Accounting, microfoundations, hybridization and longitudinal conflict in a Finnish health care organization

Antti Rautiainen, Toni Mättö, Kari Sippola and Jukka O. Pellinen
School of Business and Economics, University of Jyväskylä, Jyväskylä, Finland

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Abstract

Purpose – This article analyzes the cognitive microfoundations, conflicting institutional logics and professional hybridization in a case characterized by conflict.

Design/methodology/approach – In contrast to the majority of earlier studies focusing on special health care, the study was conducted in a Finnish basic health care organization. The empirical data include 36 interviews, accounting reports, budgets, newspaper articles and meeting notes collected 2013–2018.

Findings – The use of accounting techniques in this case did not offer professionals sufficient support under conditions of conflict. The authors suggest that this perceived lack of support intensified the negative emotions toward accounting techniques. These negative emotions aggregated into incompatible professional-level institutional logics, which contributed to the lack of hybridization between such logics. The authors highlight the importance of the cognitive microfoundations, that is, the individual-level interpretations and emotional responses, in the analysis of conflicting institutional logics.

Practical implications – Managerial attention needs to be directed to accounting practices perceived as frustrating or threatening, a perception that can prevent the use of accounting techniques in the creation of professional hybrids. The Finnish basic health care context involves inconsistent political decision-making, multiple tasks, three institutional logics and individual interpretations and emotions in various decision-making situations.

Originality/value – This study develops microfoundational accounting research by illustrating how individual-level cognitive microfoundations such as dissatisfaction with budgeting, aggregate into professional-level institutional logics, and in our case, prevent professional hybridization in a basic health care setting characterized by conflict and three separate institutional logics.

Keywords Hybridization, Case study, Institutional logics, Cognitive microfoundations, Health care accounting

Paper type Research paper

Introduction

Recently, institutional research has been extended by an emerging microfoundations agenda. Tolbert and Zucker (2020) define microfoundational research in institutionalism as studies focused on "explaining the links between patterns of behavior in a collectivity and individual-level cognitions and behaviors that produce and change the collective patterns" (p. 4). The microfoundation studies focusing on cognition, that is, on *cognitive microfoundations*, emphasize thought structures and emotions that influence behavior and potentially influence the group-

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level institutions (Haack *et al.*, 2020). According to Malhotra and Reay (2020), the topic of institutional logics has garnered renewed attention through the microfoundational approach. They call for research on institutional complexity in terms of multiple institutional logics and their microfoundational elements. In addition, Haack *et al.* (2020) note that little empirical research has been directed to microfoundations of institutions. The cognitive microfoundations underlying conflicting institutional logics and the resulting possible professional hybridization remain unaddressed in the accounting research literature. In this article, we aim to address this topic by analyzing how, from an accounting perspective, cognitive microfoundations aggregate into professional logics and, in our case, block professional-level hybridization.

Hybridization involves a combination of multiple, normally separate, elements, such as goals, institutional logics or control elements (Battilana *et al.*, 2020; Grossi *et al.*, 2020; Skelcher and Smith, 2015). On the professional-group level, institutional pressures to adopt hybrid operating practices, such as the pressure to adopt new accounting tools, can lead to professional hybridization in terms of blended expertise or logics (Greenwood *et al.*, 2011; Kurunmäki, 2004; Reay and Hinings, 2009). However, such pressures may also lead to segregation (or compartmentalization, see, e.g. Kastberg and Lagström, 2019) of these professional groups and their practices, even conflict (Fischer and Ferlie, 2013). There is a need to better understand professional hybridization and the role of individuals and accounting in it (Berry *et al.*, 2009; Grossi *et al.*, 2020; Maran and Lowe, forthcoming). Cognitive microfoundations and their influence on the institutional logics at the professional level have not been addressed in a context marked by a pressure to adopt accounting techniques, such as participatory budgeting, by non-accounting professionals. Therefore, we consider *individual-level* perceptions, and emotions like anxiety or dissatisfaction (see Greenwood and Hinings, 1996; Lok *et al.*, 2020), and their influence on professional-level institutional logics, and the hybridization outcomes between these logics in a context characterized by resistance to and conflict over pressures for accounting-related hybridization (Fischer and Ferlie, 2013; Skelcher and Smith, 2015).

Previous health care accounting research has focused on special health care contexts (hospitals, emergency units and mental health units) with relatively clear tasks and work descriptions (see Firtin and Karlsson, 2020; Fischer and Ferlie, 2013; Kastberg and Lagström, 2019; Kurunmäki, 2004). In contrast, this study analyzes a Finnish *basic health care* organization (in UK terms, a primary care organization). The case organization is referred to here as Case Health Care (CHC). CHC carries out a wide range of tasks and has a complex organizational structure governed by municipal political decision-making, making it a suitable context for studying hybridization in basic health care.

Institutional theorists have long emphasized the influence of different institutions on the individual (e.g. Greenwood *et al.*, 2011). However, as Haack *et al.* (2020, p. 23) point out, "institutions come from somewhere." Adopting a microfoundational perspective makes it possible to analyze the individual-level responses and their influence on the more aggregated levels (Haack *et al.*, 2020). Thus, acknowledging the potential impact of cognitive microfoundations on professional-level institutional logics facilitates further understanding of the professional hybridization phenomena (Barney and Felin, 2013; Greenwood *et al.*, 2020; Lok *et al.*, 2020; Toubiana and Zietsma, 2017). In this study, we ask:

> How do individual-level cognitive microfoundations aggregate to professional-level institutional logics in a basic health care context where hybridization pressures include the use of accounting techniques?

Our longitudinal empirics are gathered from a Finnish organization we call CHC, characterized by its many organizational levels, multiple professional groups and conflict, a scenario that permits a study of how cognitive microfoundations (individual interpretations and responses) influence multiple institutional logics. We contribute both to the discussions on institutional logics and cognitive microfoundations in health care accounting context

(Fischer and Ferlie, 2013; Kurunmäki, 2004; Reay and Hinings, 2009). We analyze the cognitive microfoundations underlying three institutional logics in a situation where professional hybridization does not occur despite the institutional demands for the use of accounting tools like participatory budgeting. Hence, this study provides information on a scarcely observed phenomenon: non-hybridization. *Health care* (medical), *administrative* and *political* institutional logics were observed in our case.

This study contributes to emerging microfoundational research by focusing on the influence of the individuals on the higher-level institutions. Our findings indicate that accounting tools such as participatory budgeting were introduced to CHC's basic health care professionals, but despite pressures for hybridization, we observed non-hybridization. Instead of a swift transfer of technologies, we found long-standing frustration with the use of accounting tools, alongside dissatisfaction and other negative emotions, amplifying the incompatibility of professional logics. The cognitive microfoundations aggregated into professional-group-level institutional logics and practices, explaining the case hybridization developments that manifested as an escalating conflict (see Fischer and Ferlie, 2013; Greenwood and Hinings, 1996) and non-hybridization. This study also contributes to health care accounting research by providing evidence on why professional hybridization may be more unlikely in the basic health care context, particularly in the local Finnish setting. In our case, the inconsistent political logic hindered attempts to achieve hybridization between professional logics.

Next, we outline the recent literature on microfoundations with a focus on cognitive microfoundations. Then we present how these microfoundations affect the way institutional logics are applied by professional groups. Subsequently, we analyze the way conflicting institutional logics relate to hybridization pressures concerning accounting tools. Health care accounting provides context for the study, after which our data and methods are introduced. The empirical basic health care case section follows, and the study ends with a discussion and conclusions.

