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## Accounting Dilemma and Health Care's Accounting Control

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### ABSTRACT

This study aims to describe the phenomenon of accounting dilemma in the accountingization process of health services as part of the implementation of New Public Management in Indonesia. This study uses the case study method in two public hospitals owned by the Provincial Government in Indonesia. The results show that the dilemma is related to the doubts of accountants regarding the implementation of quality control and cost control as the implications of the national health insurance system implemented by the government. Conflicts of interests, idealism, society's interests, and the demands of the government make various accounting tools is only used as forms of ritual and legitimacy. This study uses a case study in two government hospitals as a portrait of the implementation of accounting for health services in Indonesia. This study portrays the phenomenon of accounting dilemma that occurred and suggested in the next study to produce an accounting system that is in accordance with government-owned health services. The researchers proposed a more appropriate management accounting system to government health services by considering public health sector management accounting (PHSMA). The PHSMA contains (1) the use of an organizational system with privatization at the medium level while promoting social aspects, (2) the use of government funding in the form of health operational funds to support universal health coverage (UHC), (3) using public health indicators as a basis for performance assessment and not merely use financial performance. This study emphasizes that government participation is still needed in supporting health quality improvement programs in the community through full support for health services. The sustainability of national health insurance system must be maintained. The accounting dilemma is a new concept that can be considered in the decision-making process of government institutions and can be followed up in subsequent research. Accounting dilemma is an event where an accounting system or practices should be selected under the pressure from the government, service users, and the management (internal pressure), but all of the options are equally unpleasant, not in accordance with the theory, or not in accordance with the existing data.

### INTRODUCTION

Health care is one of the main services undergoing a fundamental change with the implementation of New Public Management (NPM). NPM emphasizes on output control over government policy, decentralization of management authority, introduction to market and quasi-market mechanisms, as well as customer-oriented services (Hood, 1991). NPM emphasizes on agencification process embodied in (1) the organizational structure separation between the principal and the agent, (2) the grant of managerial autonomy, and (3) the emphasis on managerial accountability (Pollit *et al.*, 2004). The real form of NPM process is managed in Public Service Agency (PSA) on health services (hospitals and health centers). Nevertheless, the implementation of NPM in health services raises many dilemmas and paradoxes primarily related to the conflict between the various basic grades of health care quality and financial goals (Malmoose, 2015; Lapsley, 2007). Management accounting as a tool for directing the organization's existing resources in achieving objectives plays an active role in dealing with this situation.

The development of health services in Indonesia cannot be separated from the government policy on national

insurance system in the form of the National Health Insurance (in Indonesia naming as JKN). To be able to successfully deal with this system, public hospitals should implement intensive quality and cost control. The phenomenon of universal health coverage (UHC) must be addressed by the government, insurance companies, and health care providers through appropriate strategies (Bredenkamp *et al.*, 2015). In the situations of UHC, the expectations of community and government regarding the quality of health care is very high considering citizens perceive that they have equal rights as guaranteed by the national insurance system. Most of government hospitals in Indonesia has implemented the PSA system, so they are expected to be more financially independent and able to compete with private sector. National insurance system that requires uniform claim rates for services urges public hospitals to apply an appropriate quality and cost control. Public hospitals are used to be capital intensive, resource intensive, receiving high subsidies, and operating less efficiently. Accountants are dilemmatic (hereinafter referred to as accounting dilemma) in determining the choice of accounting practices that can support cost savings efforts (strategic cost reduction) yet meeting medical service standards and public expectations

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regarding the practice of the national insurance system. This study aims to describe various accounting dilemma faced by accounting managers and its implications on accounting practices in hospitals. In addition, this study also seeks to provide a solution that can be applied when accountants deal with the situation.

This article is divided into eight sections: the first describes the research background, the second discusses the concept of accounting dilemma, viz. the focus of research, the third focuses on the research context as the actual situation faced by hospitals related to the implementation of JKN and PSA system, and the fourth deals with the research methods used. The fifth and the sixth section attempt to describe accountingization process and accounting dilemmas in health care. The researchers propose the formulation of management accounting concepts relevant to health care in the seventh section as the subsequent research agenda. The conclusion of the study is provided in the eight section.

## LITERATURE REVIEW

### Conceptual Perspective: Accounting Dilemmas

NPM implementation in health services receives much criticism. Bertrand and Russell (1933) in Lapsley (2007) revealed that “blind trust” made patients pay their doctors as much money as they have, so they can provide their patients with treatment depending on their financial condition. The phenomenon of “accountingization” is feared to be able to change the social system of the organization that uses it (Power & Laughin, 1992); health care might be affected. Accounting language started to enter, changing values and dictating its activities. Accounting control in the form of clinical budgets becomes a tool in a series of clinical activity control (Power & Laughin 1992). “Care pathways” is an accounting tool to standardize health care (Gebreiter, 2017).

