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# When accounting becomes material: managing resource scarcity and patient flow in healthcare organizations

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## Abstract

**Purpose** – The purpose is to analyze the performative role of accounting in shaping organizational arrangements around resource scarcity and patient flow in healthcare organizations.

**Design/methodology/approach** – A qualitative case study was conducted at an emergency unit (emergency room) in a Swedish hospital. The study draws on interviews, accounting reports, budgets, operating plans and newspaper articles collected between 2020 and 2025 to examine the performative role of accounting in addressing resource scarcity and coordinating financial control and patient flow.

**Findings** – The study illustrates how accounting practices make crowding and resource scarcity visible, actionable and negotiable across organizational boundaries. The findings show how accounting contributes to redistributing accountability, reframing crowding as a system-wide organizational problem and enabling temporary organizational arrangements aimed at improving patient flow and managing resource scarcity.

**Originality/value** – This study contributes empirically by illustrating how accounting not only creates tensions between financial control and patient flow but also becomes mobilized by managers to make problems visible and to negotiate the redistribution of scarce resources. It therefore shows how accounting has become integrated in healthcare operations and professional work in established New Public Management settings. Conceptually, the study specifies the performative role of accounting through three interrelated dimensions: the constitution of crowding as a system-wide organizational problem, the redistribution of accountability across organizational boundaries and the materialization of temporary organizational arrangements as a response to system-wide problems.

**Keywords** Accounting, Healthcare, Performativity, Managers, Material-discursive practices

**Paper type** Research article

## 1. Introduction

Since its emergence nearly 30 years ago, New Public Management (NPM) has remained a central theme in the public sector literature (Funck and Karlsson, 2020). NPM emphasizes managerial control, efficient use of resources and accountability (Hood, 1995), which has made accounting a key element in the public sector (Hoque *et al.*, 2022). As the healthcare sector is publicly funded and operates under constant resource constraints, the efficient allocation of resources becomes crucial (Kurunmäki and Miller, 2008). According to Le Theule *et al.* (2023), the focus has shifted from securing sufficient resources for care to finding ways to distribute scarcity. Consequently, healthcare has become a setting where scarcity is naturalized and normalized, framing tensions between cost-efficiency and quality of care as ongoing systemic challenges.

Early studies of NPM have focused on the adoption and diffusion of accounting and control techniques in publicly funded organizations and explored their organizational consequences

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(e.g. Abernethy, 1996; Chua and Preston, 1994). Numerous studies have been critical toward NPM and its overemphasis on efficiency and cost control, thereby narrowing the definition of value in healthcare to what can be measured and accounted for (e.g. Chua and Preston, 1994; Gebreiter and Ferry, 2016). Scholars have also argued that NPM has fostered fragmentation by introducing new boundaries and accountability structures that disrupt coordination and holistic care delivery (e.g. Kastberg and Siverbo, 2013; Frid *et al.*, 2024). Another stream of research has criticized NPM for constraining professional autonomy, as managerial control and performance measurement narrow the space for professional judgment (e.g. Abernethy, 1996; Martinussen and Magnussen, 2011; Malmmose and Liboriussen, 2025).

In healthcare settings, such tensions are often expressed as residing between demands for cost-efficiency and professionals' concerns for delivering high-quality care. For instance, Martinussen and Magnussen (2011) demonstrate how physicians have resisted the implementation of accounting techniques, perceiving them as incompatible with professional logics of care and quality, thus revealing persistent tensions between managerial control and professional expertise in the operational core of healthcare organizations. Building on these premises, subsequent research has increasingly problematized the implications of NPM, emphasizing how its managerial and economic rationalities have reshaped professional work and organizational dynamics.

More recent accounting research has shifted attention from viewing accounting primarily as a source of tension between cost-efficiency and high-quality care toward examining how accounting and management control are mobilized in relation to the demands in established NPM settings (Almqvist and Wällstedt, 2025; Canestrini *et al.*, 2025; Fırtın and Karlsson, 2020; Malmmose and Pflueger, 2025). This shift directs attention not only to how accounting is used, but also to how it is interpreted and mobilized in everyday managerial work (Malmmose and Pflueger, 2025; Sjögren and Fernler, 2019). Recent literature reviews further call for greater attention to how healthcare professionals and managers engage with accounting and management control in established NPM settings, including the reasons for mobilizing, resisting or disregarding accounting practices in everyday healthcare work (Levay *et al.*, 2020; Hellqvist and Kurkkio, 2025). At the same time, performativity research has increasingly emphasized that accounting should not merely be understood as representational or calculative, but also as a material-discursive practice that actively shapes organizational realities (Vosselman, 2022), as activities become visible and actionable (Firtin, 2024). However, there is still limited empirical understanding of how accounting becomes performative in practice and what, specifically, it brings into being in healthcare settings characterized by systemic resource scarcity and patient crowding (Yu and Huber, 2023). In particular, less attention has been paid to how accounting participates in constituting organizational problems, redistributing accountability and enabling temporary organizational arrangements in the management of patient flow.

Against this background, we present a qualitative case study illustrating how managers engage with accounting to relate financial control to the delivery of high-quality care, focusing on an emergency unit (emergency room, ER) at a Swedish hospital that serves as a floodgate to the wider hospital system. Persistent waiting times, patient crowding and financial strain highlight how accounting shapes managerial decisions about resource allocation and patient flow. By focusing on how managers engage in accounting to make visible, negotiate and resolve systemic problems descending from resource scarcity, the study analyzes the performative role of accounting in shaping organizational arrangements around resource scarcity and patient flow in healthcare organizations.

This study contributes to recent research streams within the public sector accounting literature (e.g. Sjögren and Fernler, 2019; Firtin and Karlsson, 2020; Firtin, 2024; Almqvist and Wällstedt, 2025) by empirically illustrating how accounting not only creates tensions between financial control and patient flow but also becomes mobilized by managers to make problems visible and to negotiate the redistribution of scarce resources. The study shows how accounting plays a central role in managing patient flow in healthcare organizations and how it

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brings performative consequences for resource allocation. The paper further contributes empirically by demonstrating how managers in healthcare organizations engage with accounting to address systemic problems of scarce resources, rather than refraining from using accounting (Martinussen and Magnussen, 2011; Malmmose and Liboriussen, 2025). In doing so, the study supports recent literature arguing that accounting has become embodied in healthcare operations and professional work (Firtin and Karlsson, 2020), where accounting is essential for managing patient flow and resource scarcity.