Microfoundations, institutions and professional hybridization

Microfoundations of institutionalization

Recent research on institutionalization highlights the microfoundations of institutionalization processes (Cardinale, 2018; Greenwood *et al.*, 2020; Powell and Rerup, 2020; Haack *et al.*, 2020; Tolbert and Zucker, 2020). The literature on the microfoundations of institutions (e.g. Haack *et al.*, 2020; Powell and Rerup, 2020) explains social structures and their developments, not only through the top-down institutional pressures but through the micro-level details of institutionalization. Such details include day-to-day action and cognition, involving individual responses, thought structures, emotions and aspirations as well as local tools in the local setting (Greenwood *et al.*, 2020; Lok *et al.*, 2020; Powell and Rerup, 2020).

Microfoundational research on institutions is a relatively new field comprising cognitive, communicative and behavioral perspectives (Haack *et al.*, 2020). Among those, the communicative perspective explores communicative means, such as the use of rhetoric, to advance institutional change. The behavioral perspective analyzes the way daily activities and often mundane routines of individuals affect institutional contexts. Finally, and most importantly for this research, the cognitive perspective emphasizes thought structures and emotions that influence group behavior, which thus have the capacity to change or maintain institutions (Haack *et al.*, 2020). Contemporary researchers on cognitive microfoundations are interested in the relations between emotions and institutions, stress the mental structures and see the focus on cognition as a source of distinction in institutional theory (Haack *et al.*, 2020; Phillips and Malhotra, 2008; Voronov and Weber, 2016). That is, while researchers referring to a cognitive microfoundational setting acknowledge that macro-level institutions affect the micro-level, they argue that micro-level analysis helps "illuminate the origins and effects of the macro" (Haack *et al.*, 2020, p. 23).

The cognitive perspective on microfoundations often involves understanding institutions through different levels of analysis (Haack *et al.*, 2020). The influence of external pressures on the individual is well-documented in the research literature. For example, control organizations and unions may determine how professionals should behave (Gioia *et al.*, 2000). However, there is a lack of empirical research on individuals' emotions (Haack *et al.*, 2020), and how they contribute to group-level behavior in professional groups, thus creating both an organizationally shared and professional-group-level institutional logic.

According to Haack *et al.* (2020), theorizing on multiple levels makes it possible to examine the details of behavior rather than merely focusing on external pressures (also Harmon *et al.*, 2019). Therefore, in this paper, we acknowledge the role of cognitive microfoundations, such as individual-level issues, emotions and feelings [1], in explaining the form that professional-level logic takes in our health care case organization (see also Boedker and Chua, 2013; Greenwood *et al.*, 2020; Lok *et al.*, 2020; Powell and Rerup, 2020). The microfoundations approach facilitates analyzing "how individual-level factors aggregate to the collective level" (Barney and Felin, 2013, p. 145). Further, the research interest in microfoundations points to "the power of looking at lower-level constituent units when explaining higher levels of analysis" and "how choices and interactions create structure, the behavior of individuals within structures, and the role of individuals in shaping the evolution of structures over time. . ." (Barney and Felin, 2013, p. 144). Barney and Felin (2013) see the microfoundations discussion as an attempt to move beyond distinctions between micro and macro, thus continuing the discussions related to agency, structure and practices. In this paper, understanding both the macro- and micro-level aspects of professional behavior provides an opportunity to consider the case developments and hybridization outcomes, and to focus on individual cognition and the role of accounting in local interaction (see Miller, 1994).

Institutional logics and conflict

Institutional logics "supply and give meaning to actors' roles and behaviours" (Skelcher and Smith, 2015, p. 445), but equally, the professional role people have affects their decisions (Greenwood *et al.*, 2011). Shared established ways of making decisions are called institutional logics (Fischer and Ferlie, 2013; Greenwood *et al.*, 2011). Existing literature reveals several possible combinations of institutional logics in public sector studies (see, e.g. Fischer and Ferlie, 2013; Maran and Lowe, forthcoming; Toubiana and Zietsma, 2017). However, Bitektine and Nason (2020) identify three distinct groups following separate institutional logics that warrant attention in the analysis of microfoundations in the public sector: health care professionals, politicians and the legal or administrative group. Through our longitudinal data collection, we recognized these groups in our Finnish basic health care context. Generally, these groups might be expected to follow *health care logic* (see Toubiana and Zietsma, 2017), *political logic* (see Bartocci *et al.*, 2019) and *administrative logic* (see Rautiainen *et al.*, 2017). We will present the methodological reasoning in more detail in the data and methods section and illustrate the logics in action in the empirical section.

Toubiana and Zietsma (2017, p. 926) note that the foundation of the health care logic includes ethics of care, a focus on individuals, compassion, emotion and connection. Kurunmäki *et al.* (2003) contrast clinicians and administration (even if not expressly discussing logics). In our view, an administrative logic focuses on norms, rules and budgets. While it is rarely incorporated into health care accounting studies, we consider the political logic as potentially important when analyzing the local municipal health care context. Political logic highlights the benefits for the party and voters, although it is generally backed by the strong ideology of representational democracy, participation and voting rights (see also Bartocci *et al.*, 2019; Rautiainen *et al.*, 2017).

According to Greenwood *et al.* (2011), most studies concentrating on the (in)compatibility of different institutional logics incorporate only two logics in their analysis. The same applies to health care accounting (e.g. Fischer and Ferlie, 2013; see also Toubiana and Zietsma, 2017). However, Greenwood *et al.* (2011) note that the number of institutional logics incorporated in the analysis is one side of the complexity issue but that the extent to which the different logics in a given setting are (in)compatible should also be addressed. As such, the mechanisms and reasons for incompatibility deserve analysis, as we do not know why multiple logics result in non-hybridization or conflict in some organizations but hybridization in others (Besharov and Smith, 2014). Such analysis will be provided in this study. We illustrate how negative emotions aggregate into professional-level logics with the potential to prevent hybridization.

In the public sector, the institutional logics can conflict and still co-exist. Organizational actors often follow one prominent group-level institutional logic, which may include relatively impermeable core issues that cannot easily be changed (a core domain of expertise, Suddaby *et al.*, 2015). Managerial pressures (e.g. New Public Management (NPM), see Lapsley, 2009) and diminishing resources in public sector organizations have in some cases led to hybridization where the medical profession strengthens its position by attaining managerial skills or utilizing accounting tools (Kurunmäki, 2004; Kurunmäki *et al.*, 2003). However, NPM developments have also faced resistance, emotional responses, and prompted conflicts and other disappointing results (Fischer and Ferlie, 2013; Hyndman and Liguori, 2016; Lapsley, 2009; Lodge and Gill, 2011; Pellinen *et al.*, 2018).

Public organizations often face pressures for change and hybridization and address multiple goals and institutional logics (Fischer and Ferlie, 2013; Reay and Hinings, 2009). There is often some dissatisfaction with the accommodation of interests among the various stakeholder groups (Fischer and Ferlie, 2013; Greenwood and Hinings, 1996). "Dissatisfaction, however, does not provide direction for change" if there is no commitment to some value (or goal or logic) guiding the changes (Greenwood and Hinings, 1996, p. 1,035). The role of accounting may be in providing tools, allowing the transfer of technologies (Kurunmäki, 2004), thus directing the change toward organizationally beneficial hybridization. However, the result may also be an escalating conflict (see Fischer and Ferlie, 2013).