The results of a survey in the UK about the handling of child patients show that 12% of physicians and 17% percent of nurses consider limiting the use of resources (synonymous with equipment, drugs, and supplies) in the treatment they give to patients (McHaffie & Fowlie 1996; 4 in Lapsley, 2007). Nonetheless, accountingization is not the cause of malpractice. A survey conducted by Lapsley (2007) mentions that various cases of mal-practices that occur in the UK are not caused by “accountingization”. Out of 14 cases surveyed in 2005, only two cases, with low association, have to do with resource restrictions (budget constraint). The research of Lapsley (2007) contradicts what is feared by Power and Laughin (1992), i.e. the negative impact of accounting in clinical budgets. Accounting is used as a tool that helps the management control their finance and is not used to decide treatments to patients. Mancinatti and Pessina (2014) showed the positive impact of management accounting on hospital’s financial performance (although its significance is at 10% level). The research of King *et al.* (2010) indicated that a formal (written) budget option in small clinics is able to improve performance.

Bourn and Ezzamel (1986) emphasized that the difficulties in clinical budgeting initiatives are that the budget is perceived as a restriction for clinical freedom and an increase of clinical accountability; it is problematic in definition and result and performance measurement; and it has accounting technical problems associated with overhead cost. This problem was found in further studies conducted by Bourn and Ezzamel (1987), which indicates the existence of “defiance” on allocated clinical budget. Several studies have revealed that medical personnel prefer a stable situation stabilized and lesser administration (Brorström and Nilsson, 2008; Jones, 1999). A study conducted in Norway shows that medical staff have lower motivation due to the time they spent on administration; they focused more on target and less on patient quality. More uniquely, a study in the UK conducted by Chang (2006) show that the performance indicators set by the government is only regarded as a legitimation and fulfillment of obligations and separated from indicators that are actually used in the hospital.

Chang (2006) also showed separation between national targets and local needs and that performance measurement is rarely incorporated into local hospitals. This system is used only for survival and legitimacy. Therefore, to continue doing their duties and meeting their professional basic assumptions, doctors tend to only adopt public management for liability and legitimacy (Chang, 2006; Kurunmäki *et al.*, 2003) or, in other words, keeping the pressure from the “distance” to focus more on their primary tasks. One major consequence of the focus on public management is extensive waiting list data manipulation revealed in 2003 (Chang, 2006). This makes the usefulness of listed measurement and numbers questionable.

Personnel in government hospital will be faced with the dilemma, where they have to carry out their duties and functions as health service personnel and to keep their organization’s going concern. Medical personnel and management accountants must work together to implement quality and cost control to reach optimal position. Accounting dilemmas occur due to employee disagreement over two or more regulations or over theories that are against data (Berg, 1994). According to the dictionary, dilemma is a difficult situation that requires people to choose between two equally unpleasant or unfavorable possibilities; or situations that are difficult and confusing. Accounting dilemma is an event where an accounting system or practices should be selected under the pressure from the government, service users, and the management (internal pressure), but all of the options are equally unpleasant, not in accordance with the theory, or not in accordance with the existing data.

### Research Context

#### Universal Health Coverage (UHC) in Indonesia

Health care provided by the government is demanded to be more professional with the enactment of Act No. 24 of 2014 on Social Security Agency. The previous

government partner in insurance (i.e. ASKES) only served public hospitals. This act enables all health service providers (private and public hospitals) to partner with Social Security Health Agency (in Indonesia naming as BPJS). BPJS is government institution formed to organize social security programs in Indonesia. Today, almost all hospitals in Indonesia being partner with BPJS; they receive patients who use BPJS as their health insurance. This is a part of the government program, Universal Health Coverage (UHC) by 2019, through the implementation of national health insurance by BPJS. The current national coverage is 71.9% (about 187.982.949 participants), 27.1% are not yet covered (<http://www.pdpersi.co.id>). The implementation of UHC can be interpreted as that all Indonesian citizens must join a health insurance program, either self-financed, financed by employer, or financed by the government. UHC for health care facilities means that all health expenses will be covered by health insurance providers. Therefore, there will be less people not covered by health insurance, or none at best. In this situation, BPJS takes a “monopolistic” role in health insurance market.

In this regard, the management of health service providers should prepare resources and financial system that can respond to the national insurance system. According to the regulation of Minister of Health (PMK) No. 71 of 2013 on Health Care at JKN article 33 paragraph 1, JKN should implement quality and cost control to the criteria set by the Ministry of Health in the aspects of (1)health technology, (2)clinical considerations, (3)rate standard calculation, and (4)health care service monitoring and evaluation. Health care costs that can be covered by BPJS is determined by the Minister of Health, in which the latest rule is stipulated in PMK No. 4 of 2017 on the Second Amendment of PMK No. 52 of 2016 regarding Standard Rates of Health Services in the Implementation of Health Insurance Program. This system makes health service providers partnering with BPJS must shift their focus from pricing decision to costing decision. BPJS as the health insurance provider has issued BPJS Regulation No. 8 of 2016 on the Implementation of Quality Control and Cost Control in the Establishment of National Health Insurance. This regulation requires (1) an input standard in health facilities, (2) health care process standard, and (3) health quality outcome standard for participants