The paper also makes a conceptual contribution to the accounting literature on performativity by specifying the performative role of accounting through three interrelated dimensions. First, accounting participates in constituting resource scarcity and crowding as a system-wide organizational problem. Second, it redistributes accountability by extending responsibilities across organizational boundaries. Third, it contributes to the materialization of temporary organizational arrangements. Together, these dimensions explain how accounting, understood as a material-discursive practice (Vosselman, 2022), not only represents organizational conditions but also participates in shaping what constitutes the problem, who is made responsible for addressing it and which organizational responses become possible. In this way, the study responds to calls for greater conceptual clarity regarding how accounting becomes performative and what, specifically, it brings into being (Yu and Huber, 2023). In the present case, this is illustrated by how accounting contributes to an expanded mandate for the emergency unit, enabling a temporary organizational response to system-wide crowding while leaving the underlying conditions of resource scarcity unresolved.

We start by discussing relevant literature on accounting in healthcare settings. This begins with a functionalist perspective on accounting in healthcare organizations and outlines the well-established tension between delivering efficient and high-quality care, followed by literature on accounting practices for managing patient flow in healthcare settings. The section ends with a presentation of the theoretical lens adopted in this paper. Drawing on both a performative lens and recent work in public sector accounting, we propose a material-discursive conceptualization of accounting and show how it helps us analyze the performative role of accounting and its implications. Next, we outline the qualitative case study design and detail the procedures through which the empirical material was collected and analyzed. The empirical field study is then presented, illustrating how accounting is used to manage crowding at the emergency unit and how it renders problems visible, enables the negotiation of responsibilities and supports temporary solutions under conditions of resource scarcity. The paper ends with conclusions, limitations and suggestions for future research.

## 2. Toward a performative role of accounting in healthcare organizations

Within a functionalist perspective, accounting in healthcare is understood as a rational and technical instrument for coordination, control and performance improvement (Hood, 1995; Chua and Preston, 1994). Thus, the core functions of accounting within this perspective are identification, classification, measurement, control, reporting and assurance (Kastberg and Siverbo, 2013; Funck and Karlsson, 2020). Influenced by public sector reforms associated with NPM, accounting has extended its influence into healthcare organizations through budgeting systems, performance measurement frameworks, cost accounting, etc. (Nyland and Pettersen, 2004; Funck and Karlsson, 2020; Johansson-Berg and Wennblom, 2023). In this view, accounting provides objective and decision-relevant information that supports efficient resource allocation, managerial oversight and the coordination of healthcare activities aimed at delivering both cost-efficiency and high-quality care. Accounting is therefore treated as a technical tool for managing coordination and control problems in complex healthcare systems and viewed as an essential component of modern public sector management aimed at improving performance and strengthening accountability. However, previous research also shows that accounting may generate organizational tensions and unintended consequences (Kastberg and Siverbo, 2016), particularly in healthcare organizations where financial control and patient flow need to be coordinated simultaneously.

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*2.1 Managing patient flow in healthcare settings*

Process-oriented practices in healthcare have long been positioned in tension with accounting's hierarchical and vertical structures (e.g. Kastberg and Siverbo, 2016; Nyland *et al.*, 2017). While healthcare delivery is organized around horizontal flows of patients, information, materials and professional knowledge, accounting systems tend to segment operations into discrete cost centers or financial units, each subject to separate managerial and financial controls (Kurunmäki, 1999). Efficient resource allocation is thus planned and organized through vertical structures that define areas of responsibility and accountability. At the same time, these accounting structures are expected to support not only cost-efficiency, but also the delivery of timely and appropriate care through coordinated patient flow (Malmmose and Pflueger, 2025). As Kurunmäki (1999, p. 219) notes, "to define something as an accounting entity is to represent an area of interest, to make it real, and to circumscribe the objects and activities of which financial reports will speak."

Budgets constitute a central instrument within this vertically organized control system. In the Swedish healthcare context, budgets are legally mandated tools for financial accountability and resource control, structuring how scarce resources and patient flows are planned and managed. The budget renders boundaries and constraints tangible by specifying available resources and prescribing their allocation (Johansson-Berg and Wennblom, 2023). In doing so, it produces a visual and calculative representation of organizational limits that is widely comprehensible and can reshape how operational actors understand their work (Curry, 2024), for example through accounting metaphors or participation in budgeting processes (Carlsson-Wall *et al.*, 2016). However, when strong emphasis is placed on meeting unit-level budget targets, the vertical logic of financial control risks reinforcing fragmentation. Such focus may generate suboptimization (Kastberg and Siverbo, 2016), creating bottlenecks and crowding effects elsewhere in the system, thereby standing in sharp contrast to the process-oriented coordination that characterizes healthcare delivery (Kastberg and Siverbo, 2013).

A process-oriented structure fosters horizontal integration across units and may enhance collaboration and coordination (Oppi *et al.*, 2024). Simultaneously, managerial control decisions can designate a specific clinic or organizational unit as a primary financial responsibility center, effectively making it responsible for absorbing system-level deficits and delivering overall financial performance for the hospital or even the wider healthcare system (Llewellyn *et al.*, 2022). Such arrangements risk leading to suboptimization, where the financial strength and operational success of one unit come at the expense of others, particularly when it is given a buffering role. From an aggregated hospital perspective, this redistribution may not appear problematic, since the consolidated financial statements remain stable. However, at the unit level, these unequal dependencies and financial imbalances (Nyland *et al.*, 2017) become visible through strained workloads and deteriorating financial results. When a strict cost focus intrudes on healthcare practices built on quality and professional assessments, tensions arise. Malmmose and Liboriussen (2025) report persistent tensions between centralized accounting and local operations.

Yet, process-oriented patient flow is highly interrelated with accounting techniques aimed at enabling efficiency, predictability and coordination across healthcare units. Thus, it is too simplified to suggest that accounting merely intrudes on healthcare practices, or to frame cost-efficiency and high-quality care as inherently conflicting. In established NPM settings, accounting increasingly becomes mobilized to balance economic constraints with demands for timely, coordinated and appropriate care. To achieve high-quality care, healthcare organizations often focus on the patients' journeys through the healthcare system and the efficient management of patient flow (Kastberg and Siverbo, 2013), thereby linking quality of care to issues of throughput, coordination and resource allocation. Hopwood (1996) early suggested that accounting is not a vertical practice and called for attention to issues of the lateral dimensions of accounting.

