider it as a uniform way of management. Bureaucracy varies because organizations are diverse and develop differently (Du Gay, 2005; Weber 1922). Bureaucracy can be classified as *coercive* or *enabling* (Adler & Borys, 1996). *Coercive* bureaucracy constrains workers to particular desired behaviours. *Enabling* bureaucracy supports workers to achieve good individual performance. There are three alternative descriptors for this enabling nature. In a *soft* bureaucracy (Kärreman & Alvesson, 2004) procedures are used to support, rather than control: that is, skills are encouraged, assessed and linked to organizational objectives. In a *selective* bureaucracy (in some companies, like knowledge-intensive companies) procedures are needed to face uncertainty (Styhre, 2007). In a *learning* bureaucracy, learning-oriented characteristics of the organization's "formal" systems are combined with the distinctive characteristics of its "informal" systems (Adler, 1992). These varieties of bureaucracy (*enabling, soft, selective and learning*) characterize what is widely known as "neo-bureaucracy." What is also more apparent is that bureaucracy has evolved in two ways: by ceding its perception of control and its dominating "grip" in favour of an image of cooperation and flexibility; and by adapting to social mood and technological changes.

A neo-bureaucratic concept that covers the diverse classifications of bureaucracy is embodied in a hierarchical organizational structure in which responsibilities are defined by recognized rules, and decisions are justified by obedience to a higher authority. Also important in understanding neo-

bureaucracy is a greater commitment to informal means of communication and an appreciation of the influence of power relations (Garston, 1993). Thus, a bureaucrat can be defined as a person whose authority and status depends on his/her position in the hierarchy or as someone whose behaviour is supported by rules — even informal or cultural ones. This definition allows a flexible interpretation in which a worker can sometimes be considered a bureaucrat, despite his\her work not being bureaucratic.

2.1. Weber and bureaucracy

The core concept of bureaucracy is still much the same as espoused almost 100 years ago by Max Weber (1922) in his seminal work, translated as "Economics and Society". Weber considered bureaucracy to be the ideal type of legal domain associated with public administration. He defined ten commandments of this ideal regime (see Table 5).

Table 5

Ten Bureaucratic Commandments

Commandments
1. Bureaucrats are free and subject to authority only with respect to their impersonal official obligations.
2. Bureaucrats are organized in a clearly defined hierarchy of offices.
3. Each office has a clear defined sphere of competence in the legal sense.
4. Each office is filled by free contractual relationships. In principle, there is free selection.
5. Candidates [for posts in the bureaucracy] are selected based on technical qualifications.
6. Bureaucrats are remunerated by fixed salaries in money [usually] with a right to pension [...] The salary scale is graded according to rank in the hierarchy ... responsibility of the position and requirements of the incumbent's social status ...
7. Bureaucratic office is treated as the sole, or at least the primary, occupation of the incumbent.
8. [Serving in the bureaucracy] constitutes a career. There is a system of "promotion" according to seniority or achievement, or both. Promotion depends on the judgement of superiors.
9. A bureaucrat works entirely separately from ownership of the means of administration and without appropriation of his/her position.
10 [Bureaucrats] are subject to strict and systematic discipline and control in the conduct of office.

Source: Weber (1922: 220-221), with some minor editing.

Based on a reading of Weber (1922), Styhre (2007) derived the following four concepts as contemporary bureaucratic traits: *authority, jurisdiction, professional qualifications* and *knowledge*. He

also identified some other defining characteristics: administrative science, "tight organization", controls, instruments of power and means of administration, and concerns for record keeping. These last four characteristics are expressed in this essay by the concepts of *rationality, discipline,* and *accountability*. We add two further concepts to this list: *systemization* and *transparency.* We identify *systematization* as a bureaucratic concept since there will be a strict and systematic discipline and control in the conduct of office (Weber's Commandment No. 10). Additionally, we note that an ideal bureaucratic organization requires *transparency* because it searches for a secure and predictable environment in which a worker can recognize his/her career prospects and whether his/her likely advancement is protected against arbitrary action by authorities (Weber, 1922).

The following interpretative analysis of Weber's work suggests the presence of the following nine concepts in a bureaucracy: *authority, jurisdiction, professional qualifications, knowledge, rationality, discipline, accountability, systematization,* and *transparency.* Thus, we extend Styhre's (2007) work by introducing and considering the concepts of *systematization* and *transparency* as characteristics of bureaucracy. This set of concepts is used to argue that bureaucracy is present in the BSC.

2.2. Theorising about bureaucracy

Some authors describe bureaucracy as a process that emancipates workers. Others consider it promotes stricter control of subordinates and managers, in a network of labour dependency. Thompson and Alvesson (2005) contest the claim that the era of bureaucracy has passed. Such claims gained currency in times when rules and procedures lost importance. However, such loss of importance does not necessarily mean less bureaucracy or the end of bureaucracy (Torsteinsen, 2012).

Bauman (2008) queries whether there can ever be a non-bureaucratic organization. The existence of such an organizational form would create a state of permanent tension by demanding mobilization of rational and emotional resources, thereby implying it would result in more costs than benefits. In response to this query, our reading of recent literature points to the lack of unanimity about the nature of bureaucracy. Some observers find bureaucracy benign. Others find it pernicious. Some say it has been surpassed. Others claim it is actual. Some authors point out that innovation and bureaucracy are opposing states (Dougherty & Hardy, 1996) and that highly innovative companies are less bureaucratic. Hlavacek and Thompson (1973) argue that large firms will become non-bureaucratic. Feldman (2000) suggests that bureaucratic routines are more flexible and adaptive than is generally believed.

The emergence of New Institutional Theory (NIT) for the study of organizations (DiMaggio & Powell, 1983) has led to a questioning of previous ideas about bureaucracy. NIT assesses bureaucracy as if it was a myth of rationalism, because many bureaucratic organizations are not ruled by a conscientious rationality. Rather, they just follow what others do. Thus, bureaucracy is not justified by efficiency or technical reasons, but by a quest for legitimacy.

Rapid advances in Information Technology (IT) have had an important impact on how work in organizations is conducted. This has led to increased criticisms of bureaucracy. Some of this criticism seems well founded because of the inability of bureaucracies to deal with new socio-economic organizational models, involving:

- virtual organizations that take advantage of technology by overcoming the physical proximity of their workers (Alexander, 1997) and the spatial and formal limits of companies (Kotorov, 2001);
- organizations in networks based on inter-company collaboration (Oliver, 2004);
- project organization, based on autonomous interrelationship projects under common coordination (Midler, 1995); and
- learning organizations (Senge, 1990).

These models are characterized by new forms of control and discipline. They are concerned more with the consequences of behaviours rather than with norms. They value commitment over obedience. Because of this, the models are called *post-bureaucratic*. Core values of bureaucracy such as centralization, hierarchy, and formality are replaced by new buzzwords such as flexibility, cooperation, and dialogue. However, scrutiny of these models shows that, given an absence of rules, workers try even harder. Paradoxically, this is a way for these models to achieve domination (Robertson & Swan, 2003). Thus, a question arises as to whether this new order envisages the refinement of bureaucracy or the surpassing of it.

In view of the above, we contend that it is more sensible to refer to *neo-bureaucracy* than to *post-bureaucracy*. Farrell and Morris (2003) offer support for such a view.

2.3. Neo-bureaucracy

Bureaucratic organizations are continuously affected by the social environment (Styhre, 2007). This has encouraged them to adapt to modern times, legitimating the idea of neo-bureaucracy instead of post-bureaucracy (Farrell & Morris, 2003). There are strong grounds to argue that the concept of bureaucracy

remains relevant, despite its modifications and re-formulations. This is because the bureaucratic organization has proven capable of managing opposition, absorbing cultural changes and adapting to technical innovation (Adler & Borys, 1996; Styhre, 2007). Bureaucratic rules and procedures are claimed to be an answer to contemporary challenges because they can enhance the adaptability of companies and lead to better performance (Callon, 2002).

Salaman (2005) considers that the most recently adopted management practices enhance bureaucratic order and help to maintain centrally-determined rules and control behaviours in the majority of organizations. As examples of this, observers have drawn attention to the case of call centres (now ubiquitous and completely standardized) (Taylor & Bain, 1998); and to the diversity of activities with well-defined behavioural rules, that apply to fast-food chain employees (Ritzer, 1993). In such settings, the relationship with the client is pre-established and determined by management. This way of understanding the reality is described by Ritzer (1993) as the McDonaldization of society. Korczynski (2002) uses the term "client-oriented bureaucracy". The new technologies and their complexity do not eliminate the centralization of power. Instead, they facilitate the exercise of power at a distance (Miller & Rose, 1993) and lead to improvements by adapting to an unstable environment (Reed, 2005).

The bureaucratic order has been adapted, rather than transformed, in modern times (Hales, 2002). The hierarchical division of bureaucracy is not as rigid as in the past, since employees can be distinguished by their capabilities and not by the functions they perform (Castells, 2000). However, organizations continue to focus on control issues and regulations in distinctive ways. One virtue of bureaucracy is its capacity to deal with ambiguity: it is adept at creating procedures that introduce some predictability (Styhre, 2007).

Public administration in Western countries has undergone a form of reorganization in which it incorporates the same management principles as do private organizations operating in a competitive market context (Newton, 2005). Such reorganization often promotes the market economy as being instrumental to a process of de-bureaucratization. However, the reorganization involved has increased central control and audits, introducing new levels of bureaucracy (Clarke & Newman, 1997). Empirical studies have revealed that de-bureaucratization in Western society has been very limited (Thompson & Alvesson, 2005) and that the complexity of public service is best managed by a centrally-controlled regime (Holmes & Sunstein, 1999).

In the corporate sector, some companies are not perceived as bureaucratic. This is because they value cultural aspects or are concerned with developing an amenable, friendly environment in which

employees feel fulfilled and recognized. However, companies can be structured bureaucratically through the hierarchy they adopt or through their strict regulation of functions.

In defending bureaucracy, Feldman (2000) presented a set of techniques intended to streamline the bureaucracy and make it innovate and creative. These techniques involve the use of leadership methods, artificial intelligence, and/or market-oriented management. They promote responsiveness and adaptability to economic and business dynamics. Mechanisms that create predictability and order are crucial in dealing with important innovative processes (Craig, 1995). Large bureaucratic enterprises have proven capable of innovation (Styhre, 2007). The bureaucratic principle of not identifying work with a worker facilitates flexibility. In this way, work functions are more amenable to change than are the personalities of workers (Kallinikos, 2004).

Two other reasons for advocating bureaucracy as an organizational model are first, that it provides labour security and social security (Jones et al., 2005); and second, that it helps build a stable and predictable identity, even in an unstable and culturally-fragmented environment (Du Gay, 2005). Bureaucracy has the capacity to promote the right context to stimulate better behaviours (Courpasson, 2000). Bureaucracy is important too because it discourages people from taking voluntary actions that can generate unconscious risks. Bureaucratic constraints on the freedom of managers are good reasons for the maintenance of bureaucracy and not for its extinction (Du Gay, 2005). Bureaucracy balances the dangers of arbitrary power.

Thus, in view of the above, the idea that we live in a post-bureaucracy world should be denied. Many observers have perceived the social and technological changes that have occurred in recent decades as the end of the bureaucracy. However, this is an exaggeration, since organizations have adapted bureaucracy to new contexts. There continues to be a focus on control issues and regulations, within hierarchical divisions of bureaucracy. This focus may not be as rigid as in the past, and may place high value on organizational culture. Thus, bureaucracy is presented as an enabling factor, not a coercive factor (Adler & Borys, 1996). Bureaucracy today is not the same as it was in the mid-20th century – it is a neo-bureaucracy. Nonetheless, the organizational form, bureaucracy, continues. This is partly because it has benefited from informational and technological innovations. The neo-bureaucratic organization is a hierarchical one, with formal rules and responsibilities, where decisions are justified by a higher authority. It still aims to control the inherent uncertainty of the human factor. It represents a formalization of practices, anchoring an organization in written rules and formalisms (as considered by Stinchcombe in

1959). However, this concept also values informal communication and powerful influence, something not considered in Weber's original concept (Garston, 1993).

Goodsell (2004) advocates bureaucracy by presenting it as a means for giving coherence to the complexity of public action. Through the regulation that is an inherent part of bureaucratic endeavour, it is possible to create an environment that limits, but also allows, commitment to a mission beyond profit. Under such a view, bureaucracy represents a condition, rather than a limitation, for freedom. According to Styhre (2007), bureaucracy is, and will always be, one of the main forms of organization.

In the following section, we present the research method and the main objectives of this study.

3. Research Method

The main objective of this essay is to understand whether the phenomenon of bureaucracy exists in the BSC as a component of MAS in contemporary organizations. We address this objective by drawing on the work of Weber (1922) and more recent literature on bureaucracy (especially Styhre, 2007). We use a coding scheme developed during the reading of this literature to relate it to the BSC literature. This involved a set of nine themes/concepts that we use to identify bureaucracy. Then, after reviewing the work of Kaplan and Norton (1992; 1996; 2004) on the BSC, we address the relationship between the BSC and the bureaucracy. This relationship is explored by looking for correspondences between each of the nine themes/concepts and the processes, rules and features of the BSC. A conceptual matrix summarising the main themes/concepts we relied on is presented below in Table 6.

4. Discussion: Bureaucratic Principles of the BSC

Initially, management accounting was considered mainly as providing cost information for organizations. However, understanding of management accounting is viewed now as being much more complex — as a set of processes known as MAS that provide information to help management make the best possible decisions and thereby create value. MAS are not simply mechanical processes. They also have a persuasive and narrative role, and a community creator role (Hoskin & Macve, 1986). MAS are conceived as a way of communicating that represents reality so as to assist decision-making (Quattrone, 2015). Individuals mentally construct MAS with virtuosities and limits. MAS should be seen as more than simple collectors and processors of information, but as a way of influencing behaviours, proposing questions, and stimulating new analysis. The BSC, a component of broad conceived MAS, incorporates these traits.

Bureaucratic organizations are based on record-keeping (Maniha, 1975). The emergence of bureaucracies cannot be separated from new technologies. Both are based on saving, sharing, and reproducing information. Therefore, just like management accounting, bureaucracy is based on the information capabilities of an organization. There is an immediate relationship between the two concepts. MAS are well suited to impartial systems of performance evaluation. This arises because of their capacity to validate disciplinary order by saving and dealing with relevant information.

Over time, the bureaucratic form has adapted to new contexts and challenges (Hales, 2002). Contemporary MAS have adapted similarly too. For example, new accounting systems call for forms of bureaucratic control of routines and rules (Clegg et al, 2005). The BSC is an example of a component of MAS that evidences bureaucratic form. To illustrate this, we now describe the concept and processes of the BSC and highlight its main traits in relation to the nine bureaucratic concepts we proposed (*authority, jurisdiction, professional qualifications, knowledge, rationality, discipline, accountability, systematization, transparency*).

The BSC is a strategic management tool developed by Kaplan and Norton (1992). Its constant evolution has led to an aligned and global measurement model that allows the organization to be oriented towards value creation (Pérez Granero et al., 2017). The BSC focuses attention on four fundamental analytical perspectives of an organization: learning and growth, internal business process, customer, and financial (Kaplan & Norton, 1992). Learning and growth is often regarded to be the most important perspective, since it helps an organization to change and improve (Kaplan & Norton, 1996). This perspective values and enhances learning ability, at an organizational and individual level. The BSC cares

whether all functions are performed by capable, qualified workers. The BSC tries to foresee new competitive advantages. From this, the presence of the bureaucratic concepts of *knowledge* and *professional qualification* is evident.