In this paper, we analyze how the individual-level issues, like anxiety and dissatisfaction, in the long-term aggregate into professionally segregated institutional logics (Greenwood *et al.*, 2020; Lok *et al.*, 2020) and lead to a resistance of hybridization pressure and escalating conflict. Therefore, professional hybridization does not follow directly from institutional pressures or organizational form but may depend on the complex responses among professionals, that is, multiple individual ways of reacting to the multitude of change pressures or to complex organizational structures (see Pellinen *et al.*, 2018). Nevertheless, the individual-level analysis of cognitive microfoundations, their aggregation into professional-level logics and the resulting non-hybridization of these logics in the basic health care setting has not received accounting research attention.

Professional hybridization

Hybridization involves a combination of multiple, normally separate, elements, such as goals, institutional logics or various funding and control elements, such as market- and hierarchy-based governance structures (Battilana *et al.*, 2020; Battilana and Lee, 2014; Grossi *et al.*, 2020; Skelcher and Smith, 2015). This paper focuses on *professional hybridization* (Ahrens *et al.*, 2018; Greenwood *et al.*, 2011; Fischer and Ferlie, 2013; Kurunmäki, 2004; Reay and Hinings, 2009). Institutional pressures can lead to professional hybridization encompassing blended expertise or logics (Greenwood *et al.*, 2011; Kurunmäki, 2004; Reay and Hinings, 2009). However, such pressures may also lead to a variety of negative *individual-level* responses, like anxiety (Lok *et al.*, 2020), that aggregate through multiple instances to professional logics and

potentially into non-hybridizing responses (e.g. resistance and blocking influences, see Fischer and Ferlie, 2013; Oliver, 1991; Skelcher and Smith, 2015) [2].

Skelcher and Smith (2015) present five types of potential hybrids: segmented, segregated, assimilated, blended and blocked hybrids. Of these, the blocked hybrid is linked to the unsuccessful hybridization of conflicting institutional logics among professional groups within the organization (see Fischer and Ferlie, 2013; Johanson and Vakkuri, 2018; Skelcher and Smith, 2015). In recent research, cognitive microfoundations such as emotions are linked to understanding the way institutional logics interrelate and become hybridized (Malhotra and Reay, 2020), a situation that invites a multilevel and longitudinal analysis of hybridization.

Public health care organizations are usually institutionally complex, containing multiple, often conflicting institutional logics. (Toubiana and Zietsma, 2017, Smets *et al.*, 2015, Bitektine and Nason, 2020; Greenwood *et al.*, 2011). As such, health care organizations also contain multiple strong professional groups following different institutional logics (Kurunmäki, 2004; Kurunmäki *et al.*, 2003; Pellinen *et al.*, 2018). This makes them potentially vulnerable to contests (or conflicts) over organizational power, which may escalate into a conflict that threatens the whole existence of the organization (Fischer and Ferlie, 2013). However, crises and conflicts may also threaten professions and the existence of the organization (Fischer and Ferlie, 2013). Situations perceived to be threatening often provoke resistance (Oliver, 1991) and individual negative emotions such as anxiety (Lok *et al.*, 2020).

Kurunmäki (2004) writes about the transferability of accounting techniques as a basis for the professional hybridization of non-accounting professionals. She notes that management accounting expertise in Finland involves an abstract body of knowledge coupled with different managerial and accounting tools, which are frequently utilized in non-accounting contexts. This makes possible the hybridization of accounting and non-accounting expertise. Kurunmäki (2004, p. 328) suggests "that greater attention should be paid to the roles of [accounting] techniques, and their mobility between professional groups, rather than focusing almost exclusively on abstract knowledge." In this paper, we explore the role of accounting techniques in a conflictual context. The prominent accounting techniques provoking individual cognitive responses in our case include participatory budgeting and performance measurement.

The health care sector as a context for hybridization

In health care accounting studies, medical professional work is often seen as unmeasurable and difficult to control (see Gebreiter, 2016; Gebreiter and Ferry, 2016). Accounting techniques based on diagnosis-related groups (DRGs) help make medical operations more calculable (Preston, 1992; Samuel *et al.*, 2005). Costing systems based on the DRG, like other standard costing systems, have their problems; there are no comparable true costs (Chua, 1995; Llewellyn and Northcott, 2005). Despite that criticism, DRGs have had symbolic success and influenced the hybridization of management accounting and clinical definitions and practices (Chapman *et al.*, 2014; Samuel *et al.*, 2005). Although potentially there are differences in using DRG costing information in a hospital setting or municipal decision-making, DRG costing is typically utilized in Finland for cost management. Further, the developments in the DRG costing process can be affected by political and field-level changes (Kantola and Järvinen, 2012), where the goals of the system emerge during the process (Chapman *et al.*, 2014, p. 360; Kantola, 2015). Further, the use of new systems or techniques may transfer aspects of professional hybridization in the hospital context (see Kurunmäki, 2004).

In business-oriented hospitals, detailed cost categorization can be relevant for managers in the clinical processes (Pizzini, 2006). In Finland, however, basic public health care is mainly tax-funded without business or market incentives for health centers. The basic health care context has attracted relatively little research attention. General practice as such has been

studied for example by Broadbent *et al.* (2001) regarding accounting-related change efforts and resistance in the UK, but the main focus was not on hybridization. Nevertheless, accounting typically facilitates making sense of changes and enables control within organizations (see Chapman *et al.*, 2014; Pflueger, 2016). However, performance measures combining financial and societal issues may suit hybrid organizations (Grossi and Thomasson, 2015). For example, measures such as customer surveys and questionnaires have been used alongside costs and budgets to hold professionals and organizations to account and used as elements of accounting control systems (Pflueger, 2016). There have been calls for more attention to practices, and the role of accounting in professional service organizations (Chapman *et al.*, 2014; Levay *et al.*, 2020).

Major organizational changes or other disruptions can cause emotional responses (Boedker and Chua, 2013; Greenwood *et al.*, 2020, p. 13; Toubiana and Zietsma, 2017), even escalating conflict in health care (Fischer and Ferlie, 2013). Such special circumstances tend to involve unclear responsibilities, rising costs and anxiety experienced by the members of the organization (Boedker and Chua, 2013; Blomgren, 2003; Chua, 1995; Greenwood *et al.*, 2020, p. 13; Llewellyn and Northcott, 2005). Regarding changes, we may separate external sudden events (Sargiacomo, 2015), internal general pressures for cost control (Chapman *et al.*, 2014) and slow historical development of practices (Fischer and Ferlie, 2013; Gebreiter and Ferry, 2016).

The prominence of an institutional logic over time, or in special circumstances, depends on the power of the professional or organizational group representing it, such as power related to expertise, authority, or legislation (Malhotra and Reay, 2020, p. 248). Further, a big geographic (physical) distance between groups may allow the continuation of segmented or demarcated practices (Lounsbury, 2008; Smets *et al.*, 2015; Rautiainen and Järvenpää, 2012). These responses to conflicting logics can be useful in understanding professional hybridization in the health care context as well.