Management of patient flow can be understood as the practice of ensuring that patients move smoothly and efficiently through a "process of care" (Kastberg and Siverbo, 2013). This

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implies minimizing delays and maximizing predictability. However, patients' conditions may change, making it difficult to streamline patient flow. In healthcare, therefore, flow cannot be viewed as constant. Rather, units may operate with different definitions of efficient flow: some may seek to increase throughput, while others may wish to reduce it. In other words, managing patient flow depends on a unit's capacity, which it cannot fully control. Beyond capacity constraints, availability also depends on whether patients receive the necessary care and can be discharged.

Le Theule *et al.* (2023) insightfully demonstrate how "death disrupts accounting" (p. 12), prompting accounting to assume new forms and additional roles even when patient flow is the primary focus. In this sense, accounting is not constant; rather, it is continually becoming "what it was not" (Hopwood, 1987, p. 207) and is constructed at the margins of other disciplines (Miller, 1998), such as healthcare, where accounting may take on different roles, have different meanings and be enacted in new innovative ways.

### *2.2 Performative role of accounting*

While accounting is malleable and shaped by its context, it also has performative effects on actors and their activities that may vary due to how accounting is enacted (Firtin, 2024). Scholars adopting a performativity lens examine how numbers, classifications and calculative devices configure action; define what is considered relevant; and influence how organizational actors think, act and behave (e.g. Revellino and Mouritsen, 2015; van Erp *et al.*, 2019; Firtin and Karlsson, 2020; Firtin, 2024).

Accounting's performative role has, for example, been examined by Revellino and Mouritsen (2015) when they analyzed the relationship between calculative practices and innovation processes. They argued that calculative practices, such as accounting, operate as an engine for innovation. Through their capacity to prompt new questions and reveal new opportunities, accounting draws actors into innovation processes and encourages them to undertake new actions. Further, Revellino and Mouritsen (2015) argued that the development of an innovation can be understood as a historiography of gradual shifts, in which its character emerges incrementally and ultimately proves to be more surprising and far-reaching than what the individual steps initially suggested. This reflects a form of performativity whereby newly generated insights motivate actors to undertake new actions. In this way, accounting contributes to reducing perceived complexity and rendering the effects of innovation more predictable. When accounting is performative, it is thus understood as shaping and influencing the practices of managers, firms and institutions.

Performativity in healthcare organizations has also been studied by van Erp *et al.* (2019) and Firtin and Karlsson (2020). Firtin and Karlsson (2020) showed that accounting terms, such as efficiency and control, were accepted and reframed into medical terminology (healthcare quality and security), reshaping medical professional work in terms of practices and emerging roles. Thus, accounting becomes performative and constructs organizational realities and provides directions for action.

However, performativity in accounting research is not a uniform concept; it constitutes a multifaceted theoretical framework encompassing several definitions and diverse ways in which it has been operationalized. As Vosselman (2022) notes, accounting has been conceptualized as a discursive frame, a calculative act, a mediator enabling action at a distance and as a material-discursive practice. These perspectives resonate with broader notions of performativity (Orlikowski and Scott, 2015; Gond *et al.*, 2016), including constituting realities, shaping subjectivities and bringing theories into being. Barad (as cited in Orlikowski and Scott, 2015) argues that in order to exist, discourse must be materialized in some form and in specific times and places. Accordingly, discourse and materiality are understood as mutually constitutive rather than analytically separable phenomena. Building on this perspective, Orlikowski and Scott (2015) argue that materiality and discourse are constituted through each other and therefore are ontologically inseparable. Rather than

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positioning material elements as separate entities and examining how they influence or afford discourse, the focus shifts to materialization, that is, how discourse is materially enacted in practice. Consequently, material-discursive practices direct attention to doings and enactments rather than to representational accounts of reality.

Orlikowski and Scott (2015, p. 700) argue that "performativity offers a way of understanding how the world is constantly being made and reconfigured in material-discursive practices." Following this perspective, we address how accounting becomes materially enacted in practice and how such materialization contributes to shaping organizational realities. Rather than treating accounting as a neutral representation of organizational conditions, we analyze how accounting participates in constituting problems, responsibilities and organizational responses to resource scarcity.

## 3. Research design

The purpose of the study is to analyze the performative role of accounting in shaping organizational arrangements around resource scarcity and patient flow in healthcare organizations. Given the purpose, a qualitative case study design was selected (Flyvbjerg, 2006) to examine the performative role of accounting and how managers in healthcare organizations mobilize accounting to manage patient flow and redistributions of scarce resources.

### *3.1 Case description and selection*

The present study is undertaken in Sweden, a welfare state with a long tradition of NPM reforms (Sjögren and Fernler, 2019). In this context, accounting and control have become increasingly central features of public sector governance. We conducted a case study of a regional hospital (RH) located in a region where the entire healthcare system is affected by resource scarcity, constraining the provision of both effective and high-quality care (Regional strategic plan, 2019, 2020, 2021).

The region's demographic development follows a pattern observed across much of the Western world: the proportion of predominantly healthy, working taxpayers is decreasing, while the proportion of elderly individuals in need of healthcare is increasing (Regional strategic plan, 2019, 2020, 2021). However, in global comparison, the pace of development in this particular region is among the highest. These demographic and financial pressures have intensified concerns regarding capacity, efficiency and control, making accounting and management practices central elements of the healthcare organization.