The BSC also helps to display the integral vision of an organization and how innovation is actively supported by an organization's culture (Ax & Greve, 2017). Furthermore, the BSC aligns all organization perspectives with central objectives (Quesado et al., 2014; Kaplan & Norton, 1992), idealizing a system. The BSC seeks to help understand what happens in an organization that is committed to cooperation, control, learning, and adaptation. Thus, this means that an organization is committed to *systematize* the organizational order — a concept crucial to bureaucratic order.

The BSC uses a strategic map to highlight co-relationships between the four perspectives and each of their designated performance indicators (Kaplan & Norton, 2004). This helps to engender a rational order by eliciting a coherent sense of organizational reality, and by preventing managers and employees from going in different directions and with different interests to those of the organization (Kaplan & Norton, 1996). Although Ittner and Larcker (1998), Nørreklit (2000) and Malmi (2001) have questioned such a deterministic relationship, these relationships are consistent with *rationality* – a defining trait of bureaucracy. Accordingly, every plan and measure operates from the strategic level to the operational level; and from the general level to the individual level. As such, an *authority* principle is present. The strategic design serves as a central authority that instigates a participative culture and identifies major responsibilities.

To achieve the major goals of a BSC it is important to design procedures and define tasks accurately. The formal definition of different functions and tasks represents the bureaucratic concepts of *jurisdiction* and *discipline.* Workers know what their obligations and functions are, the criteria by which they will be evaluated, and consequences of divergent behaviors (Kaplan & Norton, 1996). They receive the information needed to perform their functions, as well as feedback to help them improve. Here, the *transparency* concept is present. The BSC tries to be as objective as possible, whilst caring for organization flexibility and adaptive capacity.

In implementing a BSC, managers should be concerned about motivational factors too. They should involve workers in a collaborative regime, not a imposed one, in defining procedures and clarifying their various functions and sensible performance measures (Cokins, 2014). A culture where the driving forces are not the fear of penalty or the expected reward, according to the performances. In such an

organizational culture, commitment overlaps obedience. However, it should do so within the security and transparency that an established order guarantees, in line with the idea of neo-bureaucracy.

The BSC evolved from linking an organization's strategic management system with its reward system (Speckbacher et al., 2003). This occurred in a management control framework that was anchored by accurate and continuous performance evaluation measures (Kaplan & Norton, 2004). The BSC is based on performance evaluation and features metrics and patterns established in a way that is symptomatic of the bureaucratization of control (Ferner, 2000). Personal *accountability* is based on *transparent* and known responsibility criteria — both bureaucratic concepts. The BSC emphasizes the link between rewards and *accountability*. Goals and performance evaluation are defined to encourage workers to adopt organizational interests, and promote self-control (Du Gay, 2005). Although there is *discipline,* this is not intended to be oppressive, but respectful. Therefore, the BSC is an evaluation and control process that strives to evince personal responsibility. It is *neo-bureaucratic* in the sense that workers are induced to feel some autonomy in their position.

Thus, we contend that the BSC incorporates bureaucratic principles in a way that counterbalances negative perceptions of bureaucracy. Table 6 synthetizes the relations between bureaucratic concepts and the BSC traits described above.

Table 6

Bureaucracy Concepts and the Balanced Scorecard

Concepts of Bureaucracy	Balanced Scorecard Kaplan & Norton (1992; 1996; 2004)
Rationality	Strategic map.
Jurisdiction	Procedures. Tasks. Functions. Control.
Discipline	Collaborative Regime.
Accountability	Responsibility. Reward.
Systematization	System idealization. Alignment.
Transparency	Feedback.
Authority	Hierarchy. Participative culture.
Professional qualifications	Learning and growth perspective.
Knowledge	Learning and growth perspective.

The BSC is one manifestation of how management accounting has evolved technologically and socially, by making use of bureaucratic concepts. These concepts convey the ideas of *soft* bureaucracy (Kärreman & Alvesson, 2004), *selective* or *enabling* bureaucracy (Adler & Borys, 1996; Styhre, 2007), and *learning* bureaucracy (Adler, 1993). In the era of neo-bureaucracy, traits of coercion and rigidity have been eliminated. Commitment is valued over obedience in a culture committed to a sense of order or discipline. This conditions and contextualizes individual freedom and keeps the organization flexible and adaptive.

The BSC can be conceived to be bureaucratic because it maintains a hierarchical organizational structure in which responsibilities are defined by recognized rules and decisions are justified by obedience to a higher authority.

5. Conclusion

To the best of our knowledge, this study is the first to address the relationship between bureaucracy and the BSC. We have reviewed the relevance of bureaucracy for MAS in contemporary organizations. We have outlined features of bureaucracy that are evident in current BSCs.

We find that the BSC reflects a neo-bureaucratic order by tacitly recognizing positive aspects of bureaucracy. However, the bureaucratic order we highlight differs from nineteenth century conceptions of bureaucracy. New terms have arisen (such as learning, enabling or soft) to describe bureaucracy. This leads to assimilating a new conception of bureaucracy in the design and implementation of the BSC. Like any bureaucratic regime, the BSC develops control processes and defines tasks accurately. However, the BSC should also be recognized for pursuing commitment rather than obedience; and for operating under a hierarchical order that involves employees in defining goals and functions.

We present a new analytical perspective of the BSC, thereby broadening the scope of extant studies on the BSC. As a theoretical contribution, we have highlighted the value of nine concepts that define a contemporary bureaucratic organization. We apply these concepts to develop a theoretical understanding of the BSC as a neo-bureaucratic tool. The summary of findings in Table 6 can be used in future empirical research on the topic. The perceived relationship between bureaucracy concepts and the BSC suggests that a good way of assessing the degree of bureaucracy in an organization is to study its MAS.

The present research can be a starting point for further research on a topic that is largely unexplored in the literature: the presence of bureaucracy in the MAS. This essay does not offer empirical support for the arguments made. Thus, future research would be beneficial if it used case studies to validate the relationship between the bureaucracy concepts and the BSC concepts proposed in this essay. Future research could also evaluate other prejudices about bureaucracy (especially in the context of other management accounting techniques, such as Total Quality Management or Activity Based Management).

Essay 3 - Bureaucracy and the Balanced Scorecard in Health Care Settings[3]

[3] Earlier versions of this essay were presented at the *XVIII Encuentro AECA*, Lisbon, 2018, titled *O Balanced Scorecard e a Burocracia no Meios Hospitalar – Revisão de Estudos Empíricos* and at XXIV Workshop on Accounting and Management Control (Konopka), Coimbra, Portugal, 2019, titled *The Balanced Scorecard Impact on Hospital Bureaucracy*. It was also presented at EEG Research Day, Braga, Portugal, 2019, titled Neo-bureaucracy in a Portuguese´s Local Health Unit Managed by the Balanced Scorecard; and at 19th Annual Conference of the European Academy of Management, Lisbon, Portugal, 2019, titled *Neo-bureaucracy in a Portuguese´s Local Health Unit Managed by the Balanced Scorecard*. The essay was published in 2020, in the *International Journal of Health Care Quality Assurance* 33(3): 247-259, titled *Bureaucracy and the Balanced Scorecard in Health Care Settings* (WoS Indexed Journal).

Bureaucracy and the Balanced Scorecard in Health Care Settings

Abstract

We explore the relationship between the Balanced Scorecard (BSC) and neo-bureaucracy by investigating whether the operationalization of the BSC incorporates 'neo-bureaucratic' ideas; and whether the BSC implemented in a Portuguese Local Health Unit (LHU) evidences a neo-bureaucratic approach. We conduct semi-structured interviews with LHU staff and analyse documents to assess whether features of bureaucratic organization were evident in the use of a BSC by the LHU. We found nine bureaucratic features evident in the LHU's BSC. These were systematization, rationality, authority, jurisdiction, professional qualification, knowledge, discipline, transparency, and accountability. The BSC used at the LHU evidenced a neo-bureaucratic approach. Our study helps to demystify bureaucracy and overcome prevailing prejudices regarding some of its principles. Health care managers should recognize and endorse neo-bureaucratic principles in developing a BSC. They should recognize the BSC as involving a neo-bureaucratic approach. The BSC is a valuable management tool that hospital managers should find useful fostering flexibility, collaboration, innovation and adaptation – all of which should help lead to improved health care outcomes.

Keywords: Balanced Scorecard, Bureaucracy, Health Care Management, Management Accounting, Organizations, Portugal.

1. Introduction

This paper provides a nuanced understanding of the features and characteristics of a management tool that is widely used to facilitate the management of health care facilities: the Balance Scorecard (BSC). A review we conduct of studies that report the use of the BSC in health care settings reveals evidence of bureaucratic principles. We also study whether the BSC used in a Portuguese Local Health Unit (LHU) evidences adoption of bureaucratic principles.

The present study is the first to explore the bureaucratic implications of the BSC in a health care context. Our intent is to promote awareness of the characteristics of the BSC when it is used in health care settings. In particular, we explore whether the BSC evinces any, or all, of nine neo-bureaucratic traits in those settings. This exploration is not conducted for reasons of curiosity or simply to rehabilitate the (usually) odious reputation of 'bureaucracy.' Rather, the intent is to promote deeper insights into the presence of neo-bureaucratic traits. This, thereby, will assist with the use of the BSC in operational management of health care facilities.

Health care organizations have a reputation for being rigid and difficult to manage (Chang et al., 2017). Often, this is attributed to the conflicting interests of doctors, nurses, administrators, and community members. One way of addressing the intrinsic problems of coordination and collaboration in health care management is to develop a strong and appropriate culture in which the particular interests of various parties are reconciled with collective needs (Glouberman & Mintzberg, 2001). However, a persistent difficulty is to ensure that management of health care facilities adapts to an environment characterized by continuous technological evolution and increasing financial and social demands.

Good management support systems are required to address this issue of adaption. The BSC has been adopted widely as a management tool to implement and reinforce good management control (Koumpouros, 2013). A BSC approach can be beneficial to the management of hospitals by helping to evaluate performance, implement policies, facilitate control, aid accountability, and assist with strategy development (Gao et al., 2018; Aidemark & Funck, 2009).

In response to ever-changing technological, demographic and cultural factors, government-sponsored hospitals have instituted control systems that exhibit traits of a bureaucratic order — perhaps in response to demands of government bureaucracy (Lega & Pietro, 2005). Nonetheless, management accounting systems in health care organizations struggle to adapt to cultural challenges. Often, they inadequately prepare hospitals to deal with social, environmental, and political issues. The BSC offers a potential

solution to this because it encourages collaboration and cooperation, and promotes an integrated culture (Kaplan & Norton, 1996).

The next section of this paper reviews empirical studies of the use of the BSC in a hospital environment, highlighting the bureaucratic features of a BSC. We then outline the research method and main findings of the Portuguese case study we conduct, before engaging in discussion.

2. The Balanced Scorecard and the Health Care Environment

Although the BSC was developed initially for private sector business organizations, its use has quickly extended to the public sector, including health care facilities. The BSC is claimed to lead to better management because it enhances control, reduces uncertainty, and helps organizations achieve their objectives (Aidemark, 2001). The BSC has been adopted widely to evaluate health care performance. Nonetheless, in some countries, such as Portugal, the BSC is under development (Gonzalez-Sanchez et al., 2018). As its name suggests, the BSC provides a 'balanced' information system. The aim of the BSC is to yield a more acute and apolitical assessment of hospital performance — and one that will help to optimize efficiency and effectiveness in providing hospital services (Cleven et al., 2016).

The BSC identifies four crucial perspectives that affect an entity's activity and outcomes. These are *employee learning and growth* → *internal processes* → *financial* → *customers* (Kaplan & Norton, 1996). When properly adapted to the management of hospitals, the BSC can help achieve self-set goals and goals that are imposed by law or government regulation. In hospital settings, the four perspectives of the BSC have been adapted to focus on patients specifically, and to engender a patient-centeredness in strategic decision-making (Lin et al., 2013). The BSC has been claimed to encourage effective clinical teamwork, clarify processes and outcome indicators, and improve leadership (Jones & Filip, 2000). The BSC can be adapted to meet the particularities of hospitals (Catuogno et al., 2017).

In the health care sector, advances in information and communication technologies have led to a proliferation of potential performance indicators. These rely on data that are often scattered in non-integrated systems. A potential benefit of the BSC is its capacity to provide a platform for the selection of performance indicators that will help achieve desired outcomes and facilitate complex changes (Al-Katheeri et al., 2018).

The BSC is well-suited to the analysis of performance in large and complex hospitals (Yap et al., 2005). The BSC relies on quantitative transparency induced by feedback so that employees are aware of how their performance is measured. Such transparency is crucial in sustaining the reward mechanisms that encourage employees to perform better (Gibbs et al., 2004). This is important because of the reliance by the health care industry on performance incentives and measures that incorporate responsibility and integrity (Nur & Ramli, 2015).

The BSC stresses the importance of continuous learning in driving organizational performance and in sustaining innovation and continuous improvement (Kaplan & Norton, 1996). However, in Brazil, Correa et al. (2014) found that a hospital's BSC inhibited innovation and creativity, promoted immobility,

and discouraged activities that pushed performance ahead after the original targets had been achieved. Two other studies have reported that a bureaucratic culture has impeded initial implementation of a BSC (Türkeli & Erçek, 2010; Rabbani et al., 2010).

Nonetheless, the potential value and relevance of the BSC in addressing the distinctive challenges faced by hospital managements is well-supported in other studies: for example, those of Gurd and Gao (2007), Emami and Doolen (2015), Trotta et al. (2013) and Niemiec (2016). The British National Health System has implemented the BSC (Radnor & Lovell, 2003). In Italy, the strategic use of management accounting tools, such as the BSC, has improved health care processes (Demartini & Trucco, 2017). In China, health system reforms aimed at solving operational inefficiencies, have led to the gradual implementation of the BSC (Lin et al., 2014): for example, the BSC is used to evaluate operating room performance in a Shanghai hospital (Lin et al., 2013).

3. Bureaucracy and the BSC in the Health Care Environment

3.1. Concepts of bureaucracy in the BSC

Many organizations have adopted the following principles of classical bureaucracy: rational organization, objectivity, and legal authority (Weber, 1922). A classical bureaucracy embraces guidelines that are legal (e.g., impartiality), economic (e.g., efficient task execution), social (e.g., minimization of conflict) and ethical (e.g., dignity). Nonetheless, classical bureaucracy has proven inadequate in coping with the pace of change in contemporary society and the wide range of specialized professionals found in modern health systems (Lega & Pietro, 2005). The broader concept of bureaucracy has not been discarded in those settings. Instead, the premises of bureaucracy have been adjusted. This has led to what is now termed 'neo-bureaucracy' (Farrell & Morris, 2003).

Neo-bureaucracy maintains the classic bureaucratic concepts of systematization, rationality, authority, jurisdiction, professional qualification, knowledge, discipline, transparency, and accountability (identified in the second essay – The presence of bureaucracy in the Balanced Scorecard). However, as outlined below, it does so in a different way.