### Public Service Agency (PSA) Financial System

The implementation of NPM in public sector institutions has been criticized in the aspect of “accountingization” (Power&Laughin,1992). It is a process to explicitly state the categorization of costs in various purposes, whereas cost tended to be aggregated, clustered, or not defined (Hood, 1995). This phenomenon occurs in the implementation of Public Service Agency System (PSA-System) in health care. In accordance with Act No. 1 of 2004 concerning State Treasury, government units that implement PSA-System are given the flexibility so that they can implement

their service management with sound business practice in accordance with the characteristics of their industrial system. The implementation of PSA-System is a form of agencification process in the implementation of NPM. NPM emphasizes output control over government policy, decentralization of management authority, the introduction to market and quasi-market mechanisms, as well as customer-oriented services (Hood, 1991). NPM emphasizes on agencification process embodied in (1) separation between organizational structures, i.e., principal and agent, (2) grant of managerial autonomy, and (3) emphasis on managerial accountability (Pollit *et al.*, 2004). With the issuance of State Government Regulation (PP) No. 23 of 2005 on Financial Management Board and the Regulation of Minister of Internal Affairs No. 61 of 2007 on Technical Guidelines for Financial Management of Public Service Agency, today almost all government hospitals in Indonesia use PSA in their financial management.

### Health Care Accounting Control

The Chartered Institute of Management Accountants (CIMA) defines management accounting as a part of management activities concentrating on the identification, presentation, and interpretation of information used in strategic formulation, activity planning and control, and decision-making. In the field of health care, Cook (1995) identified the frequently asked questions physicians made about accounting:

- (1) What is the rate for a service product?;
- (2) What is the rate for an activity?;
- (3) What is the rate for each patient category?;
- (4) Which one is cheaper between providing meals, laboratory, pathology using third party or providing them by yourself?;
- (5) Which one is cheaper between expanding the building or building a new one?;
- (6) When we renew tools?; and
- (7) How can we ensure continuity? This process, in accounting, is often referred to as budgetary control.

Budget policy in hospitals is directed to link between accounting practices, individual behavior, and organizational performance. However, physicians’ organizational culture is very strong in shaping the organizational behavior of hospitals. However, what is quite challenging is how accounting can affect the behavior of clinical managers to achieve their organizational goals (Abernethy & Stoelwinder, 1995). The research of Mancinatti and Rizo (2014) shows that the commitment to clinical budgets affects performance mediated by budgeting information. However, several initiatives have been launched in various countries to implement clinical budget in failing hospitals. This situation is referred to as “accounting failure”, a condition where doctors in hospitals do not want to accept or act on budget information in performing their duties (Pollitt *et al.*, 1988; Preston *et al.*, 1992)

**Table 1:** Dimensions of Budget Failure in Hospital

No.	Cause	Research Location	Researcher
1	The power struggle between hospital doctors and hospital administrators	Finland	Kurunmaki (1999)
2	Organizational separation between doctors and administrative staff with each different culture	Sweden	Coombs (1987)
3	The resistance of hospital doctor to reform initiative that blocks the activity doctors with budget	New Zealand	Doolin (1999)
4	Resentment over the idea of the use of accounting and financial information	UK	Jones and Dewing (1997)
5	Failure in integrating hospital doctors in the management by way of retaining the trust and support of clinical colleagues	Australia	Abernethy & Stoelwinder (1990) Abernethy (1996)
6	Budget is made in uncertainty about what should happen	UK	Preston <i>et al.</i> (1992)
7	Main operational difficulties in making different parts of a complex hospital organization, together to support clinical budgeting system	UK	Packwood <i>et al.</i> (1991)

Source: Lapsley (2001)

Clinical Budgeting basically concerns with the agreement on the service plan and future expenditure, which is then used to monitor how the plan is realized. Clinical budgeting may not be drafted without the participation of doctors. Most features of clinical budgets are in the form of budget for each service department (which is controlled by the doctors) along with the right to use the budget authority for the provision of services. It is expected that they can keep the budget adhered to (Wicking *et al.*, 1983). Furthermore, the budget will be accepted if (1)the budget is attached to the hospital doctors as the budget holders and (2)pressure from the environment, such as competition to get resources, exists. Requests from physicians related to budget are:

- (1) Give proper funding and commitment,
- (2) Give relevant cost information,
- (3) Evaluate the trial,
- (4) Give controllable costs, and
- (5) Give activity and case mix information,
- (6) Give alternative treatment costs,
- (7) Give a real budget, and
- (8) Increase patient care emphasis (Lapsley, 2001).