For several years, the region's healthcare sector has been under strained financial pressure, reaching new proportions during the pandemic from March 2020. The National Health Inspectorate (NHI) and the Swedish Work Environment Authority have pointed out that the regional healthcare system is characterized by resource scarcity, which challenges the provision of both efficient and high-quality care (National Health Inspectorate, 2024; Regional strategic plans, 2019, 2020, 2021). In this study, high-quality care is operationalized through organizational measures and practices related to patient flow, including availability, waiting times, patient safety incidents and the ability to provide patients with timely and appropriate care by either transferring them to suitable wards within acceptable timeframes or discharging them within acceptable timeframes. Cost-efficient care is operationalized through effective utilization and coordination of available resources, including care spaces, staffing and hospital capacity, to maintain patient flow and minimize unnecessary waiting times and prolonged stays. Scarcity was operationalized by the NHI as an inability to provide 180 care spaces, rendering resource scarcity visible and actionable through a concrete measure of hospital capacity. It was accompanied by a conditional fine of 10 MSEK in the event of non-compliance, as reported in one of the largest national newspapers, Dagens Nyheter, in 2022. A care space, sometimes referred to as a hospital bed (Kurunmäki and Miller, 2011) or ward bed

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(Kraus *et al.*, 2017), includes everything needed to provide immediate healthcare: room, bed, staffing, linen, food and other resources. Thus, a care space can be understood as encompassing all necessary resources required to deliver care to a patient.

The hospital has repeatedly been criticized for long waiting times for patients in need of care, an issue that has been debated in the media. In this paper, we focus on the emergency unit, as it reflects the overall condition of the regional healthcare system and makes tensions between financial control and horizontal, process-oriented patient flow particularly visible. The emergency unit depends on the effective functioning of both preceding and subsequent units; when these units lack capacity, patients remain in the emergency unit, resulting in crowding (see Figure 1 for RH's organizational structure).

Patient crowding in the emergency unit arises from an overload of patients and reflects a complex interplay between the number and types of patients arriving at the unit (inflow), the efficiency of clinical throughput within the unit and the discharge or transfer of patients to other units (outflow). In this sense, the emergency unit serves as a critical point where system-wide resource constraints, demographic pressures and organizational control practices converge. Figure 2 illustrates the emergency unit and the different classifications and categorizations of patients that take place at the unit, and the inflow and possible outflow of patients.

### *3.2 Data collection*

Empirical data were collected through interviews as well as internal documents and external publicly available sources. The primary empirical sources were interviews and internal documents related to the management of the hospital. The interviewees were selected to capture how decisions were made across organizational levels at the RH that influenced patient crowding and the availability of care spaces. A total of 19 interviews were conducted (see Table 1). We focused on managers and controllers with budget responsibility, as well as healthcare professionals affected by these decisions. We also included the RH's patient safety

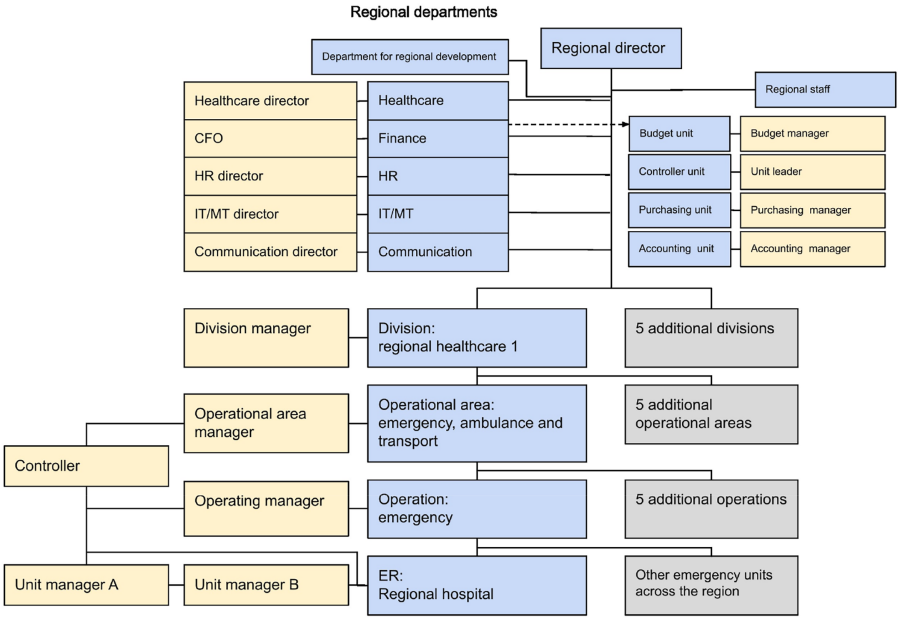


**Figure 1.** RH's organizational structure. Source: Developed from regional documents by the authors

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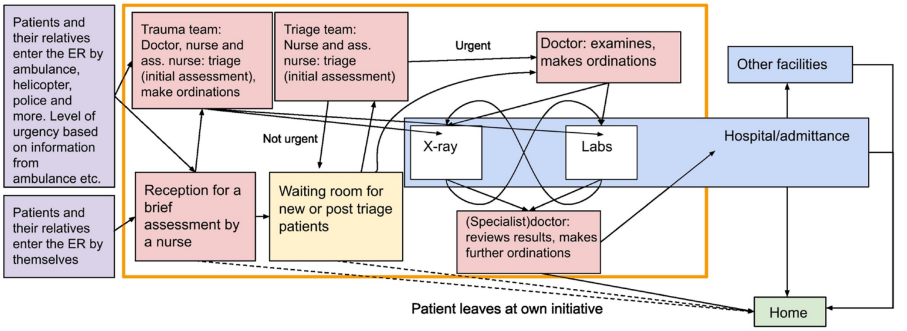


**Figure 2.** Emergency unit organizational overview with patient flows. Source: Developed from interviews by the authors

**Table 1.** Interviews

| No | Role | Professional training | Organizational level | Interview length (min) |
|---|---|---|---|---|
| 1 | Nurse | Nurse | Hospital screening unit | 72 |
| 2 | Doctor | Doctor | Hospital ward | 67 |
| 3 | Teacher in nursing | Nurse, assistant nurse | Hospital ward | 47 |
| 4 | Speech therapist | Speech therapist | Primary care | 76 |
| 5 | Coordinator | Assistant nurse | Primary care | 68 |
| 6 | Nurse | Nurse | ER | 60 |
| 7 | Doctor | Doctor, specialist | Hospital ward | 80 |
| 8 | Doctor | Doctor, specialist | ER, hospital ward | 91 |
| 9 | Nurse | Nurse | ER | 93 |
| 10 | Patient safety coordinator | Nurse, specialist | Regional level | 62 |
| 11 | Nurse | Nurse | ER | 60 |
| 12 | Doctor | Doctor, specialist | ER, hospital ward | 78 |
| 13 | Unit manager | Nurse | ER | 49 |
| 14 | Assistant nurse | Assistant nurse | ER | 61 |
| 15 | Division manager | Doctor | Regional level | 65 |
| 16 | Head of financial control | Accountant | Regional level | 75 |
| 17 | Controller, unit leader | Controller | Regional level | 69 |
| 18 | Operating manager | Nurse | Operational level | 62 |
| 19 | Controller | Controller | Operational area level, operational level | 78 |