The health care field has witnessed both hybridization and conflicts among professionals (Fischer and Ferlie, 2013; Jacobs, 2005; Kurunmäki, 2004). Kurunmäki (2004) found that top medical professionals in the central hospital context (in the special health care sector) felt obliged to learn managerial techniques to manage operations and to maintain their power. Counter to that finding, Fischer and Ferlie (2013) identified a conflict between rules-based and ethics-based logics in clinical risk management and high emotional involvement among interested parties. This situation led to disputes, anger, and the politicization of decision-making as well as to personal anxiety and lack of trust between stakeholder groups, and even to alternative "truth regimes" and "talking past each other" (Fischer and Ferlie, 2013, p. 46). Although the focus of analysis adopted by Fischer and Ferlie (2013) was not on microfoundations, events ultimately led to conflicts, negative emotions and organizational closure. The local ways of accounting, budgeting and control may contribute to change pressures, individual emotions, and thus to the possibility of professional hybridization (see Greenwood *et al.*, 2011; Kurunmäki, 2004). As pointed out by Haack *et al.* (2020), it is important to understand the potential influence of cognitive microfoundations on the higher-level institutions, such as professional-level logics. Understanding how such professional logics form and are influenced by cognitive microfoundations permits the analysis of processes leading to hybridization or escalating conflicts. Accordingly, our theoretical framework guiding the empirical analysis consists of cognitive microfoundations, institutional logics and professional hybridization in a Finnish basic health care case context.

Data and methods

This study was conducted in a local Finnish basic health care organization (in UK terms, a primary care organization) that, at the start of this research, was financed and operated under

the governance of four adjacent municipalities. This Finnish health care case organization is the CHC. We conducted 36 interviews between 2013 and 2016 in CHC. A full list of the interviewees, dates of the interviews, and other details are provided in the Appendix. We also gathered accounting reports, containing cost estimates, population data, economic forecasts and the cost accounting principles behind the doctoral and nurse visits. Further, we analyzed accounting reports, budgets, meeting notes and local newspaper reports produced up until 2018.

Our research project started in early 2013 with seven interviews with nine interviewees, who were mostly managers and financial administration officers at CHC. These interviews provided an understanding of the financial administration of the health care services and CHC as an organization that, at the time of interviews, incorporated a total of 12 health clinics located in the region of one main city and three smaller neighboring municipalities. We asked the interviewees about the different control systems and performance measures used, the role of budgeting in health care, accounting information systems and the possible development needs of the health care system. Each interview was transcribed and analyzed so that, following the transcription, each researcher reviewed the interview material and sorted the collection of remarks into themes. These themes were then compared to enhance the validity of the interpretations. Therefore, the analysis of interview data included features of content analysis, such as categorization, and ethnographic analysis that involved trying to understand the socially constructed organizational reality (Silverman, 2001, pp. 122–129).

The first nine interviewees raised the topic of the financial constraints on the municipalities and the difficulties in getting the various professionals in the organization to take budgeting seriously. The managers in the administration suggested that other professionals working in the organization did not provide adequate inputs for the budgeting process and were largely oblivious to the budgetary processes. Interviewees raised several problems in the use of accounting tools and tensions between the various professional groups in the organization. This implied that the organization had issues related to dealings between different professionals that sometimes escalated to conflict. This suggested that the organizational professionals were following different decision-making logics and had not hybridized accounting knowledge into their work. These initial findings steered our research toward explaining the lack of hybridization between professional logics and the role of accounting therein.

Next, we interviewed 18 medical professionals from three health clinics (units of CHC). At each clinic, two nurses, two doctors, a head nurse and the health clinic's deputy chief physician were interviewed. The interviews covered topics like operations and the development needs of the health clinic, the attitudes of the medical professionals toward budgeting, performance measurement and financial administration. We also asked whether these medical professionals utilized budgeting or tried to comply with the budgetary processes. It soon became apparent that the organization involved multiple conflicting logics, disappointments, disputes and anxiety that surfaced in many ways. Further, there were differences in the working conditions and pressures felt in the health clinics that warranted further attention.

During the interviews, and while going through our interview material, we noted that many answers were emotive, expressing frustration and disappointment, for example. Further, we looked for keywords and labeled expressions that contained references to emotions or to emotional reactions (like "banging their fists on the table" depicting anger). In this analysis, following Toubiana and Zietsma (2017), we consider that meanings are carried not only by the words themselves but are related to the situation and to the way in which the words are used. We noticed that many interview excerpts contained an emotional undertone, like "it was a waste of time. . .it had no meaning" or "feeling. . .I am not very satisfied" which

depicted frustration with participatory budgeting and dissatisfaction with the perceived rush and being unable to treat patients appropriately.

Having reviewed and analyzed the data gathered from the interviews in the health clinics, the third round of interviews was again conducted with the managers and administrative personnel. The aim was to better understand the emerging topics such as the leadership situation and organizational conflicts. Finally, in 2016, it became apparent that the organizational situation and the conflicts between the municipalities had reached the point where one of the smaller municipalities left the cooperation arrangement. This prompted us to conduct yet another interview round: five follow-up interviews in the spring of 2016 with the politicians (from the funding municipalities) steering CHC. These interviews provided a longitudinal view of the change processes and harvested opinions from the politicians in charge of terminating the cooperation for the reasons behind it.

The collection and analysis of empirical data were made in accordance with the ideas of building hermeneutical understanding and knowledge. The validity of the research is increased through multiple rounds of interviews, focused research questions, and by an independent analysis conducted by four researchers. We used qualitative and quantitative data (e.g. accounting reports and population data) to obtain a broad view of the case events according to interpretive case study principles. The aim was to enhance the validity of the research through data triangulation (Yin, 1984) and by providing a rich description of case events (Kakkuri-Knuuttila *et al.*, 2008; Morgan and Smircich, 1980; Vaivio and Siren, 2010). A rich description of case events, and being familiar with the case, facilitates conveying plausible explanations of case developments (Golden-Biddle and Locke, 1993). The following empirical analysis focuses on basic health care (rather than special health care as in earlier studies) and examines three institutional logics (instead of two).

At the start of the project we discussed with the financial manager of social and health care and the director of basic health care and learned that administrative and medical professionals formed two distinct professional groups. The initial interviews illustrated both those professional groups and their distinct logics: a doctor remarked ". . .patient work, it's my top priority" whereas a financial manger noted ". . .we need to be more efficient; costs need to be controlled." During the second round of interviews, a political professional group was raised as an important third professional group in the municipal health care field, for example concerning decisions about CHC made within the main city council and by other boards. During our longitudinal data collection, we observed that in some decision-making situations (e.g. in various supervisory boards), individual interpretations change, meaning that the logics followed by individuals were sometimes blurred and inconsistent. The observation highlights the importance of individual-level analysis and of considering politicians as a group when attempting to understand professional hybridization in the Finnish basic health care context.

For example, a deputy chief physician noted with frustration how "all decisions seem to be political decisions." Further, the director of nursing, exclaimed in the context of savings plans, "politicians, they will not let us cut anything." In the course of data collection, we thus identified three distinct groups typically expected to follow their group-level logics, which we label *health care logic* (see also Toubiana and Zietsma, 2017), *political logic* (see Bartocci *et al.*, 2019) and *administrative logic* (see Rautiainen *et al.*, 2017). The following empirical section illustrates microfoundations (e.g. emotions) and the conflicting institutional logics in more detail.

Case CHC

Backgrounds

The CHC currently provides basic health care services for about 140,000 people living in the region of the main city and two other small municipalities in Finland (at the time of the data

collection, there were three others). The CHC organization was founded in 2011 and it currently has a net budget (net expenses after small appointment fees from customers) of about EUR50m. CHC has 11 health care units (previously 12) within its area. The municipalities involved finance CHC together but in practice, the main city (as the biggest funder) largely controls CHC's operations, including political decision-making on the administrative boards. Moreover, the final budget approved by the main city council affects the appropriate CHC spending (as the provider of services) at least indirectly.