The dualism is between the perspective that health care should be oriented to quality and patient safety and the perspective that health care management should prioritize the organization's going concern. Public hospitals generally emphasize more on the aspects of health care; they do not worry much about losses that will be borne. However, along with the adoption and implementation of PSA and JKN system, public hospitals must immediately improve their managerial qualities, so they become more competitive in their rivalry with private hospitals,

which also partner with BPJS. Management accounting discipline plays an important role in this process, particularly to support quality control and cost control. In this situation, hospitals will face a dilemma, since their medical personnel as health care providers must uphold their "professional oath" but they have to maintain the sustainability of their business (Lapsley, 2007). Hospital's accountant seeks through various devices, such as clinical budget and clinical pathways budget, to implement cost standardization for health care costs control (Bosa, 2010, Gebreiter, 2017). Government healthcare agencies keep reducing reimbursement to hospitals while increasing standards of eligibility for supplemental cost-outlier payments (Zeidan & Khumawal, 2014).

Difficult situation will be faced hospitals if they cannot control healthcare cost, since in JKN system the amount of hospital income that can be claimed to BPJS is limited by Indonesia Case Base Groups (INA-CBGs) Rate (set by the Minister of Health), which is package in nature. If health care facilities cannot manage their clinical actions to their patients, we can be sure that they will suffer losses since there is a maximum limit that can be paid by BPJS for a diagnosis. This sometimes triggers fraud, which can harm patients and/or BPJS

**Cost Containment: Quality & Cost Control**

In JKN system quality control and cost control are the most crucial issues. In health services provided by the government the issue of cost containment is related to "limiting" or "reducing" health spending. This is relevant to population growth and increased health care needs of the community (Rapoport *et al.*, 2009).

**Table 2:** Form of Cost Containment and the Underlying Reasons

Underlying Logic	Directions Design	
	Service Demand	Services Supply
Bureaucracy	Limitation of eligible service users	Restrictions on the number of professionals

Market	Cost of service users	Price competition
Professionalism	- Referral requested from other professions - Referral from the profession itself	Service adjustment

Source: Andersen (2014)

The increase of health care costs can be triggered by inflation and health service volume or quantity. The result of Schleiniger (2014) in his research in Switzerland during 2004-2010 indicates that the increase of health service costs is caused by increased utilization of health care, although this does not influence the improvement of the patient's health status. Schleiniger (2014) used three cost components, namely (1) ambulatory services (outpatient costs, practitioners, and physiotherapists), (2) hospitalization and home care, and (3) laboratory and pharmacy.

Health care cost control is applied on three cost components; they are medical service, pharmaceutical and medical materials, and overhead costs. With the formulation of DRG prospective payment, the payment system of health treatment is package in nature. Hospitals should control their health care costs to ensure that the insurance claim is higher than the actual costs they incurred. Nevertheless, the results of research (Cheng *et al.*, 2009) show that, although the payment from the insurance is package, most of physician fee payments are fee for services. In addition to focusing on the medical services provided, hospitals should be able to control medical material and pharmaceutical use cost. The control is a part of doctor's authority, and it can also be dilemmatic. Hospital's overhead control is generally associated with utility, maintenance, and other support

activity cost. It is charged indirectly to the hospitals, and will indirectly affect the costs borne by them.

**MATERIALS AND METHODS**

This qualitative study was conducted in two public hospitals in East Java. The use of case study in this research is intended to deeply capture the conditions regarding the phenomena. The hospitals are:

1. HOSPITAL "A" is general hospital. Located in Malang, it is the second largest hospital in East Java, Grade A hospital belonging to the Provincial Government,
2. HOSPITAL "B" is mental illness hospital. Located in Surabaya, it is a Grade A mental hospital belonging to the Provincial Government.

The hospitals were selected as the research object based on the following considerations:

1. HOSPITAL "A" is a tertiary referral hospital with the high revenues and budget. It has implemented PSA system since 2009. It receives patients suffering from all kinds of diseases, and it becomes the main reference hospital in East Java.
2. HOSPITAL "B" is a referral hospital for patients with mental illness. Its income is very high, but it receives a high subsidy from the government. It emphasizes more on social aspect, but it still needs to implement PSA system since most of its patients are insured by the government.

**Table 3:** Characteristics of Research Object

Element	HOSPITAL "A"	HOSPITAL "B"
Ownership	East Java Provincial Government	East Java Provincial Government
Type	General Hospital	Mental Hospital
Grade	Grade A – General	Grade A – Special
Variations of Patients	High (General Patient and BPJS Insurance)	Low (Patients with Guarantor)
Revenue Target	High + IDR 600 billion	Low + IDR 40 billion
Business Orientation	High (VVIP class is available)	Low (no VVIP)
Independence level PSAs	High + 70%	Low + 30%
Standard of Quality	KARS Accreditation – Plenary	KARS Accreditation – Plenary
Implementation of PSA System	2009	2009

The data of this study was collected through observation, documentation, and interviews. Observation was carried out to examine the condition of the object, and documentation was used to collect data associated with

the profile of the hospitals, their management policies, standard operating procedure, performance reports, and financial reports. The interviews were conducted with informants as follows.