officer, whose role provided insights into how crowding, waiting times and patient safety incidents were monitored and communicated within the hospital. Together, these perspectives enabled us to trace how financial and operational decisions were formulated, translated and enacted in practice. By including both administrative and operational roles, the study captured how these decisions shaped patient flow across units, particularly in relation to the emergency unit. The interview material was operationalized to examine the financial and operational decisions made at RH, with a particular emphasis on a shortage of care spaces resulting in crowding that shaped these decisions, as well as the role of accounting and management control in this process. In this study, accounting is understood as a set of calculative practices

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and representations through which organizational activities become visible and actionable. This includes budgets, cost allocations, throughput measures, national waiting-time statistics and patient safety incidents that are mobilized in managerial efforts to allocate resources and coordinate patient flow. Interview questions were tailored depending on the interviewee's role and position within the organization, as illustrated in Table 2.

All interviews were recorded, transcribed and summarized into a case study protocol. The interviews ranged from 47 to 93 min and were conducted over the course of approximately 2.5 years, from spring 2022 to autumn 2024. Each interview was followed by a reflexive note, in which overall impressions, interpretations and reflections were documented. The internal documents (e.g. the region's annual reports, strategic plans and operating budgets) provided insights into financial oversight, resource efficiency, healthcare quality and decision-making (see Table 3). Documents are central to studying accounting, as they provide linkages between hierarchical levels and organizational settings, as well as between different points in time. Publicly available documents from, for example, the NHI were also collected. For instance, the RH was ordered by the NHI to comply under penalty of a conditional fine of 10 million SEK due to the lack of care spaces at the hospital. These documents were used to triangulate our empirical material. The documentary material was operationalized to identify and trace issues related to crowding, care-space capacity, patient flow, resource scarcity, financial performance and patient safety over time. Annual reports, operating budgets and divisional reports were used to examine how resource allocation and financial accountability were represented within the organization, while strategic plans, inspection reports and waiting-time statistics provided information on patient flow, care quality and capacity constraints. These documents complemented the interview material and enabled us to compare managerial accounts with formal organizational representations of the same issues. For this study, documents from the years 2020–2025 have been in focus.

### *3.3 Analysis*

The empirical material was analyzed iteratively between coding and gathering more material. Looking for emergent patterns and themes, as well as contradictions and inconsistencies, the analysis aimed for an openness and responsiveness toward the material (Flyvbjerg, 2006). At first, the analysis focused on understanding the context of the RH and especially the crowding at the emergency unit. Both interviews and documents were analyzed in relation to these themes. Documents were particularly useful for tracing how crowding, patient flow, financial performance and care-space capacity were represented and discussed across organizational levels and over time.

During this initial phase, we focused on efficiency and quality measures (e.g. waiting times, clinical throughput and the discharge of patients) as well as horizontal processes of patient flow. The first theme was informant-centric and addressed informants' view (Gioia *et al.*, 2013) on the tensions between vertical structures of financial control and the horizontal flow of patients. Then the first-order codes were organized into second-order themes. These were theory-centric themes and focused on how accounting was enacted by managers to solve temporal problems with resource scarcity. The progression from first-order categories to theory-centric themes and performativity-based reinterpretations is illustrated in Table 4.

The final step in our analysis was to reinterpret our empirical material in relation to our theoretical framework. Alternative interpretations initially emphasized accounting as a mechanism for control and coordination. However, as the analysis progressed, the empirical material increasingly highlighted how accounting participated in making problems visible, redistributing accountability and enabling new organizational arrangements, which led us to adopt a performativity-based interpretation of accounting as a material-discursive practice. The coding and analysis were first done by the authors separately and then discussed and reconciled to reach a shared interpretation and ensure analytical rigor.

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**Table 2.** Sample interview questions

| Sample questions | Interviewees | Organizational level | Reasoning | Links to the theoretical framework |
|---|---|---|---|---|
| How would you describe what you work with? | All | All | To gather information about the role and tasks of the interviewee and which terminology they use to describe them | |
| Do you use any tools, aids or systems in your work? | All | All | To know more about if and how (accounting) systems play a part in the interviewee's work | |
| Are you aware of any (formal) goals that exist at your workplace/unit/department? (If needed, provide examples such as accessibility, waiting times, patient throughput, patient satisfaction, number of adverse events or deviations.) | In healthcare roles (e.g. nurses, doctors) | Hospital, primary care level | To understand the interviewees' awareness of financial control and management of patient flow | Accounting as problem solving |
| How do you yourself experience these goals (or another term they use)? | In healthcare roles (e.g. nurses, doctors) | Hospital, primary care level | To understand how the interviewee sees the role and usefulness of financial control and management of patient flow | Accounting as problem solving |
| Are these goals part of your daily work? | In healthcare roles (e.g. nurses, doctors) | Hospital, primary care level | To understand how the interviewee sees the presence and usefulness of financial control and management of patient flow in their daily work | |
| What does your role look like, do you have any financial responsibility? What does that mean? | In managerial roles, with healthcare training | Operational area level | To gather information about financial responsibility and vertical organizational structures | |
| Are there situations where the financial dimension becomes especially important? Less important? | In managerial roles, with healthcare training | Operational area level l | Financial control vs. horizontal patient flow | Reframing accounting's role in managing patient flow |
| How are the goals for different units formulated? | In managerial roles, with financial training | Regional level | Financial control structures within RH | Reframing accounting's role in managing patient flow |

(*continued*)

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**Table 2.** Continued

| Sample questions | Interviewees | Organizational level | Reasoning | Links to the theoretical framework |
|---|---|---|---|---|
| Can you think of a situation where you and someone else solved a problem related to what we've discussed earlier?<br>Who was involved?<br>What was the problem?<br>How did you experience the situation – was it difficult? Easy?<br>How did you proceed?<br>How did it play out? | All | All | To know more about how accounting may play a part in solving problems, whether the perceived problem is related to accounting or not | Accounting as a material-discursive practice |
| Is there anything you think I should have asked about, or that we should have talked about now that you know what I'm interested in? | All | All | To gather information about additional topics/ directions that may enrich the study | |

**Source(s):** Created by authors

## 4. Findings

In the following section, we provide illustrative examples of how managers in healthcare organizations engage with accounting practices to make visible, to negotiate and respond to crowding in the emergency unit. We show how accounting participates in rendering resource scarcity and patient flow problems actionable, and how it shapes organizational responses to these challenges. Finally, we present a temporary organizational arrangement developed to improve patient outflow and manage resource scarcity.