The CHC has been the subject of several NPM-style projects in recent years. Activity-based costing, use of a balanced scorecard (BSC) and enterprise resource planning (ERP) systems have been adopted but the financial manager of the CHC, with frustration and perhaps cynically, considers these to be unnecessary organizational processes: "*we have these projects, but they always tend to remain superficial overviews.*" The BSC is partially used and the SAP ERP system that was adopted by the main city in 2006 had not been fully adopted by the CHC (at the time of interviews). However, manual clerical work persisted in administrative processes, and deputy chief physicians were forced to complete these office chores after their standard appointment schedules. A DRG-costing system was not used in CHC, and the DRG, as an accounting technique, was not facilitating the transfer of better practices in basic health care because of the variety of tasks involved and the preventive focus of work.

> A DRG-based accounting system is used in the central hospital. . . but in basic health care we take care of many things during the same appointment. [Director of nursing]

The main city has experienced a period of high fiscal deficits from 2004 onwards and a new city mayor was appointed in the same year. Accordingly, the mayor's period of office was characterized by intended budget cuts and attempts to change the segmented (siloed) practices.

Professional logics in the CHC

The interviews revealed that the institutional logic used was not only based on the education of the interviewee but also on the organizational position, decision-making context (different boards, committees, etc.) and the personal view of the basic task of the organization. We will next outline these differing and potentially conflicting institutional logics that individuals followed with a varying emphasis in differing decision-making situations and to convince various audiences (often in a political debate or personal dispute). Further, there were individual, micro-level views and dispositions on organizational tasks and logics. Generally, however, the institutional logics followed by individuals correspond to the medical, administrative and political professional groups that are strong and professionally relatively independent in the Finnish public sector. Next, we analyze the institutional logics and their microfoundations in more detail.

First, one CHC medical professional noted in 2013 that the medical profession followed a *health care logic*, related to the ethics of care and focusing on the individual patient, so they think that:

> Whether or not there is money, we will treat people with excellent quality, brilliantly, do all that the patient needs. [Director of nursing]

Second, the city officials were perceived by a medical professional as representing an *administrative logic* of savings and bureaucracy. The legitimacy of the administrative logic is based on legislation and good governance principles, such as having financial balance and avoiding excessive spending.

> The city mayor states in our executive board meetings that things are so bad [financially] that he will accept no explanations for why the [proposed] budget is not sufficient. [Director of nursing]

A financial manager echoed those sentiments and emphasized the cost-saving measures.

> We thought this budgeting process would proceed in such a way that during the spring we would get the political approval for these cost-saving measures because they [political decisions] are quite painful, we need to reduce the service level. . .so we will not have to fight over them in the fall [Financial manager]

Third, with regard to political decision-making, there was a *political logic* of keeping the voters happy and maintaining service volume. Generally, this logic is based on democracy and the equal rights of citizens, although it was not a uniform logic but party-specific. Even under intense budgetary pressure, the politicians were reluctant to cut services:

> The decision-makers, politicians, will not let us cut anything. Quite the opposite, they would like us to provide extra services beyond the mandatory level, for example, what their neighbor has dared to ask for. [Director of nursing]

> Well, this democratic governance is such that some people feel that the political system slows development projects. Some people have very enthusiastic development plans while others hold the opposite view and feel that this is not the right way. [Member of the Health care division]

Microfoundations and conflicts affecting hybridization

The main city's financial situation required it to slow the rise in medical expenditure and created pressures to find savings among the health units. However, this situation led to disputes in decision-making. Participatory budgeting was tried in the CHC, but it was seen as frustrating and dissatisfying by the medical professionals because the final budgets were very tight, and the suggested changes were disregarded. The accounting reports were delayed and not seen as very informative for decision-making, increasing the frustration.

> We anticipated future [budgeting] needs but now they [the administration] do not ask us anymore, but it was a waste of time. . .it had no meaning. When it goes to the political mill, the city mayor decides the budget frame and that's how it goes forward. It had no point. We can use the time more cost-effectively. [Director of services]

> We do not have forecast reports. . . and I have not seen a report of the special health care costs this year. [Ex-director of basic health care]

A sign of budget-related conflict and anxiety was the fact that the word "underbudgeting" was not permitted to be used, even if extra budgets were regularly made. Further, the accounting numbers were not trusted by the medical professionals.

> If one dared to say the word underbudgeting, well that was our style and then we applied for an extra budget. . . really, the word was not allowed. [Director of services]

> It's actually a bit of a problem that you cannot really believe in those numbers. . . they do not tell the truth [Chief health care manager]

The conflict-laden budgeting process did not serve the financial administration very well either. Despite pressures for acquiring accounting expertise, there appeared little hybridization.

> Deputy chief physicians. . .they know little about accounting . . .We'd really need them to start learning accounting; perhaps then they would understand what the numbers mean. . . They are always trying to resist different development ideas [Financial manager]

Furthermore, the management processes were complex: doctors and nurses had separate chains of command and there were several units of health care (e.g. school health care and physiotherapy) with different ways of operating and different unit managers. Further, there

were four municipalities and several political bodies involved in funding and decision-making, creating a complex organization with 11 organizational levels, counting from the operational level medical staff through various boards to the main city mayor. Frustration was apparent as medical professionals felt that the amount of administration was increasing, and they could not follow their preferred institutional logic.

> Really, there were 11 layers of administration or managers. . .you really cannot need all of them. They have forgotten why we are working here; we would like to do this patient work here. . .Lots of coffee and cupcakes are consumed by them [the administration]. . .and we have four times as many meetings as before [Doctor 1]

The organizational form with its 11 layers of administration contributed to slow management processes. Further, various political parties and boards (or their sub-groups or various committees or divisions) contributed to an overall complexity of the organizational structure and decision-making with multiple goals. There were conflicts over organizational power and allegations of hiding accounting information from other professional groups. Further, the health care logic and administrative logic seemed to be at odds in the organization. The following excerpt illustrates the complexity present and the presence of personal, group- and organizational-level conflicts:

> The city social and health managers are in serious conflict with CHC managers, they cannot discuss anything without an argument, they avoid each other. . .They cannot be around the same table, or they are fake or fighting, banging their fists on the table. You would think that this is an ordinary thing [taking care of health]. . .There are cliques. . .let's do this behind someone's back. I do not understand that, or that people in official meetings do not necessarily tell the truth. [Deputy chief physician]

The above excerpt hints at strong negative emotions like anger and anxiety in the organization and blocking attempts at hybridization. The responses to contradictory pressures seem conflict-related, manipulative and defiant (see Oliver, 1991). With the emphasis on medical work, budget processes and administration, two institutional logics are discernible: both the *health care (medical) logic* and the *administrative logic*. Further, there was political decision-making among the organizational levels. However, the *political decision-making logic* is not uniform in its targets, and the emphasis seemed to vary according to the organizational layer or unit where the decision was made. These institutional logics were blurred in the individual decision-making in the case context, where there were many goals and many opportunities for the professionals to step into other professionals' jurisdiction.