**Table 4:** Details of Informants

Element	Specification	Profession	HOSPITAL "A"	HOSPITAL "B"
Top Management	Director	Medical	1	1
Clinical manager	Chief of Inpatient Department	Medical	1	1
	Head of Pharmacy Department	Medical	1	1

Care giver	Medical specialist	Medical	1	1
	General practitioners	Medical	1	1
	Nurse	Medical	1	1
Accounting	Head of Finance	Non-Medical	1	1
	Head of Planning	Non-Medical	1	1
	Financial Reporting Staff	Non-Medical	1	1
<b>Total</b>			<b>9</b>	<b>9</b>

**RESULTS AND DISCUSSION**

**Accountingization in Organizational Perspective Accounting Ritual and Legitimation**

The increased use of accounting in both hospitals (HOSPITAL “A” and HOSPITAL “B”) has started since they implement PSAs in 2009. In meeting the requirements for implementing PSAs, they had submitted documents of (1) Hospital Governance (2) Business Strategic Plan (RSB), (3) Minimum Service Standards (SPM), and (4) Basic Financial Statements. In addition, the Directors had signed a Statement of Capability to Improve Performance and a Statement of Audit Willingness. This is where the process accountingization starts, from the preparation of basic financial statements as PSAs initial financial statement

(relating to the opening balance sheet and determination of the balance of equity), preparation of budget in Business Plan and Budget (RBA), preparation of PSAs financial administration procedures, to PSAs performance measurement. Almost all elements of the documents contain accounting aspects. Based on the interviews with the director and financial staff, the documents were intensively arranged by financial and planning department. Nearly eight years of FS-PSAs implementation, based on interviews, the documents were only viewed as a form of ritual and legitimacy. Only after JKN era did the hospitals understand the use these of the documents for managerial purposes. Some of the “accounting rituals” performed by the hospital to gain legitimacy are:

**Table 5:** Accounting Ritual and Legitimation Documents

No.	Document	Ritual	Legitimation	More Frequently Used Document
1	Hospital Governance	Update as needed	PSAs Requirements, Accreditation requirements	Hospital by Law, Medical Staff by Law, Health Care Implementation Guidelines
2	Business Strategic Plan (RSB)	Every 5 years	PSAs requirements, accreditation requirements	Target of Medium-Term Planning - and Performance Contract
3	The Minimum of Service Standards (SPM)	Update according to type of service, the annual maximum 5	PSAs Requirements	Health Care Implementation Guidelines
4	Business Plan and Budget (RBA)	Annual	PSAs requirements, Government Budgetary System Regulation	Work Plan and Budget (RKA) and Budget Implementation Document (DPA)
5	Basic Financial Statements	Annual - Audited	PSAs Requirements (especially based on Financial Accounting Standard by Indonesian Accounting Association)	Reports based on the Government Accounting Standards (SAP)

The characteristics of documents or procedures that only serve as a legitimation is the existence of other documents or procedures that actually can be used according to the needs of the hospital. In various meetings with external and external parties, accounting ritual fulfillment is a symbol that the organization has been organized accountably, professionally, and efficiently. For example, unqualified audit opinion for financial report of 2016 shows that the financial matters have been managed professionally and accountably. The preparation of Business Plan and Budget (RBA) show that the hospitals have managed to implement a sound

business practice. Such processes are a form of ritual and legitimacy as expressed in previous studies related to institutional theory (Kurunmaki *et al.*, 2003; Chariri, 2011; Gambling, 1987).

**Accounting as a Language**

PSAs application makes hospital organized in making sound and efficient business practices. Accounting is also a form of organizational efforts to achieve transparency and accountability. The informants were asked to mention three accounting (financial) terms they frequently use or hear in meetings. Most of them mentioned

- (1) Accrual,
- (2) Costs,
- (3) Receivables,
- (4) Depreciation.

From the meetings joined or interviews conducted by the researchers, unique phenomena were captured from the research objects:

#### **Accrual**

This term is most frequently mentioned by the informants, both medical and non-medical, but their interpretations vary greatly; only financial personnel are able to describe it correctly, where non-financial (medical/non-medical) personnel, including the hospital director, had various interpretations. The understanding of most informants tend to the outcome of accrual-based accounting, such as the effort to improve efficiency, better accountability, and more informative and accurate reporting, but they do not understand the difference between accrual and non-accrual.

#### **Accounts Receivable**

The term “receivables” actually became quite familiar among hospital staff along with the implementation JKN system. The management becomes very concerned with accounts receivable because most of the hospitals’ revenue comes from late-paid BPJS after the claim is verified. The term receivables is actually used by the management as a tool to explain the delay of service payment (financial incentive), as “accounts receivable” in BPJS has not been paid.