### *4.1 Chaos at the ER?*

The formal mission of the emergency unit is to provide immediate assessment, stabilization and treatment for people who arrive with urgent or life-threatening conditions (Mission definition ER). This unit makes the initial assessments and prioritizations of patients.

> The emergency unit is a very special place. I often say that it symbolizes the entire chain of care. It is completely dependent on all the units before and after functioning as they should. Because if primary care doesn't work, then patients eventually end up at the doors of the emergency room, since it is always open. And if we don't have enough care spaces, then the patients remain in the emergency room.

The division manager describes the unique characteristics of the emergency unit and its central place in the healthcare system. The emergency unit is, in many cases, the entry point for many of the region's patients who are in need of (unplanned) care. One of the unit managers describes the emergency unit as a fast-paced and stressful place, saying:

> We can't run faster than we already do. So, you have to prioritize instead. That's why there's a significant conflict. [. . .] You keep running and running, and you never reach the finish line. [. . .] And the patients shouldn't even be in the emergency room in the first place!

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**Table 3.** Sources used in the analysis

| Internal documents | Description | Number of pages | Year |
|---|---|---|---|
| Mission definition ER | A document that serves to clarify the mission and assignment of the specific ER. | 2 pages | n/a |
| Report from the Regional Patient Advisory Committee | The report presents some conclusions on why the area of operation (emergency, ambulance and transport) has received an increasing number of complaints in 2019 and is based on the annual reports of the Patient Advisory Committee of Norrbotten for 2018–2021 | 7 pages | 2022 |
| Divisional interim report | A report describing the operational performance (e.g. patient flows, capacity indicators), financial status (budget vs. actual performance) and quality and safety (e.g. patient safety indicators) | 20 pages | April, August 2022, August 2023 |
| Divisional annual report | A report describing RH in retrospective. Providing a comprehensive account of a division's performance over the full fiscal or calendar year | 19, 20, 20 pages | 2021, 2022, 2023 |
| Regional annual report | The report provides a system-wide account of performance, priorities and challenges across multiple hospitals and units within the region | 86, 72, 64 pages | 2021, 2022, 2023 |
| Regional strategic plan | A two-year regional plan, including strategies and budgets for healthcare and other areas of regional operations | 45, 55, 59 pages | 2019, 2020, 2021 |
| Operating budgets | Budgets for the operational areas within the division | 1 page | 2021–2022 |
| *External publicly available sources* | *Description* | *Number of pages* | *Year* |
| Final Report on the National Hospital Inspection | The final report from the NHI based on inspections of 27 Swedish hospitals, 2022–2024 | 19 pages | June 2024 |
| National Board of Health and Welfare | ER waiting times at RH (total length of stay, minutes), ages 19 and over, years 2016–2024 | 1 page | January 2025 |
| Dagens Nyheter | News article in one of the largest national daily newspapers in Sweden highlighting the resource scarcity and lack of care spaces at RH | 1 page | June 2022 |

The unit manager depicts a problematic situation of patients in need of care being stuck at the ER. Despite fast initial assessments that should admit patients to inpatient wards, the patients remained at the ER, and waiting times increased substantially during 2022 (see Figure 3, National Board of Health and Welfare, 2025). Figure 3 shows a marked increase in the total length of stay at the ER, reflecting growing difficulties in maintaining patient flow. As waiting times constitute one indicator of high-quality care in this case, the figure illustrates how crowding increasingly challenged the emergency unit's ability to provide timely and appropriate care.

A report from the Regional Patient Advisory Committee in 2022 point out that patients who are not always in need of emergency care end up at the ER, which makes the situation difficult for healthcare professionals in need of attending to patients' needs. Since the ER always needs to keep its doors open, that is, 24/7, year-round, reducing opening hours at the ER is not an option. Managing an ER requires another mindset than that of other units. The unit manager delineates the difficulty with managing emergency care by explaining:

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**Table 4.** From empirical observations to performativity-based interpretation

| Empirical observations | 1 st order categories | 2nd order categories | 3rd order categories |
|---|---|---|---|
| ER absorbs patients but other units retain budgets | Resource mismatch<br>Budget imbalance<br>Responsibility disputes | Patient flow dependencies<br>Budget accountability<br>Resource negotiations | Accounting becomes performative through redistribution of accountability |
| Patient safety reviews, throughput times, waiting times | Crowding affects patients<br>Need to convince other units<br>Sharing information | Visibility of crowding<br>System-wide problematization<br>Decision influence | Accounting becomes performative through reframing of organizational problems |
| Close care funding and short-stay ward | Alternative solutions<br>Funding applications<br>New ward creation | Resource reallocation<br><br>New care provision | Accounting becomes performative through materialization of organizational arrangements |