The concepts of bureaucracy are:

(1) Systematization: strict and systematic discipline and operational control;
(2) Rationality: absence of personal interests, objectives, and arbitrariness. Guidance is provided by pre-defined rules and regulations;
(3) Authority: administrative organization is formally defined with a clear hierarchy of departments;
(4) Jurisdiction: each department has its sphere of competence defined clearly and legally;
(5) Professional qualification and knowledge: selection of all staff is based on technical qualifications;
(6) Discipline: a form of behavioural control emerging from an organization's control system, instruments of power, and means of administration;
(7) Transparency: people in an organization can perceive the reasons for their orders and the consequences of their behaviour; and
(8) Accountability: keeping records and establishing a hierarchy of responsibilities (Weber, 1922; Styhre, 2007).

Classic bureaucracy differs from neo-bureaucracy mainly in the understanding of the concept of discipline. With neo-bureaucracy, discipline arises from adaptive collaboration. In contrast, in classical bureaucracy, discipline is imposed. This conceptual difference affects how authority is perceived and

exerted; and how other bureaucratic concepts (mainly systematization, accountability, and jurisdiction) are manifest. Thus, neo-bureaucracy 'softens' hierarchical authority. Decisions are not taken rigidly from top to bottom in the organizational hierarchy. Rather, rules are negotiated, and flexibility in individual circumstances is respected. Neo-bureaucracy is more enabling than coercive (Adler & Borys, 1996). Because of this, it is conducive to helping organizations deal with innovative, but sometimes disturbing, processes (Craig, 1995). The neo-bureaucracy approach in cutting-edge technology companies helps to create innovative records, improve security, and promote labour transparency (Styhre, 2007).

The use of a BSC implies initiating, continuing or adapting the bureaucratic order in an organization. This often evinces the presence of neo-bureaucratic concepts (as argued in the second essay – The presence of bureaucracy in the Balanced Scorecard).

A BSC is based on the systematization and monitoring of organizational activity. The design of the BSC reflects a rationality that is translated into a strategic management map. In the BSC, employees have their obligations clearly defined and framed into action plans and targets. In implementing a BSC, an authority that is not externally emphasized is prominent nevertheless. The BSC outlines an internal jurisdiction and a discipline that regulates labour relations and confers a degree of security to employees. The discipline in the BSC emerges from a collaborative culture in which several rational interests are aligned (Glouberman & Mintzberg, 2001). Such a collaborative culture minimizes the possibility that individualism will thwart the effectiveness of the BSC (Qu & Cooper, 2011).

Learning processes are a special concern of the BSC. They are crucial to innovation and business growth. Learning denotes that knowledge and professional qualifications are priorities in achieving success. The BSC also highlights the principle of accountability and supports this through processes of control and coordination (Kaplan & Norton, 1996). The BSC strives for transparency by clearly defining responsibilities and functions; and by informing employees about their performance in terms of implemented indicators (Kaplan & Norton, 1996). Executive leadership is crucial in implementing the BSC and ensuring employees collaborate and aspire to organization development (Adler & Borys, 1996).

3.2. Review of studies reporting use of a BSC in hospitals

We searched the terms 'BSC and hospitals' and 'BSC and health' on the website of *B-on* (https://www.b-on.pt/). This website contains journals listed by the *Web of Science, Scopus* and *PubMed*, among others. The following search filters were applied: integral texts, peer review, published in academic journals, and written in English. The search revealed 124 studies. Within those papers, we searched the

exact expression of any of the nine bureaucratic features aforementioned. We also searched for synonyms or related terms that might point to the same characteristics such as cooperation (for discipline), training (for professional qualification and knowledge), hierarchy (for authority), control (authority, jurisdiction or accountability), and formality (jurisdiction). Despite the high number of papers searched, few identified bureaucratic features: only 16 mentioned at least one of the nine bureaucratic features. The studies are reviewed below.

In the United States, a study of MedCath hospitals reported that the BSC was effective in streamlining organizational learning and updating staff knowledge and professional qualification (Guinane et al., 2006). Another US study in hospital settings stressed the importance of the BSC's learning and growth perspective in achieving improved performance because of the focus it applied to the professional qualification and knowledge of hospital staff (Emami & Doolen, 2015). In Taiwan, Wu and Kuo (2012) highlighted the importance of the BSC in evaluating information technologies, learning, and knowledge.

By using the BSC as a way of evaluating performance, Gao et al. (2018) suggested ways of improving performance in five Chinese hospitals. In particular, they recommended knowledge development through medical training.

A Brazilian study of the BSC in two hospitals (one public and one private) emphasized the importance of promoting collaborative dialogue; and highlighted the potentially imposing nature of the presence of an appropriate and contextualized discipline (Correa et al., 2014).

In the United Kingdom, a study of the National Health Service acknowledged the growing importance of assessing performance when providing health care services and highlighted the BSC's ability to meet accountability requirements (Radnor & Lovell, 2003). In a US study, Walker and Dunn (2006) showed how accountability that was developed through applying BSC metrics improved performance and strategic management. A study in an American university hospital concluded that the BSC was valued in a multi-interest environment because of its capability to develop accountability adjusted to such an environment, and because it was sufficiently transparent to be considered reliable (Trotta et al., 2013).

In Lebanon, a study of the BSC in 52 hospitals reported that improved services arose because benchmarking and evaluation standards improved accountability (El-Jardali et al., 2011). Similarly, hospital administrators in Ontario, Canada, emphasized the helpfulness of the BSC as a tool for comparative evaluation and external accountability (Chan, 2004). Yap et al. (2005) refer to a hospital report that revealed 55% of hospitals in Ontario have an accountability framework in which the BSC was important. A Malaysian study of the structure of private hospitals, and their performance in terms of the

BSC, mentioned the development of a strongly centralized and formal structure — indicating authority and the development of accountability (Nur & Ramli, 2015). Such a structure assisted in evaluating performance because of its emphasis on transparency. A Californian study of the implementation of the BSC in a group of hospitals also acknowledged the creation of transparency and accountability (Hwa et al., 2013).

In Jordan, a study endorsed the BSC approach as a means of evaluating hospital performance. The BSC was found to help achievement of the main objectives of the Jordanian public health sector (cost efficiency and transparency) (Nassar et al., 2015). In Australia, Van de Wetering et al. (2006) studied the application of the BSC in the Picture Archiving and Communication System of a large hospital. They reported a dominant transparency perspective. In similar vein, the relevance of transparency for a successful BSC was demonstrated in the US in a financially struggling community teaching hospital (Lorden et al., 2008).

The preceding literature review finds the term accountability expressed in eight studies, transparency in six, knowledge in four, professional qualification in two, and discipline and authority in one. Table 7 summarizes these studies with reference to bureaucratic concepts. Thus, the bureaucratic features of accountability and transparency were especially prominent. None of the empirical studies reviewed made a straightforward mention, or alluded to, jurisdiction, systematization, or rationality. However, due to the small number of empirical studies conducted, the absence of these terms does not allow any reliable conclusion to be drawn. The review conducted indicates the current importance of some concepts of bureaucracy and hints at their close relation to the BSC.

For purposes of additional validation, and to add another contextual setting to the empirical database, we report below on a Portuguese case study. Our aim is to determine whether the features that describe bureaucratic order were present in a BSC in a Portuguese LHU.

Table 7

List of Studies of BSC in Hospitals with Reference to Bureaucratic Concepts

Concepts of Bureaucracy	Balanced Scorecard Papers
Systematization	—
Rationality	—
Authority	Nur Faezah Mohd and Ramli (2015)
Jurisdiction	—
Professional Qualifications	Emami and Doolen (2015) Guinane et al. (2006)
Knowledge	Emami and Doolen (2015) Gao et al. (2018) Guinane et al. (2006) Wu and Kuo (2012)
Discipline	Correa et al. (2014)
Transparency	Hwa et al. (2013) Lorden et al. (2008) Nassar et al. (2015) Nur Faezah Mohd and Ramli (2015) Trotta et al. (2013) Van de Wetering et al. (2006)
Accountability	Chan (2004) El-Jardali et al. (2011) Hwa et al. (2013) Nur Faezah Mohd and Ramli (2015) Radnor and Lovell (2003) Trotta et al. (2013) Walker and Dunn (2006) Yap et al. (2005)

4. Research Method

4.1. Setting and case purpose

The operational setting was the LHU of the North Regional Health Administration (RHA) in Porto, Portugal. This LHU is a public legal entity, is entrepreneurial in nature, and has administrative and financial autonomy. In 2018, the LHU comprised seven primary health care services, a hospital (with 1867 employees and 342 beds), an intensive care unit, a Care Support Area, and management and logistic areas.

We explore whether features of bureaucracy were present in the BSC to manage the LHU. Based on the second essay – The presence of bureaucracy in the Balanced Scorecard nine bureaucracy features were proposed: systematization, rationality, authority, jurisdiction, professional qualification, knowledge, discipline, transparency, and accountability. Were these features present in the LHU's use of the BSC?

4.2. Data collection

We used an interpretative, qualitative approach (Beuving & Vries, 2015) to collect data. This involved document analysis and interviews of key employees (Somekh & Lewin, 2005). First, we met with a member of the LHU board in 2014 to assess the organizational structure of the hospital; understand how to best select interviewees; and assess how to gather information about the operational functioning of the hospital's BSC.

Nine staff members were interviewed between 2015 and 2018. The length of the interview process had the additional benefit of allowing us to assess the temporal sustainability of the BSC in the LHU and the consistency of responses over time. Some interviewees had responsibilities across more than one department. After the ninth interview, it became apparent that no further interviews would be necessary since it was unlikely that extra insights or added value would accrue beyond this 'saturation point' (Somekh & Lewin, 2005, p. 37). We selected interviewees based on their area of responsibility and rank in the hospital's management. They comprised a member of the board, the manager of the contracting office, the manager of the planning and control office, two service managers from the Care Support Area, and four department managers (every manager responded directly to the board of directors). The interviewees were selected because they presented an integrated view of the management, but from different perspectives (Appendix A presents the list of the interviews conducted).

The interviews were conducted in Portuguese, the native language of all interviewees, at the interviewees' workplace. The average duration was 57 minutes. We develop a script that was specific for this study using the bureaucratic features developed in the literature review (Appendix B presents the list of the interviews questions). We sent the script of the proposed interview to interviewees in advance to allow them an opportunity to prepare. The interviews were semi-structured to facilitate flexibility and spontaneity. The questions had dual intent: first, to verify how the design and implementation of the BSC were followed; and second, to highlight any bureaucratic features of the BSC. Interviewees were given time to develop their responses. Whenever necessary, we read back answers to interviewees in summary form to confirm their understanding. Six of the nine interviews were recorded. Three interviewees did not give permission to record the interview. We used *Transcreve* to help transcribe the recorded interviews and *N-Vivo* to help analyse interview content. We sent all interview transcripts to respondents to allow them to check for accuracy and make any necessary amendments.

We also analysed several of the LHU's internal documents. These included the annual report and accounts; annual report of activities of the internal audit service; code of ethical conduct; internal control report; internal regulation; objectives, indicators and targets maps; plan of activities and budgets; program contracts; regulation internal communication of irregularities; report of corporate governance; sustainability report; strategic map and strategic axes (Appendix C lists the documentation analysed). To enhance reliability and counteract the risk of bias in the interviews, we triangulated results with the document analyses for assurance purposes.

4.3. Data analysis

To validate systematization, we examined how the plans of each department articulated and how their objectives influenced the individual objectives and actions of employees. In doing this, we explored whether managers understood their contribution to the higher goals of the LHU. With respect to rationality, we searched for rational criteria in the hospital's strategy. For authority, we assessed whether there was a well-defined hierarchy, with well-differentiated responsibilities. In terms of jurisdiction, we sought to understand whether protocols and action plans were defined, whether responsibilities were recognized and formalized, and whether there were any informal relations evident. In addition, we sought to understand whether staff agreed with the processes instituted, followed them, and engaged in any discretionary behaviours.

With respect to professional qualification and knowledge, we looked for aspects of learning and growth, such as training actions that gave personnel formal employment-related credentials. Regarding discipline, we explored whether a recognized order was present and, if so, how to characterize that. For transparency, we focused on the existing feedback processes in the LHU. We wanted to know whether personnel were aware of evaluation criteria and trusted the evaluation process. We also explored the existence of control through accountability or reward processes.

5. Results

The LHU's implementation of the BSC occurred in two stages. In 2008, the initial implementation was driven by mimetic isomorphism — that is, by a management decision to follow the lead of private organizations. In 2010, coercive isomorphism was evident in the imposition of the BSC by the RHA: that is, by an external (political) decision (DiMaggio & Powell, 1983). The LHU developed the BSC for clinical departments of medicine, surgery, anaesthesia, outpatient care, nursing mothers and youth, imaging, diagnosis and treatment, emergency and intensive medicine, and mental health. The BSC was also developed for three of the eight services provided by the Care Support Area: social service, nutrition service, and central sterilization service. At the end of each year, the following year's activities plan and budget were drawn up and submitted to the board of directors for approval, along with BSC indicators.

During the phasing-in of the BSC, meetings were held to provide information and allow for interaction between departments. When scorecards for individual departments were created, there were concerns about the way several departments were strategically aligned. This concern was expressed in the LHU:

> *There has to be alignment. If the objectives of the services are disconnected from the objectives of the people, of the employees, each one is working in opposite directions* (Interview A, Member of the Board);

> *Despite increasing the workload, the BSC helps organize the data and interconnect the strategic objectives of each department* (Interview B, Manager of Contracting Office).

There is an understanding, at least at the managerial level, that:

> *... our decisions are always supported, even if unconsciously, by the objectives that ultimately will translate our vision, our mission* (Interview A, Member of the Board);

> *There has to be an alignment with the plan ... this has to be an orchestra, we have to play all together to the same side* (Interview I, Manager of Mental Health Department).

We noted an unfolding of indicators, from the global to the individual:

> *There are individual indicators and the overall performance index ... the indicator may or may not be fulfilled, but ... the results in some indicators compensate the results in others* (Interview B, Manager of Contracting Office).

Each department of the LHU is concerned about their performance as they internalize the commitment with the program contract:

> *... we intervene in all situations of the organization; if we say that we will not evaluate network situations we will undermine the external contracting of the institution* (Interview D, Manager of Social Office).

In the third clause of the 2010 program contract, the LHU undertakes to develop an internal contracting process with its production units. This should define the BSC with objectives and indicators for all clinical services / departments and centers of responsibility aligned with LHU strategy. All the performance indicators contracted externally with the RHA, and the internally established objectives, were included in the BSC. This was because they all affected the level of hospital financing. The process of collecting information for the diverse range of performance indicators was lengthy: some were not easily measurable and their calculation was not automated by the information system. A common criticism was of the inadequacy of the information system for the demands of the BSC. The compilation of much relevant information for the BSC was not centralized and its integration into the BSC was very time-consuming.

> *... there is a work data construction, there is a work of analysis, there is a work of articulation with other departments ... it's a lot of work ... at this moment, we do not have yet a BI solution that allows us to present the data reliably and completely in the way that the contracting policy office requires. ... Basically, what the BI systems build is a Tableau de Board*

> *not, the Balanced Scorecard, because it cannot associate the indicators to each strategic objective* (Interview A, Member of the Board).