> Politicians want to be officials and officials want to be politicians: the strategic and operative actions have become blurred. . . and this is not just a problem of the politics of different parties but a regional politics problem as well; they try to keep the approval of their own village. [Chief health care manager]

The regional politics aspect mentioned in the excerpt above is highlighted for example if budgeting discussions indicate the need to shut down a health clinic to reduce costs. However, politicians did not approve the plan:

> We could shut down a certain clinic immediately, even tomorrow, we already have a plan for it. But the politicians would need to agree. [Deputy chief physician]

On some occasions, the same representatives seemed first to approve and then, in a higher decision-making body, to disapprove of certain decisions. This suggests how mixed individual-level pressures lead to inconsistent individual decisions on various political committees, which can lead to an uncertain focus of operations and anxiety and hamper the possibility of hybridization at the professional-group level because of the constantly shifting

emphasis of the three segregated logics in the case organization. The case organization offered many opportunities for such inconsistent individual interpretations and responses to institutional logics with the 11 levels of administration.

> Our politicians, when they are on the board and on other committees, well they may not have exactly opposing views, but there is an inconsistency that makes this difficult. [Chief health care manager]

The doctors and nurses are led by different managers and there is little cooperation among those management lines. The segregated situation is amplified by the multiple views of the political parties and unions so that there are few indifferent issues (cf. Carlsson-Wall *et al.*, 2016), and many decision-making situations involve frustration, stubbornness and hostility. The longitudinal dissatisfaction, visible for example in the budgeting process, may have contributed to the escalation of conflicts. Further, on the various boards and committees the individual interpretations of logics were blurred and inconsistent.

> All decisions seem to be political decisions, the main city's basic welfare board decides something, and then city social and health care managers take a stand that this cannot be decided and our CHC managers are not consulted at all. . . .it was a shock to me that the left hand does not know what the right hand is doing [Deputy chief physician]

The institutional logic selected affects how organizational goals, such as cost-effectiveness, are perceived. The views among medical and administrative professionals relating to practices diverged:

> They [medical professionals] basically automatically request new resources and we here in the financial administration try to say that we need to be more efficient; costs need to be controlled. [Financial manager]

> I do not spend or waste resources for nothing. I order those examinations that need to be ordered. [Doctor 1]

The CHC with its varying goals, conflict, negative emotions (e.g. frustration with accounting practices) and multiple non-hybridized professional groups is not an easy environment for developing accounting, budgeting or performance measures. Further, many development ideas are buried under organizational bureaucracy and disputes. There was frustration and disappointment with the working processes and statistics systems.

> We have to dictate calls and. . . we put diagnoses on the computer and the cream of the nation [National Institute for Health and Welfare] has invented a demonic volume of statistics for us to submit that does not benefit us at all. . .they take a lot of time, and part of the patient time goes to this kind of non-patient work. . . .it is a day-to-day survival game here. . . I do not see any use of them [the statistics systems], they hamper, slow the work [Doctor 1]

Administrative logic in the CHC supports control and demands for health professionals to account for their work. However, this may conflict with the needs of patient work. Laborious statistics and information technology (IT) systems were introduced at the national level, which led to doctors spending more time on non-patient duties. This had an effect on the perceptions of being rushed that contributed to negative emotions such as frustration. One doctor stated in a frustrated tone:

> When I think of the patient appointments, they have diminished. I am a doctor, I should be doing patient work, it's my top priority but there is a conflict. I do everything but the patient work and still I get paid better than before. Perhaps it's not so cost-effective then. [Doctor 2]

Further, there is a lot of variety in basic health care tasks where all areas of life may be discussed:

> If there is an acute respiratory infection it will not take me 20 minutes, it's 5 minutes and the patient is out of here. . . But when some grandma with 12 possible internal medicine diseases comes, then, once she's here, she starts discussing them all, and often just wants to hear if it is serious or not. . . [Doctor 1]

Administrative logic involves meetings and an increase in the administrative workload. Problems of information exchange also seem evident, suggesting blocked organizational practices, even frustration.

> We have meetings for nurses and doctors and a common meeting. . . and a statistics work group. . . Discontinuities in information exchange exist and then we are finding a guilty person. [Chief nurse]

The budget cuts driven by the city mayor targeting cost-effectiveness have also reduced the attractiveness of the organization as an employer and led to some doctor positions being unfilled, which again resulted in the administrative burden being distributed to fewer doctors, highlighting the pressures for professional hybridization. The working conditions were perceived as poor: there was a lot of work and stress, conflicts, which results in employee anxiety and tiredness, especially for the deputy chief physicians:

> I do normal [medical] work all day and then start the administration after 4 p.m., so I have very long days. . . I work 10 hours a day, then I go home and prepare food, walk the dogs, and go to bed. I do not have any life, except for the summer cottage at weekends. . . I get good pay but that does not provide much comfort. What do I do with the money if I'm always at work? [Deputy chief physician]

Even if the deputy chief physicians are forced to do both medical work and administration, there is no real hybridization; there is, however, frustration and the administration is seen as extra work as the above quote suggests (see also Fischer and Ferlie, 2013). The developments led to growing conflict and segregated practices as the professional groups seemed to target different things (e.g. quality of care vs financial savings).

Negative emotions from hybridization pressures

During the period of this study, the chief health care manager of the CHC was replaced three times. This led one of the ex-managers to criticize the difficult operating context:

> I criticized the decision-making in [the main city] and still think that it is confusing. . . there are many interest groups, which does not make managing easy [Ex health care manager]

Different emotional responses to institutional pressures were evident within the CHC. The frustration of the medical professionals with the working conditions was evident. One deputy chief physician said in a weary tone:

> We used to have a whole different way of working and I always say that we are pestered at our workplace because we cannot talk about our previous ways of working. It's poison and it's wrong and we do not do that [Deputy chief physician]

Other comments summarize the personal sense of frustration and dissatisfaction as follows:

> I would like to look at the patients in peace and get the feeling back that I am doing my job well. . . .now one just tries to swiftly do as much as possible and I am not very satisfied with that [Deputy chief physician]

> I do not have any power; I only have responsibilities. . .bottom-up initiatives are submerged in there somewhere [layers of bureaucracy]. . . [Deputy chief physician]

Many of the organizational and accounting developments have been problematic for CHC. For example, the BSC was introduced but then largely forgotten, SAP adoption was not completed and also some national-level IT systems were considered constraining and

laborious (e.g. patient statistics systems by the National Health Institute). There was evidence of avoidance of new accounting practices and blocking of hybridization pressures. This was highlighted by the general poor fit between core operations and organizational structures, control systems and managerial processes in the case organization, with several interest groups, political parties and managerial emphases.

> This democratic decision-making slows down development projects. . . [Member of the Health care division]

The health clinics are monitored organizationally, by the funding municipalities, and nationally, so local accounting is not necessarily the key control issue, and it may occasionally seem counterproductive for some professionals. Reasons behind this segregation include rigid traditions related to professional unions and to political and individual views.

> We should get rid of silo thinking. . . This public system is so very rigid, well. . .slow. I would like to believe that it is possible for it to change. . . .when we talk as individuals the discussion is quite different from when we start talking through institutions. . . we tried one recruitment where we set just a higher education requirement but then the doctor's union threatened the city as they wanted a doctor to be the manager. [Internal auditor]

A big politically and professionally structured organization is prone to conflict, and the power of unions, related to political decision-making style in the city, was also reported by one chief health care manager (who later resigned). Further, there were frustrations regarding staff unions in terms of how administrative and political logics could clash and how local decisions are subject to field-level ideologies.

> Some ideas are not acceptable ideologically. . .and then there is the damn strong power of unions and professions. [Chief health care manager]

> The staff union gets involved and puts pressure on politicians. . .if you try to make operations more efficient. . .they start smoking you out through the political structure by saying that you are no longer trusted or some nonsense like that. [Ex-deputy city mayor]

The medical staff is affected by professional norms, but from an administrative point of view, it is a profession with considerable strength, autonomy and legitimacy, which made it possible for the group to block hybridization pressures and attempts to introduce savings with tight budgets. Consequently, segregation of logics, and the somewhat inefficient (administrative-logic-based) budgeting traditions and health care processes continued.