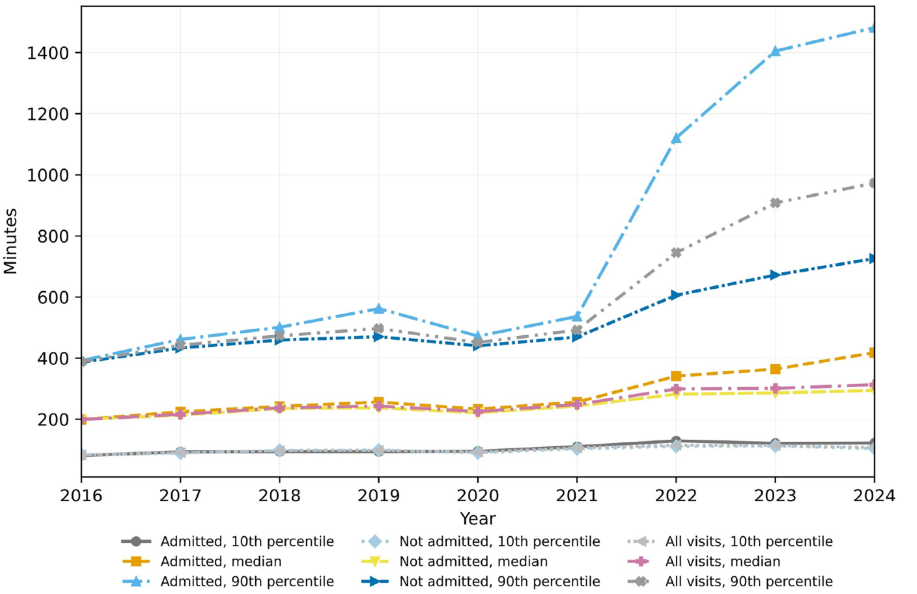


**Figure 3.** ER waiting times at RH (total length of stay, minutes), ages 19 and over, years 2016–2024. Source: National Board of Health and Welfare (2025)

What's different is that, in a hospital ward, if someone who is scheduled to work calls in sick before the weekend, they simply reduce the number of care spaces. But when it comes to the emergency room, if someone calls in sick before the weekend, we just have to find a solution. We cannot reduce our availability.

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Yet, the possibilities to reduce crowding and reach availability goals are limited due to events outside the unit's control, which the ER managers are aware of. One specific neighboring unit that receives many ER referrals reportedly avoids attending unit meetings aimed at improving care space accessibility, according to a controller working with emergency operations in the region. While crowding initially appears as a patient flow and quality-of-care problem, managers increasingly translate these concerns into accounting terms. Through cost information, patient flow statistics and budgetary calculations, the consequences of prolonged ER stays become visible not only as risks to patient care but also as inefficient use of organizational resources. Accounting thus provides a language through which concerns for high-quality care and cost-efficiency can be articulated simultaneously and communicated across organizational boundaries.

The division manager explains how cost information in relation to patient types and flows at the ER is used to gain access to some of the resources that initially are allocated for that specific hospital unit, whose referred patients are often kept waiting in the ER for long periods of time. So, to raise awareness, the managers turn to accounting numbers. The division manager explains:

> Everything costs [counts on one hand], and suddenly everything ends up at the emergency room [shows increasing distance between hands, indicating expansion], which under normal circumstances would have been handled in a ward. That's not fair. It's not fair for the patient, and it's not fair in budgetary terms either. The emergency unit is currently in a situation where it is very difficult to impose strict savings requirements. It simply doesn't work because we need to provide better care for the patients. And then I need to stand up and say so. I can point directly to the neighboring unit and say: "You're the ones not admitting the patients, so it's your budget we should be taking the resources from, because the patients are here at the emergency room." This is completely obvious, and we have the numbers to prove it!

The quote illustrates how accounting is mobilized to connect concerns for patient care with concerns for resource utilization. Patients remaining at the ER are not only framed as a quality-of-care issue but also as a budgetary issue, as resources allocated to one unit are effectively consumed by another. Through cost information and patient flow data, crowding becomes visible as a shared organizational problem rather than solely an operational challenge for the emergency unit. Accounting thus enables managers to articulate claims for resource redistribution by linking patient outcomes to financial consequences.

However, as the division manager readily admits, the ER's claim to the neighboring unit's budget reflects a short-term perspective, which is not a viable solution, as patients in need of specialized and advanced care cannot be adequately treated in the ER, even if the budget is redistributed. The division manager nuances the idea of reallocating resources since the aggregated resources will still not be enough:

> The problem is not solely the resource allocation; we also have a bottleneck to attend to. There are too many patients at the emergency room and everyone says: "We need more money and more resources for the emergency unit!" Is that the right solution then? No. Maybe we need to increase capacity upstream or downstream. So where should the focus lie when it comes to resource allocation?

The unequal cost allocation among the various units as an argument to reallocate resources seems to be yet another attempt to achieve an increased number of available care spaces, this time by the threat of financial damage. The manager highlights how crowding at the ER can only be counteracted by changes elsewhere in the healthcare system, an issue where help is sought from the controller.

### *4.2 When the ER cannot close, another winner takes it all*

From the controller's viewpoint, the crowding at the ER is closely tied to the vertical structure of the management accounting system present at the RH. The vertical structures underscore how budgeting practices can create misaligned incentives, where some units appear financially

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stable despite failing to provide care at their assigned capacity. At the same time, the ER absorbs the overflow of patients and associated costs, which negatively affects patient care and the unit's financial performance. The controller concurs with the view presented by one of the unit managers at the emergency unit, but relates the crowding of patients to the cost allocation of patients:

> To be blunt, one could say that we currently have problems in some hospital wards that are unable to fulfil their assignment, but financially, their unit almost comes out as winners. They have a budget based on their provision of [a specific amount] of care spaces, and they deliver care to patients within those care spaces. But when they can't manage to deliver care, due to a lack of staff, where does the patient end up? At the emergency room. This incurs additional costs. No patient should ever stay at the emergency room for more than four hours. Unfortunately, they do stay longer than that, some even for longer than a day, and the unit is not budgeted for that. So, it's not good for our patients because they do not receive care at the right level, and it's not good financially either.

The controller highlights how the insufficient number of care spaces at other units limits the possibilities for the emergency unit to meet its budget (Annual reports; regional and divisional, 2021, 2022, 2023). The controller also recognizes the somewhat inverted incentive structure that follows from a division of units with separate budgets. Hospital units that fail to provide care come out as financial "winners," while the emergency unit in this case "loses," along with the patients who are kept waiting at the ER (Divisional interim report, 2022, 2023).

This becomes visible in the operating budget, where the ER shows a deficit of −222.5 while the Operating Area Joint Services reports a large surplus of 839.2 (Operating budget, 2021–2022). Overall, however, the division's budget is balanced (see Table 5). As illustrated in Table 5, financial imbalances that are highly visible at the unit level become less apparent when viewed from the aggregated divisional perspective. While the emergency unit absorbs costs associated with patient crowding, the overall financial position of the division remains stable. The table thus highlights how accounting representations can simultaneously reveal and obscure organizational problems depending on the level at which they are reported.