The planning and management control service collected information from the diverse departments. Subsequently, the contracting office analysed the information and reported detailed deviations from the plan to the management board. If the deviations were negative, new information could be requested from the respective departments and plans proposed for improvement. This analysis was performed quarterly. All departments were provided with feedback from the departmental indicators in the BSC.

All departmental strategic maps in the LHU were derived from the LHU's overall strategic map. Objectives and measures were defined and framed for strategic purposes in order to avoid discretionary drift or abuse:

> *This is the great advantage of the Balanced Scorecard. It allows us to focus and look at the strategic map, and think about what we want, where we are and where we want to go, if we are doing our job well, if we are in line with our objectives or are escaping from them…It is very easy to deviate from our focus. The day-to-day is so intense, we no longer have the capacity and the distance to see things more comprehensively, so the option for the Balanced Scorecard; It forces us to think strategically. The Balanced Scorecard is much more than a scorecard* (Interview A, Member of the Board).

There was a properly formalized hierarchical order in the LHU. Each department had a management team with a director (a senior doctor), a manager, and a nurse or technician. Generally, all staff knew who they reported to and who reported to them. Department managers reported directly to the board of directors, and in turn, they reported to the RHA. Despite a well-defined hierarchy, the management teams had some autonomy, and there was a culture of communicative leadership.

The LHU operated a 'shared folder' system in which global information for each department was available for regular informal communication between departments. Staff felt free to discuss what was expected of them and the consequences of their acts:

> *... people are much more documented. They have, in fact, much more information about what they actually produce and perform, and the impact the results of their departments or services have in the overall fulfilment of the institution's objectives. ... For me, the Balanced Scorecard is a vehicle of communication par excellence and I think it has ... fulfilled with its fundamental role* (Interview C, Manager of Planning and Control Manage Office).

Protocols and action plans were well defined and staff recognized their functions and responsibilities. There are examples of directors that suggest the importance of stipulated protocols:

> *... telephone and verbal requests were often used. I abolished them that because the requests should not be made in the corridors. There has to be a protocol ...* (Interview D, Manager of Social Office).

An *Internal Regulation* clarified the constitution, organization, and objectives of each department, together with the competencies of their management team. A document titled *Segregation of Functions* and the *Corporate Governance Report* clarified the functions of the board directors. Although workers agree with established processes, there is some flexibility. Sometimes the order has to be submissive to the real aims of the organization:

> *...we have to give a timely and adequate response with quality to the situations that we have to work on ... so that the patient is served [in order] that the institution also has a good image ...; [the BSC] 'is an analytical support instrument that can help us in the design of the service, in the intervention of the service, but in the day-to-day we have to work with the citizens* (Interview D, Manager of Social Office).

The LHU had a *Knowledge Management Service* with a training centre and a library. This service diagnosed the training needs of the diverse departments and established an annual training plan. Several training courses were offered to improve the diffusion of the BSC. There was good awareness of training

courses. However, there were concerns about the general lack of financial resources to fund training activities and about the lack of time to attend training. Nonetheless, training and knowledge were generally highly valued and encouraged. In 2017, the LHU was associated with 82 research studies and 57 articles published in journals indexed in *Pubmed*. The LHU encouraged research and identified research projects and outcomes in the *Sustainability Report*.

There was an established order in the LHU, fostered by a *Code of Ethical Conduct*. This code expressed a *Policy of Conflict of Interest* and promoted discipline and a collaborative spirit, as intended by the BSC. The content of this document develop and care for a collaborative spirit, as intended by the BSC:

> *All communication channels are fostered so that the opinion of each professional is considered and duly valued and respected* (Code of Ethical Conduct, p. 8).

It projects a safe environment that invites the participation of all personnel in the design of the BSC. This is done by 'meeting with everyone from departments and management councils to define the strategic map and the Balanced Scorecard' (Interview B, Manager of Contracting Office).

The LHU had established a set of strategies, policies, processes, rules, and procedures as part of an internal control system. Expected operational deviations and instances of internal non-compliance had to be justified by the directors responsible — not as a penalty, but as a natural way of improvement. All employees, except physicians, were subjected to an individual assessment process. An *Internal Control Report* guided the communication of irregularities (such as violation of regulatory and deontological principles and legal provisions) by members of statutory bodies, employees, and suppliers. Of the various internal control mechanisms implemented at LHU, the following stand out:

- *Code of Ethical Conduct;*
- *Administrative and accounting procedures;*
- *Certification by ISO 9001: 2008 normative reference;*
- *Rules of procedure;*
- *Segregation of functions;*
- *Continuous training of human resources;*
- *Conflict of interest policy;*

· Reporting of irregularities. (Internal Control Report, 2016, p.5).

This regulation also required information about any damage, abuse or diversion relating to the LHU's assets and about events that diminished the LHU's image or reputation. Internal reporting of irregularities shall describe facts indicating:

· Violation of legal, regulatory, and deontological principles and provisions by members of the statutory bodies, workers, suppliers of goods and service providers in the exercise of their professional positions;
· Damage, abuse or misuse of LHU's or its users' assets;
· Damage to LHU's image or reputation (Internal Control Report, 2016, p. 6).

6. Discussion

Implementation of the BSC involved designing strategic maps, seeking a collaborative organizational culture, and aligning a plurality of interests with the LHU's mission and objectives. The LHU sought to have its component parts articulate with a common purpose — one that was formally presented and subjectively understood. The alignment of the strategy of departments (a sign of *systematization*) indicated awareness of the implications of a department's performance to other departments and to the organization as a whole. The BSC's strategic map was reflected in departmental strategic maps, confirming thereby the presence of a deliberate plan and an idea of *rationality*.

The demarcation of responsibility in the LHU's hierarchical structure could lead to a lack of communication. However, this was counterbalanced by regular meetings between department directors and the board of directors, and between department directors and their subordinates. There was a well-defined *authority* in the LHU and clear reporting responsibilities.

Discipline was evident in a regulated order that did not preclude departmental autonomy. Disciplinary order was framed by a collaborative culture in which the responsible authority used negotiated accountability mechanisms, typifying a neo-bureaucratic order.

The bureaucratic feature of *jurisdiction* was evident in the unambiguous formalization of functions and responsibilities for each working position. Despite this formalism, staff were encouraged to suggest alternatives and improvise short-term solutions. Thus, this evidenced typical neo-bureaucratic traits of flexibility and adaptability.

The LHU's maintenance of an active training centre to promote the development of professional competencies evidenced concern for *professional qualifications* and *knowledge*.

Staff had a good level of understanding and acceptance of procedural rules that ensured an *accountability* based on disciplined, continuous information feedback processes.

The commitment to comply with objectives based on the hospital contracting with the RHA stimulated the processes of *accountability* and *transparency*.

These above findings are consistent with the literature review that reported evidence of only six of the nine bureaucratic features of interest. The present study finds evidence of these six features too. But, importantly, it also finds evidence of three features not reported previously: *jurisdiction*, *systematization*, and *rationality*. The features of *systematization* and *rationality* were strongly apparent in the design of strategic maps that helped execute the BSC. Design of the strategic maps fostered a collaborative and participative regime. Additionally, a collaborative approach to management was aided strongly by the two

bureaucratic features of *rationality* and *systematization*. The organizational culture generated fostered dialogue and a sense of interdependence.

7. Conclusion

We found the nine features of a bureaucratic order in the Portuguese LHU managed by the BSC, indicating an inherent neo-bureaucratic approach. Since a hospital is a bureaucratic organization, the generally good reception accorded to the BSC in effecting health management can be understood: hospitals encapsulate the fundamental features of bureaucratic order. The BSC accommodates a bureaucratic order while changing that order in a way that addresses lingering bureaucratic problems. The BSC helps to advance a neo-bureaucratic approach by offering a way of addressing bureaucratic health management problems. These include those highlighted in a study of performance management in Portuguese primary health care, such as distrust in the administrative bureaucratic process, lack of coordination and accountability processes, and issues of formal communication and control (Silva & Ferreira, 2010).

The implementation of the BSC enhances the traits of *systematization* and *rationality*. It instigates a neo-bureaucratic order through a cultural change that is intended to address bureaucratic health management problems. The bureaucratic traits of *discipline* and *authority,* cultivated by the LHU's management in the contemporary social context, are publicly ill perceived. The BSC can help to alleviate this image by developing a collaborative culture that enables their acceptance in the organization.

This study provides new insights to the implementation of the BSC and bureaucracy in hospital contexts. The BSC assumes bureaucratic traits but endorses a neo-bureaucratic approach. This is important to improve health care outcomes because it fosters flexibility, collaboration, innovation, and adaptation. The continual presence of bureaucracy in a contemporary management tool (BSC) helps to demystify bureaucracy in hospital contexts.

This study contributes to the body of knowledge about the BSC. It will help promote better social and economic understanding of the bureaucratic values and empowering hospital management. Future research could beneficially explore how the BSC can change perceptions of bureaucracy in health organizations in different contexts, particularly in non-Anglo-American contexts. There would be benefits too from inquiring whether, and is so how, a pre-existing bureaucratic order hinders the implementation of a BSC. Because leadership is an important element of a BSC's success, future research addressing leadership in health care organizations would be very pertinent and helpful. A research question of relevance is "Does poor leadership promote failure of a BSC?"

Essay 4 – Reasons for Bureaucracy in the Portuguese Public Sector Enterprise Health Care – An Institutional Logic Perspective[4]

[4] An earlier version of this essay was presented at the Second PhD Workshop, School of Economics and Management, University of Minho, Braga, 2019, titled *Hospital' socio-cultural environment sustaining neo-bureaucracy.*

Reasons for Bureaucracy in the Portuguese Public Sector Enterprise Health Care – An Institutional Logic Perspective

Abstract

There is widespread perception that bureaucracy is present in Portuguese health care management, and that it is widely deprecated there. We address this dissonance by studying the Portuguese Public Sector Enterprise Health Care (PSEH) context. We seek to understand how a bureaucratic approach to management exists. The study is based on document analysis and extends the Institutional Logic Perspective (IPL) developed by Thornton, Ocasio, and Lounsbury (2012) to the health care context. In the socio-cultural context of the management of PSEH, we observe three institutional orders with their own institutional logics: state, community, and profession. Our findings reveal that state logic is dominant and is in conflict with professional logic. We find that state institutional logic and professional logic both have a bureaucratic logic in contrast to the informal (and much weaker) logic of community. The need to resolve conflicts between different logics induces a neo-bureaucratic approach to management. This essay contributes by identifying the institutional drivers of bureaucratic logic in the PSEH.

Keywords: Health Care Management, Institutional Logic Perspective, Neo-Bureaucracy, Portugal.

1. Introduction

Portuguese public health care management is perceived to be bureaucratic, a feature that is considered likely to hinder good management. However, for some authors, bureaucracy is still considered a proper management method in health care (Schofield, 2001). Indeed, bureaucracy has persisted in health care despite the transformation of Portuguese public sector hospitals into Portuguese Public Sector Enterprise Health Care (PSEH).

The purpose of this essay is to understand how the institutional context can justify bureaucracy in PSEH management, and how the institutional context can help to develop a neo-bureaucratic culture (as was the case with the Local Health Unit (LHU), third essay). The present essay explains the persistence of bureaucracy, in a neo-bureaucratic form in the PSEH, using an institutional approach based on the Institutional Logic Perspective (ILP) (Thornton et al., 2012). Such an approach is better attuned to dealing with the heterogeneous and dynamic context of health care services. The two central concepts of this essay are ILP and bureaucracy.

An institutional approach to the study of health care organizations has been advocated by Machado-da-Silva et al., (2001), Misoczky, (2005), among others. The use of an ILP allows going beyond strict institutional factors, to paying attention to their particular logics and relationships, and to acknowledging the intrinsic ambiguity of any social reality. ILP is based on the observation of several institutional orders and their dialogical process. These orders have institutional logics that are shaped by cultural beliefs, goals, norms, rules, and practices that structure cognitive behaviour and decision-making (Friedland & Alford, 1991; Thornton et al., 2012). In particular, the ILP provides an interpretative institutional scheme that recognizes the individuality of social actors and avoids a deterministic view of any social reality. For these reasons, ILP is understood as a metatheory and not as a theoretic framework to be tested (Thornton et al., 2012).

The other main concept used in this essay is bureaucracy. This is a management method originally characterized as possessing the features of rationalization, division of labour, and the institution of rules and regulations defined by an organization's guiding authority (Weber, 1922). According to this view, bureaucracy represents a process of formalizing practices and anchoring them in organization-specific rules and formal procedures (Stinchcombe, 1959). The original concept of bureaucracy has evolved to neo-bureaucracy (Farrell & Morris, 2003), a kind of bureaucracy committed to informal means of communication and concerned with the creation of a collaborative organizational culture. An institutional approach is also appropriated to study bureaucracy, as is suggested by the term *institutionaucracy* (Bolon,

1998). This term translates the incorporation of bureaucratic principles such as rationality, efficiency, control, and accountability in an institutional environment with normative concerns. As a dominant management method, bureaucracy was even considered a particular institutional logic in the Chinese context (Zhou, 2010). In this case, bureaucracy was so disseminated that fostered a collusion behaviour among local governments.

We use archival sources comprising legislation on health care and public hospitals, press articles, government documents on health care, statutes of the professional orders and published works on the Portuguese public health care sector and public administration. Emerging data were coded and analysed according to the theoretical framework used to study how the institutional context justifies the bureaucratic approach in the management of the PSEH.

The objectives of this study are to present reasons for the persistence of bureaucracy in the PSEH context, and to demystify bureaucracy. We identify the relevant institutional orders of PSEH management, we characterize the institutional orders in terms of bureaucracy and found that the most relevant is the state. In doing so, we contribute to the understanding on how institutional context explains the bureaucratic logic of the Portuguese PSEH. We also contribute by extending the ILP to the Portuguese health care context.

Section two presents a literature review. This characterizes the context of the emergence of the PSEH by relating it to the subject of bureaucracy; and it presents the ILP and its application in the health care context. This is followed by an exposition of the research method (Section three). Thereafter, based on the ILP, we present the relevant institutional orders and characterize their logics (Section four), relating them to the bureaucracy topic. Finally, we discuss the institutional reasons that justify the bureaucracy of the management of a PSEH (Section five). The last section presents conclusions.

2. Literature Review

2.1. The emergence of Public Sector Enterprise Health Care in Portugal

Studies in the 1990s identified bureaucratic culture in hospital management as the main barrier to good administration (Reis, 2004). Public hospitals maintained the centralist culture of health governance. This entangled them in a bureaucratic and command/control web reproduced that was internally within the organizations (Raposo, 2007). Resources were used inefficiently, leading to high spending and debt accumulation. In 2010, Portuguese public health expenditure was 10.7% of Gross Domestic Product (GDP). This compared with the average of 9.5% in the European Union (OECD, 2010).