> The city mayor was once talking about objectives, this financial situation is so severe. . . But I looked at the faces of the doctors and chief physicians and. . . I read on their faces; say what you want but we'll do what we like. [Deputy city mayor]

However, despite the presence of institutions such as staff unions and strong professional groups, an internal auditor emphasized the role of the individual:

> What is your operating logic? Are you serving yourself. . .or are you a public servant, seeing that everything works out well for the taxpayer? [Internal auditor]

After the fourth round of interviews, an external consultant was hired to analyze the management practices and the work climate in CHC. Further, the local newspaper broke the story that once again a chief health care manager had resigned, suggesting an individual-level response to the frustrating situation. The deputy city mayor said that there had been conflicts between health care managers and politicians and that it was not certain if the position would be filled at all, suggesting organizational changes.

The CHC case conveys the segregation of management processes and conflict among medical, administrative and political professional groups. The situation led to a drastic

organizational change in 2017 where one of the small municipalities removed itself from the cooperation agreement. However, in the one small municipality mentioned, the operating conditions were more favorable, and gradually the remedy to this multilevel complexity and the conflicts visible in the operations and main city relations involved leaving the CHC organization.

> We [in the small municipality] were fed up, while we had doctors. . . to have to compensate for the neighboring health units [to do their work when they lacked resources]. [Doctor]

> . . .there were some crossed swords [conflict] and it [the departure of the municipality] annoyed people and. . .made the ending of the cooperation a bit more difficult. [Doctor]

Further, two small health clinics are currently operated by a private company, suggesting a change in the traditional way of operating, and even a shift in the emphasis of political logic because, at the beginning of the study, politicians tried to minimize outsourcing.

Discussion

Previous research on hybridization has specified different hybrid organizational forms (e.g. Skelcher and Smith, 2015) and explored professional identity and hybridization (Barney and Felin, 2013; Fischer and Ferlie, 2013; Suddaby *et al.*, 2015). Recently, the microfoundations of institutions have received more attention as an avenue to explore the influence of micro-level social processes on the more aggregated levels (e.g. Haack *et al.*, 2020; Toubiana and Zietsma, 2017), and there have been calls to understand the influence of individual-level issues on the hybridization processes (Berry *et al.*, 2009; Besharov and Smith, 2014; Firtin and Karlsson, 2020; Greenwood *et al.*, 2011; Grossi *et al.*, 2020; Kastberg and Lagström, 2019).

Health care accounting research has focused more on special health care contexts (hospitals, emergency units, mental health units) with relatively clear tasks and work descriptions (see Firtin and Karlsson, 2020; Fischer and Ferlie, 2013; Kantola and Järvinen, 2012; Kastberg and Lagström, 2019; Kurunmäki, 2004). In contrast, we analyze the role of accounting techniques in the context of a change pressure for hybridization, and cognitive microfoundations that aggregate into professional-level institutional logics in a Finnish *basic health care* organization characterized by a longitudinal conflict. Further, instead of two institutional logics (found in earlier health care accounting research, e.g. Fischer and Ferlie, 2013; see also Greenwood *et al.*, 2011; Toubiana and Zietsma, 2017), we analyze *three* logics (health care, administrative and *political*). In municipal basic health care, the goals and tasks are more varied, allowing coexisting and multiple logics–three in our case–for which accounting provides context and language through a budgeting process but where the accounting information is interpreted differently among professions and by individuals at various decision-making levels.

Our first contribution concerns the emerging microfoundational research on institutions (Greenwood *et al.*, 2020; Haack *et al.*, 2020; Lok *et al.*, 2020). This study illustrates individual-level cognitive aspects (interpretations and emotional responses, see Boedker and Chua, 2013; Toubiana and Zietsma, 2017) that influence the institutional logics of the professional groups. In this study, we show how longitudinal negative emotions stirred by a pressure to institute hybridization aggregated into incompatible institutional logics in the organization, led to professional segregation, conflict and organizational cooperation being shattered. This study therefore highlights the negative emotions related to the use of accounting techniques as a basis for non-hybridization outcomes. Strong negative emotions related to accounting practices make professional hybridization less likely (see Fischer and Ferlie, 2013; Skelcher and Smith, 2015).

In our basic health care case, conflicts among professional logics affected interpretations of goals such as cost-effectiveness. Further, many decisions were subject to political

considerations and multilevel negotiations, resulting in long, cumbersome processes. Medical professionals felt that the institutional practice of participatory budgeting was unimportant and ineffective, and complained that the administration was constantly underbudgeting. Further, the medical professionals had become accustomed to obtaining supplementary budget funding each year, and so the time spent trying to produce accurate budgets was considered to be wasted by many medical professionals. The city administration sought savings and complained that doctors should start learning accounting and considering the availability of funds. Gradually individuals' frustration, especially with the budgeting process, nurtured group-level dissatisfaction and resistance to the actions of other professional groups and the institutional logics they represent. Consequently, attempts to push participatory budgeting triggered negative emotions such as frustration, and medical professionals gradually stopped participating in the practice. We argue that despite pressures for hybridization (Grossi *et al.*, 2020; Kurunmäki, 2004), the negative emotions present were an underlying reason for non-hybridization.

Here, the focus on cognitive microfoundations illustrates that the processes caused the individuals on both sides to feel dissatisfied, and the differences between the logics and professions to be amplified. Consequently, the segregation of medical, administrative and political decision-making remained and there was little hybridization among the professional groups. Further, the long-standing dissatisfaction contributed to resignations and to the departure of a small municipality from the CHC cooperation arrangement.

Our second contribution concerns health care accounting research and is based on the finding that full hybridization (see Kurunmäki, 2004; Skelcher and Smith, 2015) is not easily achieved in the Finnish basic health care context with its many municipal-level goals and political decision-making characterized by inconsistent logic (particularly the *political logic*). We illustrate this inconsistency in the political logic by showing how politicians argue for cost-effective behavior on various boards and demand participation in budgeting processes intended to cut costs. At the same time, politicians tend to promote the agenda of their immediate constituents and act in a context-specific manner as opposed to acting as a uniform professional group. This is because the individual interpretations of the politicians change in various decision-making situations which prevent the formulation of a consistent operating logic, and consequently makes budgeting and performance measurement difficult. Politicians might, for example, argue for cost-effectiveness or demand participatory budgeting on the basic welfare board that governs a health care provider, and then, at a higher decision-making level, block cost-saving measures in the municipality council to appease their voters. This inconsistency between political demands and decisions hinders attempts to enhance cost-effectiveness (e.g. attempts to close clinics) and makes it hard to develop and utilize accounting techniques such as budgeting or performance measurement in a focused way, which, in turn, amplifies discontent and negative emotions among the medical professionals.

Another important health care accounting finding was that accounting and IT techniques introduced, such as the BSC, SAP, and patient statistics systems (advocated by the National Health Institute), were considered non-essential or too laborious and were thus not used in a way that would have supported effectiveness or information exchange. Further, the Finnish basic health care context is characterized by the need for savings, complicated budget processes and by multiple organizational layers that further complicate hybridization between professional groups (cf. Kurunmäki, 2004). When a conflict is prolonged and risks become institutionalized in itself, non-hybridization may be a way to reduce personal-level conflict over the budgeting process and accounting tools. In such a situation, cognitive microfoundations at the individual level maintain the segregation between professional logics.