#### **Depreciation**

This term is actually related to the habit of the management in explaining that the difference between accrual and non-accrual is related to the existence of “depreciation”. It is interpreted as a reduction of “physical quality”, “asset utilization”, or a decrease in assets’ economic value due to usage or age, so the value of the asset should be reduced by depreciation. This term is also used by the management to encourage optimal use of assets, asset maintenance, and purchase priority for fixed asset in the budget.

#### **Price vs Cost**

This term appears primarily during the interview with medical personnel about clinical pathways (CP). Medical personnel see health care more as “cost”, so there is a confusion between “cost” and “rate”. This resulted in confusion between health care rate and health care costs. The components of rate are hospital cost and incentive fee for service provider (doctor, nurse, etc.). Hospital cost is used for services other than employee resources (such as medicine, patient meal, supplies, maintenance, or other overhead), while incentive fee is used for remuneration for service providers and management. The confusion occurred because incentive fee and hospital cost were spent as the cost and left no surplus for the hospital, so

the cost of health care (for patients) = cost of health services for the hospital. However, when analyzed more deeply, this is a legacy from the previous system, as public hospitals, that the price of health care services paid by the patient will return to the patient as much as the costs incurred by the hospital. In conclusion, almost never does hospital take profit from its patients.

The explanation above is consistent with the research of Liguori & Steccolini (2017). Accounting language can become a tool of political communication and legitimacy in an effort to demonstrate

- (1) Power or authority (authorization),
- (2) Issues of transparency or accountability (moralization),
- (3) Illustration of events (narrativization),
- (4) Norms and ethics (Normalization),
- (5) Personal commitment and dedication (Pathos), and
- (6) Activity rationalization (rationalization).

Nonetheless, the issue of “de-coupling” to protect power (as in the institutional theory) is not readily apparent in the study because the management has sought to disseminate information relating to accounting and intensively attempted to increase its staff’s understanding. Accounting is not made into something difficult and unreachable by other parties with no interest.

#### **Accountingization in Accounting Control’s Tools - “Accounting Dilemma”**

##### **Clinical Pathway**

Management accounting in health services focuses on cost management associated with health care in order to achieve efficiency while maintaining quality and prioritizing patient’s safety (Tan et al, 2009). Because of market failure in determining the price of health care, the state regulates it in the form of regulation for service product, service price calculation rules, provisions for updating the price of service (Grzybek, 2014). Health care seeks to control costs in order to achieve a standardized service quality. Hospitals design standard cost information system in order to provide health care on the basis of care pathway (CP), an essential accounting tool that helps accountants to connect health care practices, service quality, and standard cost (Gebreiter, 2017).

As public hospitals, the operation of HOSPITAL “B” and HOSPITAL “A” is based on hospital regulation established by the Governor. The regulation requires that the provision of services for patients should be based on Medical Services Standards and Nursing Care Standards. Both hospitals have established clinical pathways although not for all services.

Based on the interview, the consideration for CP selection is based on the most frequent diagnoses handled based on the pattern of disease morbidity. However, along with the improvement in JKN services, HOSPITAL “A” has already formed a special team to handle CP by comparing the consequences of DRG-service package in INA-CBGs. The team intensively works together with medical, nursing, and pharmacy committee and other medical support to determine the optimal stage to guarantee

quality and cost. Until this research was conducted, there had been no specific documents relating to the evaluation of CP regarding cost efficiency of health services.

The discussions with the informant from HOSPITAL “A” reveal that quality control and cost control have been able to provide significant savings related to the cost of health services, especially for JKN patients.

“JKN makes medical committee and pharmaceutical committee look for the most efficient cost over INA (INA-CBGs). The biggest saving comes from the choice of drugs and BHP (medical supplies) given, because doctors cannot give drugs as they want, but they are already by default. It keeps the hospital away from losses because of JKN”

In contrast to what happened in HOSPITAL “B”, the full implementation of CP is dilemmatic, because the recovery rate of psychiatric patients cannot be predicted accurately. The criteria for the patients to be discharged from mental hospital is only based on the condition when (1) the patient does not endanger themselves and others, (2) the patient is free from comorbidities (non-mental illness) or the comorbidities was cured or can be treated outside the hospital.

“The recovery from mental illness is difficult to predict... we discharge patients based on the standard. Although the medication from JKN for certain drugs is only enough for up to 24 days, we will continue to treat the patient until the patient can be discharged. This Hospital “B” has many social elements. “

In its development, cost information is very important especially when health care is based on diagnosis related groups (DRGs) as the approach to cost accounting system in determining the service cost on the basis of homogeneous individual service group (the implementation of cost accounting methods used in determining DRG turns varies among countries, primarily related to methodology, data sources, and regulations governing the accounting charge, but almost all focus on calculation accuracy (Grzybek 2014). DRG implementation with a prospective health insurance system makes the payment system to hospitals in packages of health services at a certain diagnostic package irrespective the actual expenses incurred.