To face these shortcomings, the Portuguese State introduced enterprise management of public hospitals (Law 27, 2002). Following the principles of New Public Management (NPM), hospital management changed to improve efficiency by requiring a higher degree of responsibility by public managers and greater accountability on their part (Harfouche, 2008). There was an intended to abandon the monolithic, bureaucratic/administrative and monopolistic public sector system; and to arrange the health care system in a network characterized by a plurality of providers through the development of the public sector contractual model (OPSS, 2003). This meant a separation between the financing agent (Ministry of Health) and the providing agent (hospital). Also, intends to foster a market logic by which hospitals were autonomous and strove to satisfy public demands. Initially, this approach turned public hospitals into joint-stock companies with publicly owned capital. However, in 2005, there was a legal change: hospitals would no longer be regulated as "joint stock companies" but would be known as "public sector enterprises". As public sector enterprises, hospitals have greater administrative, financial, and patrimonial autonomy (Decree-Law 93, 2005). The evolution of the PSEH, based on the NPM, tried to emphasize user and client interests above ministerial concerns (Egeberg & Trondal, 2009). A shortcoming was that this approach failed to consider the unrepresentative nature of most clients (Peters & Pierre, 1998).

With hospitals as enterprise entities, the financing model depended on program contracts that set objectives and quality criteria. The program contracts are based on production (output) instead of historical costs (inputs) (Silva & Cyganska, 2016). This aimed to regulate health demand and to distribute demand by diverse public hospitals strategically. Decision-making, service acquisition and hiring human resources became faster, since these activities were no longer under the direct administration of the state (Rego et al., 2010), despite state regulation of them (Bilhim, 2014). Such autonomy implied managers

acted responsibly and according to the procedures of the Statute of the Public Manager (EGP – *Estatuto do Gestor Público*) (Decree-Law 71, 2007). Regular accountability, such as monthly publication of the "Tableau de Board" and annual management reports were required (Harfouche, 2012). Incentives linked to the performance of management practices were now considered an important motivating tool for professionals, thereby contributing to increased quality, efficiency and user satisfaction (Reis, 2005).

The process of public hospital transformation into PSEH reflected a will to cut bureaucracy in hospital management. The change sought to reconcile management autonomy with government supervision, to have regard for the economic rationality of investment decisions (Barros & Simões, 2007). The development of information tools and flexibility in purchasing and in hiring human resources was brought. However, the health governance model just apparently changed from a bureaucratic/administrative one to a business-centred one (Raposo, 2007). For some, the PSEH represented a stricter regime of strategic guidance by the Ministry of Finance and the Ministry of Health. This was viewed as corroborating the idea that, apart from the legal status of the hospital, everything else remained substantially the same in hospital management (Abreu, 2003; Saúde, 2010). The legal transformation of hospitals into the PSEH was not accompanied by decentralization at an intermediate level: the internal hierarchical structure was maintained. The bureaucratic *modus operandi* was kept, with little transparency and with high dependence from different professional groups (OPSS, 2009). The governance system for the PSEH was still very central, with many decisions kept as top management functions. Management inefficiency remained. Productivity bonuses did not really exist, nor did the freedom to hire. These restrictions led to a lack of motivation amongst skilled professionals[5]. Though government tended to move away from management and planning functions, its role as the health system regulator was kept or even reinforced (Simões, 2004).

The problem in the health system is not financing, but the imposed rules that undermine management[6]. This is a common problem of Portuguese public administration: too much bureaucracy at the level of practice, routines and procedures. However, paradoxically, this has been accompanied by a lack of bureaucratic responsibility and ethics (Cunha, 2004). Despite political efforts to reduce bureaucracy, the legislation to change the behaviour of administration officials and agents has proved

[5] Lopes, M. A. (2019, May 13). Os hospitais do SNS são bem geridos? *Observador*. Retrieved from https://observador.pt/especiais/os-hospitais-do-sns-sao-bem-geridos/

[6] Barros, P. P. (2018, July 29). O SNS vai ser sustentável nos próximos 20 anos. *Revista Forbes*. Retrieved from https://www.forbespt.com/lideres/pedro-pita-barros/?geo=pt

insufficient and ineffective. The administrative and legislative simplification program (Simplex), as well as the restructuring program of central government, showed much concern with the burden bureaucracy imposes on public administration. Management accounting tools adopted in the private sector, such as the Balanced Scorecard (BSC), are embedded in a logic of legal-regulatory compliance: they do not serve to user citizens well (Tavares, 2019).

In centralized political systems (e.g., France), power is an accepted fact and the role of bureaucracy in establishing and maintaining state power is generally recognized (Peters & Pierre, 1998; Pollitt & Bouckaert, 2000). Despite the changes driven by NPM reforms, the persistence of bureaucracy is not specific to the Portuguese public administration. The NPM challenges and reinforces bureaucracy (Kettl, 2000). After NPM type reforms, the Italian public administration remained linked to a bureaucratic model (Tomo, 2019).

In the UK, the decline in bureaucracy in service delivery agencies was merely transferred to auditing and control agencies: the overall system was no less bureaucratic (Power, 1997; Barberis, 1998). In the context of the British public service, competitive pressures and increased reliance on performance management and monitoring are new modes of central control and formalisation that depart significantly from the ideal-type of post-bureaucratic organization (Hoggett, 1996; Farrell & Morris, 1999). These contexts represent a bureaucratic logic. The PSEH was developed in line with the NPM in the British public service. Thus, it also reflects the persistence of bureaucratic logic and the "continued dominance of bureaucratic values within public sector organisations, despite the post-bureaucratic discourse of NPM and the changing political and economic context" (Parker & Bradley, 2004, p. 211). Instead of a shift from bureaucracy to post-bureaucracy, bureaucracy continues as neo-bureaucracy. Thus, it is a change that is not associated with less control but with different mechanisms of control.

2.2. The Institutional Logic Perspective in the health care sector

New Institutional Sociology (NIS) appeared when cognitive, cultural and normative aspects were considered important to the understanding of organizations. The quest for legitimacy in their social context leads organizations to change. NIS explains the changes as processes of isomorphism (competitive, coercive, normative or mimetic) (DiMaggio & Powell, 1983). As an evolution, the concepts of institutional logic (Friedland & Alford, 1991) and ILP (Haveman & Rao, 1997; Thornton & Ocasio, 1999; Thornton et al., 2012; Scott et al., 2000) emerged. Isomorphism is no longer the dominant analytical lens. Instead, an agency's capacity is valued in an environment of institutional pluralism or institutional complexity

(Guerreiro et al., 2020). The analysis goes beyond legitimation theories that characterized neo-institutionalism. Central to this development is the understanding of an institution as an objective reality, with symbolic and practical expression, and as one that provides stability and meaning to social life (Thornton et al., 2012).

According to this notion, core institutional orders are proposed. Each order has a particular logic that shapes organizational preferences, interests and behaviours (Friedland & Alford, 1991). Five institutional orders were identified by Friedland and Alford (1991) (capitalist market, bureaucratic state, democratic regime, nuclear family, and Christian religion). Thornton (2004) considered six (market, corporation, profession, state, family, and religion). Thornton et al. (2012) added one more (community). Such institutional pluralism is justified by the need to understand practices and beliefs that contradict the idea of an institutional dominium (Friedland & Alford, 1991). Thus, we should consider distinct institutional orders, with their interrelated identities and logics, because they frame individuals and the behaviour of organizations (Friedland & Alford, 1991; Thornton et al., 2012).

Thornton and Ocasio (1999) defined institutional logic as a social construction: that is, as historical patterns, assumptions, values, beliefs, and rules through which individuals produce and reproduce their material subsystems, organize time and space and give meaning to their social reality. Each institutional order promotes its logic, with organizing principles that enhance certain behaviours that may conflict with others. An institutional logic is an information filter (Prahalad & Bettis, 1986) and a provider of a particular rationality with material and symbolic representation. Institutional logics should not be considered as "good or bad", but just as a system of beliefs and practices that privilege certain practices and organizational adjustments (Styhre et al., 2016).

The ILP is founded on four principles of analysis (Thornton et al., 2012). These involve

(1) articulating a structural analysis with the autonomy of social actors (agency theory);
(2) observing material aspects (practices and structures) and symbolic aspects (meanings and ideas) of their mutual influence;
(3) recognizing the contingency of institutions (historically contextualized); and
(4) assuming the complexity of institutional reality that unfolds into multiple fields of analysis.

The ILP represents an integrative approach of social life in its structural, normative, and symbolic dimensions. In a plural environment, individuals and organizations may develop different identities according to the institutional orders that momentarily prevail (Kraatz & Block, 2008). The ILP approach

recognizes the coexistence of multiple social identities in individuals and organizations (Thornton et al., 2012). It also recognizes that individuals and organizations, though conditioned themselves, also condition the ruling institutions. So, the study of a social reality must consider the micro-level (individuals), the macro-level (societal) and the meso-level (organization and collective identities (Glynn, 2008)). This approach is necessary to determine whether the causes of institutional change are structural changes or the actions of social actors.

The ILP imposes itself as a metatheory, avoiding a deterministic explanation of organizational or individual behaviour. It contextualizes such behaviour in institutional terms, by valuing the agency capacity of people and organizations, and endorsing the concept of the institutional entrepreneur (Maguire et al., 2004). This perspective is not restricted to explaining homogeneity because it addresses organizational heterogeneity. To this end, it outlines a process of real analysis and identifies relevant institutional orders of the socio-cultural context with the corresponding institutional logics. These orders are proposed as ideal types that provide a method of interpretative analysis of reality. A set of categories of analysis (such as sources of legitimacy, informal control mechanisms, sources of identity, root metaphor, basic norms, sources of authority, economic system, basis of attention and strategy) are proposed to understand the institutional logic of each order (Thornton et al., 2012).

Distinct institutional logics interrelate in a complex way that allows for different organizational outcomes. ILP approaches organizational reality by considering the interrelated institutional logics, sometimes in a relationship of complementarity or competition. In this interrelation, syntheses or transfers may arise between different logics or a dominant logic may arise to overrule others. The contradiction between multiple institutional logics enables individuals, groups, and organizations with cultural resources to transform identities, organizations, and societies (Friedland & Alford, 1991). So, individuals and organizations can exploit these contradictions and mobilize different logics in favour of one that supports their interests (Greenwood et al., 2011). Moreover, not all individuals relate to these logics in the same way. Some individuals have different access to knowledge and information or activate this knowledge in different ways. The maintenance of a logic depends on the behaviour and interaction of people in the organization (Lander, 2016). Thus, it is important to inquire about different modes of social interaction in the organization, mainly in decision making, training and collective mobilization (Thornton et al., 2012). According to ILP, inconsistencies and contradictions can arise that cause institutional dynamism.

The ILP represents an evolution in the study of organizations since it acknowledges their cultural heterogeneity (Lounsbury, 2008). An ILP recognizes that individuals and organizations, as active and

unpredictable actors, can disrupt and affect the structural context. Crisis and institutional changes in an organization are understood by changes in the interdependent relationships of institutional orders (Thornton et al., 2012), either for internal or external reasons to the organization. The current logic can change or be replaced because of new rationality, new practices, technologies or regulations, and new social identities in the organizational structure (Meyer & Hammerschmid, 2006).

Hospitals are heterogeneous organizations with multiple actors. They come from different backgrounds and interests, but share norms, routines and practices (Styhre et al., 2016). The study of hospitals has to acknowledge that different logics explain on-going changes in the dominant logics (Waldorff, 2013). In this field of institutional plurality (Kraatz & Block, 2008), the complexity intensifies the uncertainty about the future evolution of hospital management (Miller & French, 2016). The emergence of new logics (Waldorff, 2013) and their confrontation with current ones (Waeger & Weber, 2019), can be expected. So, the ILP seems to be an appropriate approach, as evidenced by recent efforts to apply ILP to study health organization behaviour in different cultures and countries (Xing et al., 2018; Mannion & Exworthy, 2017; Vickers et al., 2017; Yiannis et al., 2017; Styhre et al., 2016; Currie & Spyridonidis, 2016; Hafsi & Hu, 2016; Lander, 2016).

As good examples of the application of the ILP in the hospital environment, we highlight the study of the hospital environment in the United States. There the shift from a professional logic (concerned with quality of care) to a state logic (centred on the democratic aspect of equal access to care) is observed. This tended towards an efficiency-centred management logic (Scott et al., 2000). Reay and Hinings (2015) investigated how the competition between logics can be managed by the development of a collaborative regime in health care. Kyratsis et al. (2017) showed how the evolution of institutional logic affected professionals in the health system by changing their professional identities. Other studies have analysed how social actors can be influenced by factors external to the contextualized institutional orders (Waldorff & Greenwood, 2011).

3. Research Method

3.1. Purpose and research question

The following general research question is addressed:

How does the institutional context of PSEH management justify its bureaucratic approach?

Using an ILP, the three specific interconnected research questions are:

(1) What are the relevant institutional orders in the socio-cultural context of PSEH management?

(2) Are the institutional orders equally relevant, or is there a dominant one?

(3) How are the institutional logics of these orders characterized in terms of bureaucracy?

This essay characterizes the institutional logics relevant to the PSEH context, in terms of bureaucracy. Then it proceeds to study how they relate, in order to understand how the bureaucratic logic of PSEH management is formed. This work adopts the ILP and uses archival sources to characterize the institutional context of PSEH.

3.2. Research design

The research has four procedural steps. In the first three steps, we address each of the three specific research-questions presented above. In the fourth step, we use the information collected in the previous steps to address the general research question. The outcome of the three first steps is presented in the Results section. The outcome of findings in respect to the general research question is presented in the Discussion section.

The first step presents the relevant institutional orders in the socio-cultural context of PSEH management. Among the seven hypothetical institutional orders proposed by Thornton et al. (2012), three are chosen as relevant in this context: state, community, and professional. These orders represent the principal stakeholders in an adaptation of a previous study in hospitals (Rodrigues, 2011). We consider the professional order as primarily comprising the managers, physicians and nurses. The market order will not be considered, even though the purpose of transforming the public sector hospital in a PSEH was to introduce some market competition (Moreira, 2004). However, there is only one financier and regulator: the state. The PSEH will not really compete with other hospitals in the exercise of public health care duties. Furthermore, patients are allocated to certain hospitals and social tax fees are defined by the state. Therefore, though the notion of the PSEH is built around the sense of the market, we decided not to consider the institutional order of the market as being relevant to this study. We also point out that

though PSEH is a training institution, we do not consider this institutional dimension because it is secondary in the PSEH management context.

In the second step, we study the relevance of the institutional orders in the PSEH context. We seek to determine whether there is a dominant order among the three orders and how influential each order is.

The third step, separately characterises state logic, community logic and professional logic, in the public health care context, in terms of bureaucracy. To do that, categories of analysis were defined. Thornton et al. (2012) proposed a set of orienting categories of analysis (such as sources of legitimacy, informal control mechanisms, sources of identity, root metaphor, basic norms, sources of authority, economic system, basis of attention, and strategy). Thornton et al. (2012) nonetheless suggest more pertinent and refined categories of analysis, need to be considered, according to the subject of study. We start by considering the general category proposed by Thornton et al. (2012) the basis of attention as a defining driver of every logic. Taking into account the focus of this study (bureaucracy), we then consider two more of Thornton et al.'s (2012) categories: authority and control. Additionally, we added two other categories because of the peculiar nature of the subject: procedural rules and accountability.

We analyse each order through the more general category, basis of attention. In this category, we observe the purposes and fundamental aims in each order. The driving focus of the evolving institutional logic. Then, for each order, we investigate the presence of bureaucratic traits. In considering the bureaucratic basic traits, analysis is confined to the topics of authority, accountability, and jurisdiction. We do not make use of the full nine concepts defining contemporary bureaucracy (outlined in the second essay of this thesis). We focus on the traits more commonly associated with bureaucracy. These are usually related to the encumbering rules that hinder adaptive and flexible management. Taking all this into account, we choose to analyse authority, control, procedural rules, and accountability. From this set of categories, we derive the ruling logic in each order, regarding bureaucracy.