Conclusions

In this paper, we examined cognitive microfoundations underlying conflicting institutional logics and the role of accounting techniques in the hybridization pressures using longitudinal basic health care case empirics. Earlier studies have focused on two institutional logics (Greenwood *et al.*, 2011; Toubiana and Zietsma, 2017). Our first contribution concerns the emerging microfoundational research on institutions (Greenwood *et al.*, 2020; Haack *et al.*, 2020; Lok *et al.*, 2020). We show how longitudinal negative emotions stirred by a pressure to adopt hybrid operating practices aggregated into incompatible institutional logics (political, health care and administrative logics), which complicated financial decision-making, led to conflict and prevented the use of accounting tools in the professional hybridization. This was evidenced in the resistance to tightening budget control and other accounting tools (BSC and performance statistics) by the medical profession. Second, we contribute to health care accounting studies on hybridization (Fischer and Ferlie, 2013; Grossi *et al.*, 2017, 2020; Kurunmäki, 2004), concerning the inconsistency between political demands and decisions at different decision-making levels. Such inconsistency hinders attempts to enhance cost-effectiveness, creates dissatisfaction–especially among medical professionals–and further complicates professional hybridization in the Finnish basic health context.

In our Finnish basic health care context marked by a variety of tasks and multiple institutional logics associated with individual emotions, like anxiety and dissatisfaction with budgeting, the transfer of technology and hybridization was prevented (cf. Kurunmäki, 2004). The new technologies and accounting tools, like participatory budgeting, were deemed too complex or a waste of time, so accommodating them appeared as a threat to patient work and stirred negative emotions. Taking dissatisfaction (see Greenwood and Hinings, 1996) as an example of a negative emotion, we argue that dissatisfaction with accounting techniques combined with inconsistent political logic prevent professional hybridization in a public health care context. Further, we contribute to Besharov and Smith (2014) and Fischer and Ferlie (2013) by arguing that dissatisfaction with accounting techniques and practices in a context of conflicting logics creates frustration and drives the segregation of professional groups, leading to sustained conflict. In this situation, external pressures are responded to with individual-level negative emotional responses, disputes and resignations. Understanding these local mechanisms and cognitive microfoundations contributes to our knowledge of how cognitive microfoundations aggregate to professional level (Haack *et al.*, 2020).

The CHC case is an example of an organization where longitudinal conflict escalated to the point that one municipality quit the cooperation arrangement. With regard to health care and administration, for example budgeting, the case organization remained in operation after structural changes, funded by the three remaining municipalities. Strong negative emotions toward performance measures and the number of segregated professional groups and the prominence of personal disputes can be seen as indications of conflict within the organization. Our findings illustrate how conflict is inflamed if the accounting practices satisfy none of the professional groups, leading to non-hybridization between professional logics.

As a managerial implication, we highlight the organizational and emotional complexity of a public basic health care setting, when adopting accounting or managerial techniques (see Battilana and Lee, 2014). Understanding individual responses might facilitate managing accounting reforms even in conflict conditions. Managers might seek common ground on relatively minor issues to facilitate compromise and open the door to the hybridization of professional logics. A further managerial implication arising from our case is the understanding of how accounting affects individuals and directs change, especially in an emotionally threatening way (Besharov and Smith, 2014; Lok *et al.*, 2020). Here accounting touches upon the issue of what is considered proper practice, illustrated in our case through individual-level interpretations (see Ahrens *et al.*, 2018; Grossi *et al.*, 2017, 2020; Johanson and Vakkuri, 2018).

Instead of merely applying accounting (or IT) tools in the public sector, it is important from a managerial perspective to understand the cognitive processes associated with their introduction; the use of these tools link to professional-group level processes that are influenced by the emotional responses of the individuals (Greenwood *et al.*, 2020; Lok *et al.*, 2020). We illustrated how the negative cognitive responses to pressure to use accounting techniques in our case influenced the professional-level logics and prevented hybridization (Lok *et al.*, 2020; Skelcher and Smith, 2015). In CHC, few issues were politically or professionally indifferent (cf. Carlsson-Wall *et al.*, 2016). In such a context, non-hybridization responses (Skelcher and Smith, 2015) may be individuals' attempts to handle multiple tasks and to alleviate negative emotions. However, a prolonged conflict might become institutionalized in itself, making change difficult.

We recommend future public sector accounting case studies extend the multilevel analysis of the cognitive microfoundations of hybridization, including individual-level emotions like frustration and anxiety (see Boedker and Chua, 2013; Lok *et al.*, 2020; Powell and Rerup, 2020; Toubiana and Zietsma, 2017). Such analysis would aid in understanding responses to accounting tools among multiple strong professional groups. We also suggest studying the potential positive changes (in accounting and organizational practices) triggered by crises (like the current COVID-19 pandemic) or the implementation of new accounting innovations as a future research avenue.

Notes

1. Here, we consider that emotions often involve a target and even collective aspects whereas feelings are more personally manageable and may exist without a clear counterpart or cause, see also Boedker and Chua (2013).
2. Oliver (1991) presented several responses to institutional pressures, including acquiescence, compromise, avoidance, manipulation and defiance. Acquiescence means complying with new pressures; compromise means balancing at least two interests; avoidance indicates considering decisions separately; manipulation denotes changing accounting methods, etc., in order to convey a beneficial view for the manipulator; and defiance means actively resisting change pressures. Rautiainen and Järvenpää (2012) note that in the public sector, several responses may co-exist simultaneously. The multiple responses may lead to case-specific, local compromises and variations in practices (Lounsbury, 2008).

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Appendix: List of interviews

First round of interviews

Internal auditing chief *and* City auditor 6.2.2013.
Accounting chief 11.2.2013.
Financial manager of the social and health care 11.2.2013.
Director of nursing 19.2.2013.
Director of basic health care 19.2.2013.
Accounting service chief *and* Accounting secretary 17.4.2013.
Financial manager of social and health care 24.4.2013.

Second round of interviews

Health clinic 1
Nurses 1 and 2, 11.10.2013.
Doctors 1 and 2, 11.10.2013.
Deputy chief physician, 11.10.2013.
Head nurse, 22.10.2013.

Health clinic 2
Nurses 1 and 2, 21.10.2013.
Doctors 1 and 2, 31.10.2013.
Deputy chief physician, 22.10.2013.
Head nurse, 22.10.2013.

Health clinic 3
Nurse1, 9.10.2013.
Nurse2, 15.10.2013.
Doctors 1 and 2, 18.10.2013.
Deputy chief physician, 18.10.2013.
Head nurse, 18.10.2013.

Third round of interviews

Internal auditing chief and city financial chief 7.2.2014.
Deputy city mayor 18.2.2014.
Chief health care manager 18.2.2014.
Development Officer 4.3.2014.
Director of services 7.3.2014.
Ex-director of basic health care 7.3.2014.

Fourth round of interviews

Member of the Health care division* (not from the main city) 18.3.2016.
Ex-director of basic health care 22.3.2016.
Member of the Health care division (not from the main city) 23.3.2016.
Ex-deputy city mayor 23.3.2016.
Member of the Health care division (from the main city) 1.4.2016.
* Note: The health care division is essentially a part of the main city's basic welfare board but also involves representatives from the other funding municipalities, while monitoring the CHC's operations.

Corresponding author

Antti Rautiainen can be contacted at: antti.i.rautiainen@jyu.fi