The interviews and documentation show that the motivation for CP usage is stronger in HOSPITAL “A” than in HOSPITAL “B”. Quality control and cost control (CP) meetings in HOSPITAL “A” had the most attendants, relating much with the “interest” doctors, particularly specialists.

“Quality control and cost control meeting are always crowded and full of debate. Each has its own arguments, and even deadlock. This makes CP sometimes is not completed “

Health insurance policy and payment systems influence the behavior of health care providers (Nyiman *et al.*, 1990). However, aside from doctor’s idealism, it is undeniable that CP is related to doctor’s income. The results of this study are consistent with studies on DRG

in other countries. Its payment schemes affect the types of medical services, including longer hospitalization and treatment intensity (Long *et al.*, 1987). Nonetheless, in China, using a longer testing period, it turns out that there is no difference on the length of hospitalization and total medical costs between before and after the implementation of DRG payment system. However, there are findings which show that there is an increase in additional operations and a decrease from radiology and general anesthesia cost (Yuan Hu *et al.*, 2015).

### Cost Containment

Cost containment efforts undertaken by both hospitals are quite different, although both of them have not been able to show the comparison results in the form of a formal document. Quality control and cost control are taken to gain efficiency in order to avoid JKN deficit because the payment is in packages. In HOSPITAL “A” quality control is more comprehensive in all available services, although the most affected is the use of drugs and consumables. As a teaching hospital, HOSPITAL “A” is helped by Specialist Education Program (PPDS), whose main partner is Brawijaya University.

“PPDS is very helpful in our service. The high number of patients, without PPDS, the hospital will not be able to finish the job. Because they are students, of course, the cost of services can be saved “

In HOSPITAL “B”, quality control-cost control is actually difficult to do because the duration of the inpatient treatment is quite long.

“Cost control is rather difficult to implement because psychiatric patients are unpredictable, take longer time to heal. There are times when we discharged them, but their illness recurred, so there were rumors that “Hospital “B”” discharge patients who are not fully healthy. Once we tried to save through cuts in patient’s meal budget, but later the patients went crazy because the food is not good”

This becomes a dilemma for health care considering the health services are based on theoretical knowledge and strong professional norms (Andersen, 2014).

“Hospital “B” is unique ... cannot be likened with ordinary hospital. We probably cannot make profit from the mental service... so no matter how much it costs, since mentally ill people are the responsibility of the government, is reasonable for Hospital “B” to experience (financial) deficit... “

Based on the interviews and observations, cost containment efforts are done with case-by-case anticipations. There was an overspending from budget realization, and cause identification was just commencing. In fact, cost containment is a structured effort to “limit” or “reduce” the level of health spending (Rapoport *et al.*, 2009). This was confirmed by the fact that both hospitals never use unit cost information in decision-making because the information is too old and irrelevant. The unit cost is only used as a formal requirement for proposing a rate increase to the governor. Cost containment program that seeks to put the cost as it should has not been done.

### What is “Accounting Dilemma”

This study indicates that the accounting dilemma due to the application of accounting (“accountingization”), if conclusions are drawn from the discussion above, is related to:

#### Accounting Language for All

The interviews reveal that “accrual syndrome” occurs. Accrual accounting is only understood by people in accounting department. Therefore, people from management department use the term “accrual” according to their incorrect understanding for the interest of management, such as efficiency, timeliness of reporting, budget allocation, and performance evaluation including remuneration. Clearly, accrual is an organizational tool to facilitate control over employees, especially those who do not understand it. This is consistent with institutional theory (Hindman & Conoly, 2011; Kurunmaki *et al.*, 2003; Power & Laughlin, 1992).

#### Accounting Judgment for the Health Service

Accounting considerations in health services are primarily related to budget restrictions through clinical pathways mechanism perceived by health care personnel, although the impact has not been measured in the statement of budget efficiency (just a statement only). However, in practice, there is malpractice at the hospital due to those resource restrictions. This is consistent with the research of Lapsey (2007). Documented patient complaint is related to BPJS membership status (active and inactive), resulted in frequent restrictions to patients by administration officials in receiving service, but not clinical limitations. In addition, there are complaints from employees caused by late service incentive payments from BPJS (due to the complexity of the claiming procedure and the length of time they have to wait before the payment is received).

#### Accounting Principle of Clinical vs. Idealism

Discussions on clinical pathways and the implementation of JKN system have never been able to produce a comprehensive CP settlement. Conflicts between medical and finance (budget and accounting) personnel in CP is mostly related to their respective efforts based on their professional ability. However, in this situation, financial personnel tend to give in, even though most of them assume that that the motive of their counterpart is remuneration packed in professional idealism. This study found things consistent with Lapsey (2007), but there is a negative perception from financial personnel about the opportunistic behavior of medical personnel to obtain a higher remuneration.