In the category of authority, we search for the presence of hierarchy and investigate sources of authority. In the control category, we analyse the presence of mechanisms of formal and informal control of performance and results. In the procedural rules category, we analyse the presence of a work jurisdiction that defines competencies, responsibilities. Furthermore, we analyse the presence and formation of formal regulation. In the accountability category, we analyse the consequences of the control results. Overall, each institutional order is analysed according to the presence of hierarchical features,

relations of power, regulation and flexibility of the proceedings. Table 8 summarizes the categories of analysis and their issues.

Table 8

Categories of Analysis and Their Issues

Categories of Analysis	Issues
Basis of Attention	Purpose and fundamental aims.
Authority	Source of authority, hierarchy.
Control	Formal and informal mechanisms of control.
Procedural Rules	Formalization of procedures, work jurisdiction.
Accountability	Consequences of control.

In the fourth step, building on the previous analysis, we propose an explanation for the formation of the institutional logic of the PSEH management, regarding bureaucracy. Through this understanding, we can achieve a structured and plausible response to our main research question. Table 9 synthetizes the research design.

Table 9

Research Design

	First Step	Second Step	Third Step	Fourth Step
Research question	What are the relevant institutional orders in the socio-cultural context of PSEH?	Is each order equally relevant or is there a dominant one?	How can the institutional logics of these orders be characterized?	How does the institutional context of PSEH management justify its bureaucratic approach?
Purpose	Identify the relevant institutional orders.	Compare the relevance of the orders.	Characterize each institutional order, relating to bureaucracy.	Relate the emergence of the bureaucratic logic in PSEH to the presence of the relevant institutional logics in this context.

3.3. Data collection

This essay follows a qualitative approach based on content analysis. The data that feed the work were collected from a variety of sources: current legislation on health care and public hospitals, published papers in sociology related to public health care, press articles and government documents on health care, statutes of the professional orders, published works on the Portuguese public health care sector and public administration (Appendixes D and E present a list of archival sources). The information was treated according to categorical analysis. All the data were subjected to an active and continuous recursive process of reading, examination, speculation, search, selection, view, interpretation (Davie, 2008, p.1072).

In the next section, we identify the relevant institutional orders in the PSEH context, outline the relevance of each order in the studied context and provide the individual characterization of their logics in relation to bureaucracy.

4. Results

First, we identify and elaborate on the relevant institutional orders in the PSEH: state, community and, professional. Then, we characterize how the orders inter-relate under the context of PSEH. Finally, we characterize these orders according to five categories (basis of attention, authority, control, procedural rules, and accountability) to understand the institutional logics of each order in terms of bureaucracy.

4.1. Relevant institutional orders: state, community, and profession

We begin by briefly profiling the PSEH. The PSEH board operates according to the Statute of Public Managers (Decree-Law 71, 2007). Financing depends on program contracts with the Regional Health Administration (RHA), representing the state. To receive the total capitalized amount, a hospital has to fulfil its commitments with RHA (in so-called "external contracting"). In this context, we find three relevant institutional orders – state, community and professional.

State order

The state is one of the key institutional orders at work in the public sector (Meyer et al., 2014). Constitutionally, the health care service is a public responsibility that the state cannot ignore (OPSS, 2008). As a public sector entity under the supervision of RHA, public-funded and with an administration dependent on the Ministers of Health and Finance (Decree-Law 18/2017), the institutional order of the state is central in the context of PSEH. Here, the state order is understood as the public sector administration and the government.

Community order

The mission of public health care services is ruled by the health needs of the population in its influence area: health politics should be oriented by the idea of the citizen-user of the health care system (Anunciação & Zoboli, 2008). Because of the social importance of public health care in the community, the institutional order of the community is very relevant. A central purpose in health care politics for the last twenty years has been to recognize the health care user as a central voice in the development of services (Serapioni, 2016). Here the community is understood as all the users and expected beneficiaries of public health care services, including civil associations.

Professional order

In terms of management and cultural organization, professional identity is translated into a particular domain (Marques, 2012) where autonomy is very important for work satisfaction and personal development (Abrantes, 2012). The physicians/nurses represent such a domain. Because of their key place in health care, they are very influential in the PSEH context. We consider that the professional order includes all organized professional classes whose efforts assure the public sector health care service: physicians/nurses and managers. Physicians and nurses each have their professional associations (called "Orders", in Portuguese *Ordens*) and union representation too. With the technological and scientific evolution of medical diagnostic and therapeutic procedures, the technicians involved have a relevant role in health care provision. They are organized in unions whose strength can be assessed by the frequency of strikes they engage in. From January 2019 until September 2019, there were four strikes by doctors, twenty by nursing staff and nine by those employed in sectorial services (diagnostic and therapeutic technicians) (DGAEP, 2019). However, since technicians are not organized under an Order, we do not consider them in the professional order. We adopt the same view with ancillary personnel, who are also important agents in health care services. Physicians predominate over other socio-professional groups (Freire, 2014). We acknowledge that there are conflicts between Orders: for example, when nurses attempt to work autonomously in health centres or to prescribe drugs and exams[7]. The right to engage in such activities is being denied by the medical Order[8].

Despite the hospital professional managers are not organized under a professional Order, we extend our attention to them, as we do to nurses and physicians. This is because the management of PSEH is entrusted to an autonomous board of directors that includes professional managers represented by the Portuguese Association of Hospital Managers (APAH – *Associação Portuguesa de Administradores Hospitalares*).

4.2. The relevance of each order in PSEH management

The purpose of improving public health care access and quality needs to be balanced with the need to improve the efficiency and control of public expenditure (Ribeiro, 2004). This is reflected in the

[7] Enfermeiros querem passar receitas de medicação e exames. (2013, June 21). *Jornal de Notícias*. Retrieved from https://www.jn.pt/sociedade/saude/enfermeiros-querem-passar-receitas-de-medicacao-e-exames-3283882.html

[8] Sindicatos abrem guerra na saúde contra prescrições por outros profissionais. (2016, September 16). Diário de Notícias. Retrieved from https://www.dn.pt/portugal/sindicatos-abrem-guerra-na-saude-contra-prescricoes-por-outros-profissionais-5384027.html

subordination of PSEH management to the Ministries of Health and Finance (Decree-Law 18/2017). The PSEH depends on external approval of annual business plans, budgets, and accountability documents. The superintendence power of the Minister of Health in the PSEH is evident in the stipulations of article 6 of Decree-Law 233/2005, establishing and approving objectives and strategies of the PSEH. For example, the implementation of the BSC in some PSEH was imposed by a program contract. All of this stresses the overwhelming presence of the state. PSEH entities are required to prepare and disclose financial reports. Despite the attempt to make PSEH management more autonomous, it is a public sector organization with authority centred in an exterior top hierarchy that makes the most important management decisions (Bilhim, 2013). Additionally, despite the existence of new forms of hiring, PSEH administrators and most employees fit into the public administration. Also, the purchase of goods and services and the contractualization of works are subject to the rules of public law contained in the Public Contracting Code (CCP – *Código de Contratação Pública*). These features reflect the dominance of the state order in PSEH management. The presence of the state order in management activities constrains managers' autonomy.

The position of medical practice in health care management has been changing. New practices of governance in the health care sector no longer depend solely on the auto-regulatory movement of the medical Orders (Marques, 2014). Professional medical power and autonomy are now constrained more by a managerial logic of control. Conflicts arise between the state order (present in management) and the medical professional order. The state bureaucracy is considered by many to limit good medical practice. For example, a leader of the National Medical Federation (FNAM - *Federação Nacional dos Médicos*) argued: "bureaucrats are the principal enemies of the National Health Service (NHS)"[9]. Such an attitude arises due to the constraints imposed on medical practitioners, who feel overwhelmed by administrative rules and strict cost control. The pursuit of efficiency by management sometimes clashes with medical practice since physicians and nurses are constrained by management functions limiting their activities as health professionals. The business model developed by the PSEH has led to tensions among health care professionals (Carvalho, 2009). When medical practice is required to attend to management requirements rather than to patients' questions, inevitably ethical problems and discomfort arise among medical practitioners (Ribeiro, 2017). Despite bureaucratic constraints, the medical professional order is capable of reacting (Evetts, 2010), since their professional deontological code allows them the right to

[9] Neves, M. J. (2018, January 24). A burocracia e o seu particular impacto no sector da saúde no nosso País. Federação Nacional dos Médicos. Retrieved from https://www.fnam.pt/index.php/seccoes/opiniao/331-a-burocracia-e-o-seu-particular-impacto-no-sector-da-saude-no-nosso-pais

disobey hierarchical technical orders (Article 13, Regulation 707/2016). However, technical (clinical) organizational legitimacy and management organizational legitimacy must coexist and contribute to an organization's survival. Through the administrative and management process, the state order is now the principal authority in the PSEH. However, professional orders are still crucial. Conflicts between professional orders and the state order have to be addressed.

The community order is the least influential. In spite of the government's attempts to have major participation by civil society in the setting and accomplishing of public health care goals, this is still incipient (Barros & Simões, 2007; Lobo, 2008; Saúde, 2010). Nonetheless, this order exerts influence mainly through the political judgement that health care politics produces in elections (Rodrigues & Silva, 2016).

Summing up, the state institutional order is the ruling order. The professional order assumes a very relevant role in the PSEH context. The community order is the least influential. Furthermore, the conflict between the two most important orders is on-going.

4.3. Characterization of the institutional orders regarding bureaucracy

This section describes what is most valued in each of the institutional orders (state, community and professional): that is, the basis of attention around which they evolve. We find this introduction relevant because it has bearing on the motives of each order's logic and so provides a reference for better understanding of how it relates to bureaucracy. Then, we analyse each institutional order according to the categories related to bureaucracy (authority, control, procedures rules and accountability).

Category of basis of attention

In the state institutional order, the focus is the public service, and how it provides health care across the country. This focus emphasises a set of fundamental values, such as human dignity, equity, ethics, and solidarity (as stated in article 64 of the Portuguese Constitution).

Regarding the community, within a population that is increasingly aware of its rights, civil society demands quality public sector health services (Vaz, 2010). The state tends to be regarded as responsible for the health of the population and for health care delivery, taking responsibility away from any patient's choices. In seeking the more active participation of civil society in health care politics, national programs set several inter-sectoral approaches, namely partnerships with municipalities, schools and civil society, as a crucial factor for successful public health (Simões et al., 2017). There is a concerted effort to change

the attitude of the community related to public health care services, to encourage the community to be active and to participate in the development of these services.

With respect to the professional institutional order, physicians and nurses aim to strengthen their status. Management aims to deliver efficient services and to achieve equilibrium between administrative constrains and technical demands.

Category of authority

The health care sector in Portugal is supervised by the Ministry of Health and the Ministry of Finance. Thus, in the state institutional order, the authority that guides public administration is sourced in the legislative power of the Assembly of the Republic. The public institutions that have effective power over health care services include the Directorate General of Health (DGS – *Direção-Geral de Saúde*), the Central Administration of the Health System (ACSS – *Administração Central do Sistema de Saúde*), the Shared Services of the Ministry of Health (SPMS – *Serviços Partilhados do Ministério da Saúde*, EPE) and the National Authority of Medicines and Health Products (INFARMED - *Autoridade Nacional do Medicamento e Produtos de Saúde*, I.P.). Beyond the power to regulate and administer the PSEH, state authority is also evident in the manuals (e.g., Standards of Clinical Practice and Hospital Pharmacy Organization) that rationalize procedures in hospitals environment (Saúde, 2010). The state is the decisive authority in the health care environment.

Responsibility for planning and resource allocation in the Portuguese public health system, at the regional level and sub-regional level, has remained highly centralized despite the establishment of the five current RHAs in 1993 (North, Center, Lisbon and Tejo Valley, Alentejo and Algarve) (Simões et al., 2017). Strategic guidance is provided by the Ministry of Finance and the Ministry of Health (Amador, 2010) so that public hospital budgets continue to be defined and allocated by a central authority. According to the President of the APAH, the loss of management autonomy in a quest for budget control is the main question in public hospital management[10]. There is a strict hierarchical organization that is very constrained by the superior authority of the Ministry of Finance and the Ministry of Health who rule over intermediate institutions, such as the SPMS and the RHAs. This is consistent with the view of Portugal as one of the most centralized countries in Europe (Magone, 2010).

[10] Falta uma verdadeira reforma hospitalar. (2018, November 22). *Jornal de Negócios*. Retrieved from https://www.jornaldenegocios.pt/negocios-iniciativas/detalhe/miguel-guimaraes-falta-uma-verdadeira-reforma-hospitalar

At the community level, we find no formal authority since this order is part of a given culture and not part of a planned organization. However, common values and interests are recognized, and reflected in diverse associations (such as the Portuguese League Against Cancer (*Liga Portuguesa Contra Cancro*), Portuguese League Against Aids (*Liga Portuguesa contra a Sida*), Portuguese Association of Diabetics (*Associação Protectora dos Diabéticos de Portugal*) among many others) that represent various users of health care services (Law 44/2005). These associations arise as informal sources of authority in the community. They assume greater importance because they promote interactions between the health care services and the community (Serapioni, 2016).

At the professional level, the sources of authority for physicians and nurses are their Orders and their rulings. For example, it is by the authority of the Order that a physician (Law 117/2015) or a nurse is certified for practice (Law 156/2015). Since hospital managers are not ruled by a specific Order, they do not have such professional ruling authority.

Category of control

Regarding the state institutional order, formal mechanisms of control are present. The Secretariat of State for Administrative Modernization (SEMA – *Secretaria de Estado para a Modernização Administrativa*) established the Integrated System for Evaluation of Public Administration Performance (SIADAP – *Sistema Integrado de Avaliação do Desempenho para a Administração Pública*) in an attempt to introduce a type of management that was driven by measures and controlled objectives, rather than by bureaucratic regulations. This meant the introduction of formal and objective processes of control by the state for all public services and servants, including public health care services. Furthermore, starting in 2010, the Centre for Controlling and Monitoring the NHS (CCM - *Centro de Controlo e Monitorização*) manages all activities related to invoice processing. The CCM is an important body in fighting corruption and fraud within the health care sector. Also, in 2010, the SPMS was founded as the centre of purchases for the Portuguese public health sector. The intent was to achieve more controlled and efficient expenditure in public health care. These are the formal mechanism of control, particularly for the public health care system.

Among the community, public politics fosters interest and demand for transparency and control of the public health care service. Public participation and patient empowerment are major health care goals that have been inscribed in key legal documents over the last two decades in Portugal. Users have the chance to evaluate the quality of public hospitals in satisfaction surveys or through feedback on the NHS

website. Regarding control actions, Law 46/2007 establishes that every person has the right to access administrative documents (art. 5). There is an online database where anyone can access every public contract. There is also the right to know the performance results of public health institutions. This allows better questioning of administration practices (Freitas & Escoval, 2010). Nonetheless, this participation is not significant yet (Barros & Simões, 2007; Lobo, 2008; Saúde, 2010). Therefore, although civil society has formal means to monitor the performance of public services, especially in the health care sector, there is still little use of these means of control. The community is not prone to formal ways of control. However, the user's judgement is valued more today and the medical professional authority has to be sensitive to the user's perception and accept his/her control (Sarris et al., 2017). Public health care users tend increasingly to be more aware and to demand the services provided.