#### Accounting as Non-Value-Added Activities

It is indicated that there is a perception that accounting activity is an activity that does not add value to the organization. Accounting activity is only a bothersome ritual. Complicated claim requirements to BPJS, document completion, registration, and record-keeping

make the workload of health personnel higher. This study is consistent with the findings of Brorstrom and Nilsson (2008) and Jones (1999) that medical personnel tend to want a stable situation and lesser administration, whereas financial personnel believe that they are the party with a more important role since through them money from BPJS, which keeps the sustainability of the hospital, is received.

#### Accounting Performance in Health Service

The hospitals’ performance formulation set out in the Business Strategic Plan (RSB) and Business Plan and Budget (RBA) is not fully used in their policy setting and decision making. Perhaps only cost recovery and budget absorption percentage that are used as a reference, although the financial performance formulation prepared in the planning documents is quite many. This suggests that accounting performance is only a ritual and not fully used in the hospital. This is consistent with institutional theory about ritual and legitimacy (Kurunmaki *et al.*, 2003; Hindman & Connolly, 2011). This finding is also consistent with Chang’s research (2006) that performance indicators set by the government are only regarded as a tool of legitimacy and obligations fulfillment and separated from the indicators actually used by hospitals. This situation makes financial (accounting) personnel dilemmatic with their presence and professionalism at work. Accounting products are only used for rituals to fulfill obligation as government institutions. The research of Hindman & Connolly (2011) also show that the benefit of (accrual) accounting, particularly in decision-making accuracy and resource use efficiency, is being questioned.

#### Toward Public Health Sector Managerial Accounting (PH-SMA) to Respond Accounting Dilemma

Accounting dilemma in the implementation of accounting controls in response to the implementation of PSA and JKN system should be given optimal solutions so that the interest of the public and the management is not sacrificed. The researchers proposed several concepts in the implementation and development of Public Health Sector Management Accounting (PHS-MA) for further investigation:

#### Medium-Privatization

NPM concept calls for the privatization of service units that directly in contact with the public, and they should be able to compete with the same service provider from the private sector (Hood, 1991). Health service providers owned by the government are faced with variations of resources and organizational cultures. Lower resource efficiency does not allow direct competition with private sector. The concept of full privatization can threaten the sustainability of health care business because some studies show that, in fact, public health sector is more inclined to social objectives rather than providing financial performance (Brorstrom and Nilsson, 2008; Johnsen *et al.*, 2006; Talbot, 1999). The government

appear to believe that the structure-conduct-performance theory would operate, that is, by mandating a nonprofit form, public funds would not be diverted to private gain (Howell & Cordery, 2013). The implementation of PSAs as a form of quasi-non-profit organization is actually appropriate, but it must not be misconstrued as a part of the privatization of government-owned health care. However, the issue of PSAs' self-reliance should be placed more proportionally.

### Government Intervention and Funding

Normatively, public health financing system works properly if it creates welfare (Cremer and Pestieau, 1996; Breyer & Haufler, 2000). National healthcare insurance system is quite appropriate, but it must be combined with the use of tax portion and strong political intervention (Nuscheler & Roeder, 2015). Although the government expects that Indonesia will reach 100% of universal health coverage (UHC) in 2019, the research of Bredenkamp *et al.* (2015) showed that, in general, there are still problems relating to the adequacy of insurance package for non-communicable diseases (NCD) handling and outpatient care related to the prevention of the disease. In addition, there are imbalances in facilities and infrastructure, equipment, medicines, and staff (including their competence)

### Public Health Indicator

In the concept of public health, health service indicators are not only about the recovery level of hospitalized patients but also the improvement of community's health status in certain areas. Hospitals should adopt indicators set by the government or the WHO consistently. Minimum Service Standards (SPM) and public health indicators should not be seen as a form of "ritual", but they should be implemented consistently. Financial performance indicators should not be dominant in government health services. The use of non-financial performance in health care, as well as indicators of managerial performance, can improve the performance of services (Ballentine *et al.*, 1998).

### CONCLUSION

Accountingization is a part of public sector reform process in the concept of "NPM" (Hood, 1991). This study proves that accountingization process in health care is through various tools, from (1) the structure formation with the implementation of PSAs, (2) structure implementation through various policies such as clinical pathways and budgetary control, (3) to structure internalization through various practices and familiarity with accounting languages. This is consistent with institutionalization theory (Di Maggio & Powel, 1983; Hindman & Connolly, 2011; Power & Laughlin, 1992; Lapsley 2007). However, such practices have led to accounting dilemma with regard to (1) the use of accounting language or term, (2) accounting judgment, (3) conflict of idealism, (4) the usefulness of accounting

and (5) the measurement of financial performance. In this regard, we propose the development of public health sector management accounting (PHS-MA) concept to accommodate the interests of public health services, especially those owned by the government. However, this study is limited to the fact that it is a case study, from which the result cannot be generalized. However, in the implementation of JKN, it is very likely that all hospitals are experiencing the same problem since this policy in insurance system is nationwide.

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