In the professional order, there is an informal dimension of control by peers (Thornton et al., 2012) and a formal dimension by the Orders, as legislated in the Order statutes of nurses (Law 156/2015) and physicians (Law 117/2015). Managers are under the Statute of Public Managers (Decree-Law 71, 2007). The control mechanisms are exercised by the Ministries of Health and Finance (Decree-Law 71/2007, article 6).

Category of procedural rules

Looking at the state institutional order, the public administration executes its functions in a way that is akin to a bureaucratic type of organization (Tavares, 2019). It formally establishes tasks and procedures, and creates work jurisdictions that define competencies and responsibilities. This is reflected in the regulatory management mechanisms of the Portuguese health system: these are highly normative, with extensive legislative provisions (Simões et al., 2017). There are normative provisions, for example, in the Manual of Standards for Clinical Management (Saúde, 2017) and the Manual for Hospital Pharmacy (Resolution of the Council of Ministers 128/2002). The Ministry of Health develops and regulates formal procedures that are to be implemented in public sector health care management (as is the case with the CCM or creation of SPMS). The acquisition of materials is subjected to this central authority. As such, all health professionals must understand the technical procedures related to the acquisition of medicines (Aperta et al., 2015). Public health care services are concerned to achieve greater formalization of management procedures, in line with the bureaucratic organization of all public administration.

At the community level, procedural rules are commonly belittled. Citizens feel impotent when dealing with heavy administrative regulation. To speed up the system response, informal mechanisms are used

and accepted such as the use of acquaintances. This allows citizens to overrule the heavy formality due to the regulations (Tavares, 2019).

Regarding the professional order, both physicians and nurses have a protocol culture that regulates medical intervention across all the health care system. Even the duration of a medical consultation, the Order sets a standard (Regulation 724/2019). The protocol culture configures the bureaucratic feature of jurisdiction, with clearly defined competencies and responsibilities. This professional culture produces, collectively, trans-national regulations that establish conventions and the standardization of medical models (Raposo, 2010). Management is subject to the Statute of Public Manager (Decree-Law 71, 2007). Its proceedings are set and constrained by political decisions. Regardless of the autonomy of management (Decree-Law 133/2013, article 25), manager's activities have a strong bureaucratic and administrative component (Machaqueiro & Lapão, 2014), with a strict formalization of procedures.

Category of accountability

In the state order, the aforementioned SIADAP evaluates public services and public workers. The SIADAP is the most recent attempt to guarantee accountability from the public services, including health care. Every public service has a complaint procedure, which implies another level of accountability. These features portray the state order as attempting to create a culture of accountability. This present focus on accountability is a means to fight the age-old public perception that public administration is involved in secrecy (Moreira & Maças, 2003). Also, the court of auditors oversees the legality or regularity of public revenue and expenditure. Budget execution is also controlled by a government directorate. External auditing is required for all entities with a budget execution greater than €5 million, in two consecutive years.

The community order has juridical and political channels that can be used to argue for responsible health care services. The rule of law allows an appeal to the court's sovereignty so that the civil responsibility of the medical practice can be claimed. Additionally, there is political accountability because public health care services are subjected to political judgement by the electoral process since they derive from public politics (Rodrigues & Silva, 2016).

In the professional order, medical practice has its disciplinary and ethical rules enforced and controlled by the respective Order. Physicians and nurses are responsible for their actions towards their respective Orders as detailed in disciplinary regulations (Regulation 631/2016; Regulation 340/2017).

Managers respond to the Ministry of Health and the Ministry of Finance (Decree-Law 133/2013, article 25).

From the synthesis of these categorical analyses, we produce an understanding of the logic present in each order, relating to bureaucracy.

The state logic reflects a purely administrative management model[11]. There is power centralization within a hierarchical sense of authority, concern for objective control of the management of public health care, standardization and rationalization of procedures implemented, and public concern for the accountability of politics and services. All this implies a strong bureaucratic logic with great formal constraints. In public management, management tools (such as the BSC) that are imported from the private sector are usually grafted onto a logic of legal-regulatory compliance, rather than be used to serve the citizen (Tavares, 2019), thereby subsuming bureaucracy. This logic, and its shortcomings, has been recognized historically. By resolution of the Council of Ministers, the National Day of De-bureaucratization was established, in 1990, on the last Thursday of October. The digitalisation of administrative processes has been implemented with debureaucratization intent (Law 82-A/2014). However, these contributes have proved to be symbolic and have not yielded practical benefits, as our analysis concludes.

Contrary to the other analysed orders, the community is a socio-cultural expression that knows no formal hierarchy, in an informal and non-bureaucratic dynamic. The community is critical of the bureaucracy for encumbering good public services.

The Orders of nurses and physicians adopt a bureaucratic logic in which every professional is subject to a deontological and discipline regulation and is accountable for every professional act. Furthermore, to ensure security and predictability in medical action, professional procedures are standardized and regulated by professional codes that are collectively developed and continually reviewed. Thus, the professional logic (physicians and nurses) shows a peculiarly strong bureaucracy logic in which regulation and formalisms do not depart from a central and hierarchical authority but arise from a collectively developed consensus of the organisational field. Accordingly, Mintzberg (1979) considered the hospital a professional bureaucracy, since professionals tend not to act according to hierarchical authority, but to their values and codes. Medical professionals do not regard themselves to be bureaucrats, despite the organization of the profession having evident bureaucratic traits. Medical professionals just associate bureaucracy with accounting and administrative processes. Under the Statute of the Public Manager

[11] Lopes, M. A. (2019, May 13). Os hospitais do SNS são bem geridos? *Observador*. Retrieved from https://observador.pt/especiais/os-hospitais-do-sns-sao-bem-geridos/

(Decree-Law 71, 2007), the managerial profession develops its activities mainly under the bureaucratic state logic.

Table 10 synthesises the institutional logics of each order (state, community, and professional). They are characterized according to the categories that allow observing the mainstay of bureaucracy (authority, control, procedural rules, and accountability). We do not include the basis of attention since it is not related to bureaucracy, it was used to describe what is most valued in each of the institutional orders.

The peculiar institutional logic of each order is reflected in the logic of the PSEH management. In the next section, we discuss how the bureaucratic logic of the PSEH management is justified by the institutional logics of the state, professions and community.

Table 10

Characterization of the Institutional Logics of the Portuguese PSEH

	State	Community	Professional Orders	
			Management	Physicians and nurses
Authority	Highly centralized, in the Ministers of Health and Finance.	No prevailing authority.	No professional authority.	Professional orders.
Control	High control on expenses and politics in the health sector.	Very incipient.	Control mechanisms by the Ministries of Health and Finances.	Informal dimension of control by peers. Formal dimension by their orders.
Procedural Rules	Highly normative, with extensive legislative provisions.	Informality.	Subject to the Statute of the Public Manager.	Culture of standardized procedures.
Accountability	Integrated System of Evaluation of the Public Administration (SIADAP) and financial and budgetary reporting.	Rule of law and political judgement.	Reports to the Ministries of Health and Finance.	Under disciplinary and ethical codes.

5. Discussion

5.1. Perception of bureaucratic logic in the public health care

Many news stories on bureaucracy in public health care services appear in the Portuguese media. This news comes from a large spectrum of interests, from medical staff to ministers. For example, an article announced the resignation of the nine chiefs of emergency teams and the coordinator at the D. Estefânia Hospital due to "financial dictatorship" and "endless bureaucracy"[12]. Articles have drawn attention to the hopeless bureaucracy in Portuguese hospitals[13]. Health workers are invited to propose ideas to fight bureaucracy[14]. The health minister has recognized the predominance of bureaucratic rules over good health care[15]. News items refer to the lack of medication[16,17] and the dehumanization of services provided[18] because of bureaucratic rules. According to the President of the Order of doctors, success in health care should be measured by quality standards and not by the number of procedures; the private sector has less bureaucracy managing resources[19]. Other news has referred to hospital administrators being united against their loss of autonomy and degradation[20].

There is a widespread perception that bureaucratic logic dominates the provision of public health care services and that this hinders good health care management. This perception appears to be accurate because studies on PSEH in Portugal have concluded that bureaucratic logic persists (Cruz, 2013), and that there is strong hierarchical culture (Fortunato, 2014), and a defensive organizational strategy (Luís, 2016).

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[12] Chefes da urgência do D. Estefânia demitem-se. Bastonário fala em risco de colapso. (2018, December 12). *Jornal Público*. Retrieved from https://www.publico.pt/2018/12/12/sociedade/noticia/chefes-urgencia-hospital-dona-estefania-demitiramse-1854451

[13] A burocracia já parece irrecuperável nos hospitais. (2015, April 1). *Jornal Sol*. Retrieved from https://sol.sapo.pt/artigo/126105/-a-burocracia-ja-parece-irrecuperavel-nos-hospitais

[14] Funcionários da saúde desafiados a dar ideias contra burocracia. (2016, February 21). *Diário de Notícias*. Retrieved from https://www.dn.pt/portugal/funcionarios-da-saude-desafiados-a-dar-ideias-contra-burocracia-5040113.htm

[15] Burocracia pode ter predominado sobre o objetivo de cuidar das pessoas. (2016, January 20). *Jornal de Notícias*. Retrieved from https://www.jn.pt/nacional/saude/burocracia-pode-ter-predominado-sobre-o-objetivo-de-cuidar-das-pessoas-4989712.html

[16] Burocracia deixa doente sem medicação. (2011, November 27). *Correio da Manhã*. Retrieved from https://www.cmjornal.pt/cm-ao-minuto/detalhe/burocracia-deixa-doente-sem-medicacao

[17] Morte de doente com cancro põe em causa burocracia do IPO. (2019, May 8). *RTP Notícias*. Retrieved from https://www.rtp.pt/noticias/pais/morte-de-doente-com-cancro-poe-em-causa-burocracia-do-ipo_v1146230

[18] SNS: democracia e humanidade versus burocracia. Jornal Público. (2020, March 14). *Jornal Público*. Retrieved from https://www.publico.pt/2020/03/14/economia/opiniao/sns-democracia-humanidade-versus-burocracia-1907472

[19] Falta uma verdadeira reforma hospitalar. (2018, November 22). *Jornal de Negócios*. Retrieved from https://www.jornaldenegocios.pt/negocios-iniciativas/detalhe/miguel-guimaraes-falta-uma-verdadeira-reforma-hospitalar

[20] Administradores hospitalares unidos contra degradação da gestão e perda de autonomia. (2016, June 3). *Jornal Sol*. Retrieved from https://sol.sapo.pt/artigo/512308/administradores-hospitalares-unidos-contra-degradacao-da-gestao-e-perda-de-autonomia

5.2. How can the bureaucratic logic in PSEH management be explained?

Consistent with the work of Goodrick and Reay (2011) about the possibilities of the coexistence of different logics, the PSEH is classified as having three institutional logics (state, community, and profession), with the state logic dominant and conflicting with the professional logic.

The state logic is dominant for political and legislative reasons. Professional logic is also very influential. Community logic is the least influential. State and professional logics are bureaucratic while the community works within an informal logic with a prevailing disregard for bureaucratic rules (Lopes & Rodrigues, 2010). However, community logic also presents some reasons that favour the development of bureaucracy in this context as the call for transparency and civil participation in the public health care services increases. This reflects a bigger social concern for equity and efficiency in public health care services – and the bureaucracy proves to be a predictable way to achieve them (Meier & Hill, 2005). So, even though the community works under an informal logic, its demands from the public health care services may be conducive to a bureaucratic managerial logic in this sector. Additionally, medical practice can be referred to civil court. To prevent civil responsibility, hospital regulation is increased, stiffening the bureaucratic processes, in a defensive reaction to medical practice.

Thus, we did find reasons that favour bureaucratic logic. Because the logic in PSEH management arises from the presence and combination of these three logics, we argue that the institutional context had to press towards the emergence of a bureaucratic logic. There may be other good management reasons for bureaucratic logic, like the systematic constitution of multidisciplinary teams that requires more efficient control and formalization of rules, but these seem secondary in the broad institutional context.

This bureaucratic logic is affected by a conflict between state and professional orders because their interests sometimes clash. The professional medical power and autonomy are constrained by a managerial logic of control. The relative influence of these orders may vary over time, depending on the evolving institutional logics (Ruef & Scott, 1998), but they certainly have to acknowledge different interests and look for compromises. These conflicts undermine management and should be addressed through fostering a collaborative environment. More than political and social decisions, the way to achieve efficiency gains and cost control demands the participation of health care professionals (Silva, 2012). This is conducive to an evolved bureaucratic approach in which managers are more open to intra-organizational dialogue and the bureaucratic process is developed with that sense. In the LHU, studied

in the third essay, each department had a management team which included a senior doctor, a manager, and a nurse or technician. Medical staff have a special status and there is an effort to engage them in the PSEH management (Saúde, 2010).

Accordingly, studies suggest that health care organizations which invest in budgetary participation affect the sense of commitment of clinical personal. This, along with role clarity, motivates better managerial work attitudes and performance of clinical managers (Macinati & Rizzo, 2016). Non-managerial controls, like those coming from a participative culture, help to moderate the tensions that could emerge from coercive use of managerial controls (Nyland et al., 2017). Some authors argue that this is the way to lead in bureaucratic environments: to improve management quality through major accountability and ethical demands (Cunha, 2004). The professional qualification reflects this trend as it seeks to assist and support staff in developing their skills. This bureaucratic approach a new stage in the development of bureaucracy, named as neo-bureaucracy. This is a kind of bureaucracy that calls for a collaborative environment (Farrell & Morris, 1999). The political intention to involve civil society in the improvement of public health care services is also a factor that favours this bureaucratic approach because it fosters collaboration among the different stakeholders. Thus, the institutional context of PSEH justifies the bureaucratic logic. Interest in managing conflicting orders, together with the political intention to involve civil society in the health care services, marks an evolved approach to bureaucracy.

There is a will to evolve from a simple bureaucratic logic of management to a logic that integrates and coordinates the several stakeholders under a model of services centred in the quality of decentralized management leadership (Saúde, 2010). Nevertheless, the prevailing institutional context appeals for use of a bureaucratic logic.

6. Conclusion

In Essay 3, we found that management accounting tools implemented in a LHU (belonging to the PSEH) assumes bureaucratic features and fosters a neo-bureaucratic approach. Simultaneously, we found evidence for the presence of a bureaucratic logic in public health care services, despite negative perceptions of bureaucracy. Mindful of this, in the present essay we explored the justification for the continuous presence of bureaucracy in public health care services. We identified three institutional logics relevant to the institutional context of PSEH: the state, community and professional logics. The first two are eminently bureaucratic logics, while the third is non-bureaucratic.

In the PSEH the state logic prevails, professional logic is a decisive force. Community logic is, by far, the weakest and least influential. The three institutional logics fundamentally corroborate to the formation of a bureaucratic logic in the management of the PSEH. The dominant bureaucratic state logic and the unavoidable professional logic, as well as some aspects of the relation of the community with the public health care services (the demand for transparency and participation in public health care politics), justify a bureaucratic logic in management. The bureaucratic features of the two major logics in this context conform to the PSEH logic of management. Community logic, though non- bureaucratic, presses health care services towards bureaucracy with increasing demand for transparency and responsibility. The conflicting dimension between professional and state orders induces a bureaucratic approach that values the particular status of physicians and nursing staff. This implies involving all staff in a collaborative and supportive regime that engages them in management. The need to manage the relationship between the different interests in this context and the purpose of fostering community participation in the health care organization tend to acknowledge and to foster a collaborative regime. This bureaucratic regime conforms to the neo-bureaucracy approach.

To the best of our knowledge this essay is the only study about the application of the ILP in the Portuguese health care context. We better characterize the PSEH context with a novel approach to the institutional drivers of bureaucratic logic in management. We find that this institutional context composed by the state, community and professional logics would force any management tool to assume bureaucratic features, as is the case of the BSC, studied in the third essay.

As a limitation, we emphasize the subjectivity of the researcher in analysing the data and in their interpretation using a metatheory with the complexity of the ILP.

Further research could beneficially explore the implementation of different private sector management tools in the PSEH. This research could observe whether these management tools are distorted from their

original nature because of the presence of bureaucracy in the institutional context. Other research could investigate how to disrupt the prevailing institutional logics and their relations in order to break or change the bureaucratic rule in the management of the PSEH health care settings.

Conclusion

Conclusion

This thesis of four essays relates MA to bureaucracy from a general view to a more particular view of the Portuguese health care setting. The thesis begins with a general historical linkage of the concepts of MA and bureaucracy before moving to, in a second step, focus on the BSC. From here, study is centred on the BSC in the health care setting, with a case study of a Portuguese LHU. The thesis finish by analysing the PSEH context in order to understand the presence of bureaucracy in management.

The first essay ponders the relationship between bureaucracy and MA over time. It concludes that evolution of the understanding of bureaucracy is reflected in the developments on MA. The history of MA is divided into four periods - classical (1700-1950), modern (1951-1980), post-modern (1981-1990) and contemporary (1991 onwards). In each period, we analyse that how bureaucracy was perceived had consequences for how MA evolved. In the classical period, the prevailing positive understandings of bureaucracy were epitomized in Taylorism. They determined developments in MA centred on questions of control and discipline. In the modern and post-modern period, developments on MA reflected increasing criticism of bureaucracy, going beyond control concerns. Contemporary MA tools reflect the resurgence of a positive understanding of bureaucracy, often referred to as neo-bureaucracy. These relationships between the developments of MA and bureaucracy reveal conceptual correspondences between them. This suggests that a good way to understand bureaucracy in an organization is to study its MA system.

The second essay contributes to studies on a contemporary MA tool – the BSC – as a bureaucratic phenomenon. This essay identifies nine features that define a contemporary bureaucratic organization: *systematization, rationality, authority, jurisdiction, professional qualification, knowledge, discipline, transparency,* and *accountability.* Accordingly, a new analytical perspective of the BSC is developed that links these features to the workings of the BSC. Based on this analysis, the BSC is understood theoretically as a neo-bureaucratic tool.

The third essay is a case study of a Portuguese LHU that is managed according to the BSC in the presence of the bureaucracy. The essay begins with a review of literature that signals the presence of the defining contemporary bureaucratic features in previously published studies on BSC in hospitals and health care settings. Thereby, this provides a new reading of the existing literature. The set of nine defining features of contemporary bureaucracy was found in the LHU studied, conveying a neo-bureaucratic approach. The BSC enhanced matters of systematization and rationality and instigated neo-bureaucratic order through a cultural change that was intended to address bureaucratic health management problems.

This corroborated the neo-bureaucratic theoretical understanding of the BSC that was previously presented.

The fourth essay seeks to understand the PSEH context and its drive for bureaucratic management. Its resort to the ILP and so contribute to foster the use of the ILP in Portuguese health care and management studies. Following this metatheory, a particular framework was developed and adapted to study bureaucracy in the PSEH. The framework is sustained in the three fundamental orders of the studied context (state, professional, and community) and in the respective characterization, according to five categories (basis of attention, authority, control, procedural rules and accountability) that allows a fair perspective on bureaucracy in each order. Following, an understanding of the overall logic, of the PSEH, is produced. This institutional context is characterized by two bureaucratic logics (state and profession) and an informal logic (community). The conflict between the state and professional logics, and the intend to foster community participation in health care organization instigates a collaborative and supportive regime enforcing a neo-bureaucratic in the management of the PSEH. The three institutional logics presents reasons prone to the formation of a bureaucratic regime in the management of the PSEH. As such, a theoretical explanation for the bureaucratic logic in the PSEH (as the LHU studied in the third essay) is provided.

The present institutional context would force any management tool that is applied in this field to assume bureaucratic features, even when it distorts or falsifies its application. The BSC studied in the third essay ends up adjusting well to the bureaucratic logic as it assumes and stimulates the defining features of bureaucracy, developing it with a neo-bureaucratic sense. A tool that can express a way out of the bureaucratic dilemma that sees bureaucracy as an inefficient tool thought unavoidable. The BSC reveals plasticity appropriated to conjugate the institutional impositions of bureaucracy and the efficient demands of management. This might be the reason for the large adoption of the BSC in the health industry and services (Zelman et., 2003).

This thesis helps in the development of a more mature understanding of bureaucracy. Thus, instead of confronting bureaucratic practices, managers can accept bureaucracy as a form of management that is collaborative, flexible and enabling.

As limitations it is pointed out the lagged period in which the third essay was conducted (2015-2018), because of the need of constant articulation and updates of data. Also, if the third essay validates empirically the relationship between bureaucratic features and BSC characteristics established in the second essay, we should alert for the risk of unintentional bias. Another limitation is that the evidence

found of bureaucracy in the third essay cannot be generalized, as it arises from a single case study. Regarding the fourth essay, the ILP constitutes a metatheory that gives the researcher the freedom to adapt according to the study purpose. The application of a metatheory presupposes the subjectivity of the researcher that hereby is subjected to evaluation by others. The use of a metatheory is not a mere application of principles and postulates to be confirmed. Rather, it is always a proposal of a different perspective of analysis which has shortcomings and merits.

If the BSC complies with the bureaucratic logic of a Portuguese PSEH by developing a neo-bureaucratic approach, it would be interesting to investigate the implementation and performance of other recent contemporary management accounting tools in similar settings; and/or to analyse whether institutional pressures change the rules and theoretical design of such tools to abide by institutional bureaucratic logic. Other studies should investigate how to disrupt the prevailing institutional logics and their relations to change the bureaucracy in the management of the Portuguese PSEH. We also suggest future research to evaluate the existence of ill-intended bureaucracy in the MA of health care public organizations. This work could beneficially address topics such as rules, commissions and protocols, created by managers and other stockholders, to avoid responsibilities. Moreover, studies should be conducted on how MA tools can change the perception of bureaucracy in health care organizations in different contexts, and particularly in non-Anglo-American contexts.

Appendices

Appendix A: List of Interviews Conducted

	Date	Position	Method of Recording	Duration (minutes)
A	1st october 2015	Member of Board (2015 to 2018)	Transcription	73
B	29th october 2015	Manager of Contracting Office (until 2017)	Transcription	55
C	19th november 2015	Manager of Planning and Control Manage Office (2015 to 2018)	Transcription	50
D	23th november 2015	Manager of Social Office (2015 to 2018)	Transcription	66
E	24th november 2015	Manager of Quality Department and Manager of Emergency and Intensive Care Department (2015 to 2018)	Notes	80
F	23th october 2018	Manager of Contracting Office (since 2017) and Manager of Medicine Department (until 2017)	Notes	45
G	23th october 2018	Manager of Central Sterilization Office (until 2017)	Notes	45
H	26th october 2018	Manager of Surgery Department (2015 to 2018)	Transcription	41
I	30th october 2018	Manager of Mental Health Department (2015 to 2018)	Transcription	57

Appendix B: Interviews Questions

The interviews were semi-structured and a script was sent in advance to the interviewees. In this way, the order of the questions was adapted to the interviewee. The interview began with the presentation of the study, open and general questions to facilitate the beginning of the conversation and then specific questions targeted to the bureaucratic concepts. The interview concludes with a question about the self-perception of the hospital's management positioning and the future of the BSC in the hospital.

List of interviews questions about each department/service and hospital management

How does your department/service works? How does your department/service relate to the other departments/services?

How much time do you spend on information reorganization and processing?

Does the department/service have increased duties because of BSC?

What formal and informal changes the BSC instituted? What bureaucratic duties were instituted?

What major changes occur with the implementation of the BSC in several areas: relationship with patients, relationship with health care centers, service delivery...

Do you make decisions based on the BSC?

Is there more contact between people due to BSC?

List of the interviews questions order by bureaucratic features

Rationality

Do you know the criteria that drives departmental and hospital strategy? Do you recognize its rationality and relevance? Do you have a strategic map?

Authority

Is there a well-defined hierarchy, with positions well differentiated regarding responsibilities? Do you know to whom to report and who reports to you?

Accountability

Do employees know what is required of them? Do they have assigned objectives? Are there well-defined performance evaluation processes either general or individual?

Do people perceive the consequences in their performance (responsibility or recognition)?

Jurisdiction

Are the procedures all expressed and formalized or is there an informal and implied dimension?

Do people agree with the established processes? Are they scrupulously defined or is there some freedom of action?

Professional *qualifications* and knowledge

Do you know of any training programs in your department or hospital?

Do you recognize innovations in your department? Do you recognize your training needs?

Discipline

Are employee's suggestions welcomed by management?

Are there consequences due to non-compliance with formal rules? Does employee participation in developing the BSC increase their commitment to the hospital's discipline?

Transparency

Does everyone know the criteria and sources of information for their assessment?

Do employees know what the BSC indicators are? Are they given any information about them?

Are you aware of the evaluation criteria in other departments?

Systematization

How do departmental plans articulate with other departments and the LHU? Do departmental objectives influence the definition of the individual objectives of employees?

Do employees understand their contribution to the higher goals of the LHU? Do they assess their relative position to the hospital environment? Do employees recognize the defined rules as being of general interest?

How do you classify leadership: powerless, demanding, or open to communication?

Appendix C: List of Documentation Analysed

Documents from the LHU:

Annual Report and Accounts, 2015;

Annual Report and Accounts, 2016;

Annual Report and Accounts, 2017;

Annual Report and Accounts, 2018;

Annual Reports Internal Audit Service Activities, 2018;

Code of Ethical Conduct, 2018;

Corporate Governance Report, 2017;

Internal Communication of Irregularities Regulation, 2018;

Internal Control Report, 2016;

Internal Regulation, 2018;

Plan of Activities and Budgets, 2018;

Program Contracts, 2010;

Program Contracts, 2017;

Program Contracts, 2018;

Program Contracts, 2019;

Regulation Internal Communication of Irregularities, 2014;

Sustainability Report, 2017;

Strategic Map, 2013;

Strategic Map, 2014;

Strategic Map, 2015;

Strategic Map, 2016;

Strategic Map, 2017;

Strategic Axes, 2013;

Strategic Axes, 2014;

Strategic Axes, 2015,

Strategic Axes, 2016;

Strategic Axes, 2017.

Internal Documents from the Emergency and Intensive Care Department (2015), such as:

Internal Reports;

Objectives, Indicators and Targets Maps;

Plan of Activities and Budgets;

Strategic Axes; and

Strategic Map.

Internal Documents from the Surgery Department (2015 and 2018) such as:

Internal Reports;

Objectives, Indicators and Targets Maps;

Plan of Activities and Budgets;

Strategic Axes; and

Strategic Map.

Internal Documents from the Social Office (2015), such as:

Internal Reports;

Objectives, Indicators and Targets Maps;

Plan of Activities and Budgets;

Strategic Axes; and

Strategic Map.

Internal Documents from the Mental Health Department (2018), such as:

Internal Reports;

Objectives, Indicators and Targets Maps;

Plan of Activities and Budgets;

Strategic Axes; and

Strategic Map.

Appendix D: Archival Sources – Newspaper Article

A burocracia já parece irrecuperável nos hospitais. (2015, April 1). *Jornal Sol*. Retrieved from https://sol.sapo.pt/artigo/126105/-a-burocracia-ja-parece-irrecuperavel-nos-hospitais

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Barros, P. P. (2018, July 29). O SNS vai ser sustentável nos próximos 20 anos. *Forbes*. Retrieved from https://www.forbespt.com/lideres/pedro-pita-barros/?geo=pt

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Burocracia pode ter predominado sobre o objetivo de cuidar das pessoas. (2016, January 20). *Jornal de Notícias*. Retrieved from https://www.jn.pt/nacional/saude/burocracia-pode-ter-predominado-sobre-o-objetivo-de-cuidar-das-pessoas-4989712.html

Chefes da urgência do D. Estefânia demitem-se. Bastonário fala em risco de colapso. (2018, December 12). *Jornal Público*. Retrieved from https://www.publico.pt/2018/12/12/sociedade/noticia/chefes-urgencia-hospital-dona-estefania-demitiramse-1854451

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Falta uma verdadeira reforma hospitalar. (2018, November 22). *Jornal de Negócios*. Retrieved from https://www.jornaldenegocios.pt/negocios-iniciativas/detalhe/miguel-guimaraes-falta-uma-verdadeira-reforma-hospitalar

Funcionários da saúde desafiados a dar ideias contra burocracia. (2016, February 21). *Diário de Notícias*. Retrieved from https://www.dn.pt/portugal/funcionarios-da-saude-desafiados-a-dar-ideias-contra-burocracia-5040113.htm

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Morte de doente com cancro põe em causa burocracia do IPO. (2019, May 8). *RTP Notícias*. Retrieved from https://www.rtp.pt/noticias/pais/morte-de-doente-com-cancro-poe-em-causa-burocracia-do-

ipo_v1146230

Neves, M. J. (2018, January 24). A burocracia e o seu particular impacto no sector da saúde no nosso País. Federação Nacional dos Médicos. Retrieved from https://www.fnam.pt/index.php/seccoes/opiniao/331-a-burocracia-e-o-seu-particular-impacto-no-sector-da-saude-no-nosso-pais

Sindicatos abrem guerra na saúde contra prescrições por outros profissionais. (2016, September 16). Diário de Notícias. Retrieved from https://www.dn.pt/portugal/sindicatos-abrem-guerra-na-saude-contra-prescricoes-por-outros-profissionais-5384027.html

SNS: democracia e humanidade versus burocracia. (2020, March 14). Jornal Público. Retrieved from https://www.publico.pt/2020/03/14/economia/opiniao/sns-democracia-humanidade-versus-burocracia-1907472

Appendix E: Archival Sources - Legislation

Law 27/2002, of 8 November.

Law 44/2005, of 29 August.

Law 46/2007, of 24 August.

Law 82-A/2014, of 31 December

Law 117/2015, of 31 August.

Law 156/2015, of 16 September.

Decree-Law 93/2005, of 7 June.

Decree- Law 233/2005, of 29 December.

Decree-Law 71/2007, of 27 March.

Decree-Law 133/2013, of 3 October.

Decree-Law 18/2017, of 10 February.

Regulation 631/2016, of 8 July.

Regulation 707/2016, of 21 July.

Regulation 340/2017, of 23 June.

Regulation 724/2019, of 17 September.

Resolution of the Council of Ministers 128/2002, of 25 September.

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