The table shows the operating budgets for the first quarter of 2021–2022 across the operational areas within the division. Although the ER absorbs costs associated with patient crowding, the division appears financially balanced when viewed at an aggregated level. The table therefore illustrates how accounting representations simultaneously reveal and conceal organizational problems. Reflecting on this tension, the region's Head of Financial Control acknowledges the counterproductive incentives embedded in the vertical structure of the management accounting system by noting:

**Table 5.** Operating budgets per operational area within the division, 2021–2022

| Operational area | Actual SEK m 2022 (Jan–Apr) | Period budget SEK m | Budget Variance SEK m | Actual SEK m 2021 (Jan–Apr) |
|---|---|---|---|---|
| OA Neurocenter | −58.2 | −48.5 | −9.7 | −38 |
| OA Paediatrics | −151 | −141.9 | −9.1 | −139.8 |
| OA Medicine | 0 | 0 | 0 | −0.2 |
| OA Joint Services | 832.9 | 834 | −1.1 | 997.4 |
| OA Internal Medicine | −382.1 | −434.7 | 52.6 | −423.9 |
| OA Emergency | −222.5 | −208.9 | −13.6 | −232.4 |
| *Total* | *19.1* | *0* | *19.1* | *163.1* |

**Source(s):** Operating budgets, 2021–2022

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> We should work more horizontally because patient flow requires it. But since management and budgets are designed in silos, we are evaluated vertically. This means the patient does not always receive care in the most cost-effective way.

The quote illustrates how accounting is implicated in balancing competing organizational objectives. While budgets are designed to promote financial accountability and cost control, patient flow requires coordination across organizational boundaries. In this case, accounting makes visible how challenges related to cost-efficiency and high-quality care become intertwined through the organization of patient flow. Crowding at the ER is a well-known problem among personnel working at the hospital, as well as among top management in the region and the controllers. The vertical structure of the management accounting system at the hospital seems difficult to reconcile with the process-oriented perspective on how to deliver healthcare. In this case, the management of resources does not support the management of patient flow. New and creative solutions are thus called for, and one of the unit managers points out that improving patient outflow from the ER is a solution to reduce crowding. When patients have nowhere else to go, they end up staying at the ER, which negatively affects both their care and the working conditions for the staff. The operating manager problematizes patient flow:

> What's so difficult is that, since we don't work with steel blocks or something else like that, when we turn away work, we turn away patients. We've also tried to define the emergency room's assignment: What falls within our assignment? I often ask the question: "Is this within our assignment?" "No, but we do it anyway."

The operating manager reflects upon the nature of the core task, to provide care to patients in need of urgent care. Sometimes, the patients who are at the ER fall outside the formal assignment (to provide immediate assessment, stabilization and treatment for people who arrive with urgent or life-threatening conditions) of the emergency unit, and this causes crowding. However, the patients who fall outside the formal assignment of the emergency unit are treated anyway. If other wards of the healthcare organization are closed or do not admit patients, the ER is always available, but the patients do not receive the specific care they need, and the resources are not used efficiently.

> No, we're not good at [taking care of patients that should be admitted to a ward], it's not part of our assignment. Numbers and statistics help us in this, as do patient safety incidents reported by staff, like: "We didn't have time," "We made a mistake," or "We failed this patient because we had x number of other patients."

The operating manager points to the fundamental tension between the formal mission and the practical reality that many patients seeking care fall outside of the scope. The ER is not suitable for patients who should have been admitted to wards, and this mismatch creates risks for patient safety. Accounting numbers, statistics and incident reports all become important ways to make these challenges visible and to communicate the problem to management. Through these accounting practices, patient crowding is increasingly framed as a system-wide organizational problem rather than a problem confined to the emergency unit.

### *4.3 When financial information is not convincing enough*

The division manager with budget responsibility uses financial information in meetings with representatives from other units to demonstrate the problems that crowding at the ER creates. The operating manager also turns to the management accounting system to raise awareness of the seriousness of the problems at the ER. However, the operating manager uses efficiency and quality measures instead of solely relying on financial accounting information to convince other units of the problems at the ER. In doing so, the operating manager broadens the accounting representations used to communicate the consequences of crowding. Rather than relying exclusively on budgets and financial reports, patient flow measures and patient safety information become additional means through which the problem is rendered visible and actionable.

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> What we're working on now is this: How does the shortage of care spaces [at other units] affect our patients? We continue to support others with information. That's what we can do. We conduct patient safety reviews. We get support from chief medical officers to examine how patients are affected, because, as I said, we don't have money.

The quote illustrates how managers supplement financial accounting information with measures related to patient flow and patient safety when attempting to influence organizational decision-making. In this way, crowding is increasingly framed not only as a resource problem but also as a problem affecting the quality and appropriateness of care delivered to patients. The operating manager continues:

> The chief physician, responsible for the systematic work on patient safety, has been here interviewing patients. We use that material to demonstrate to division management and neighboring units: "This is how your patients are affected, and this is the throughput time for patients who should have been admitted to an inpatient ward rather than remaining at the ER."

The problem of crowding at the emergency unit is not only described in clinical or organizational terms, but increasingly through accounting practices that combine financial, operational and patient safety information. Managers and controllers draw on numbers, budgets, throughput measures and patient safety reports to make the consequences of crowding visible and to influence decision-making across organizational boundaries. Through these representations, crowding becomes framed not only as a local operational challenge but as a broader organizational problem affecting both resource utilization and the quality of care delivered to patients. Accounting practices thus contribute to redefining crowding as a system-wide issue that requires organizational rather than solely local responses. Despite the efforts to convince other units to admit more patients, the situation shows little improvement, and the national goal of admitting patients to a ward within 4 h is seldom met. To solve some of the problems, new solutions within the ER's scope are developed.

### *4.4 Redistributions of resources into new care spaces*

The lack of care spaces at the hospital has spurred ideas and initiatives aiming to improve the outflow of patients from the ER. According to one of the managers at the emergency unit, the shortage of care spaces in other wards is mainly related to a persistent lack of nurses. The unit manager calls for greater innovation in the hospital wards and emphasizes the need for top regional management to take responsibility for improving the situation. Rather than viewing crowding solely as a consequence of insufficient resources, managers increasingly frame it as a problem requiring new organizational arrangements. In this process, accounting becomes implicated in identifying possible solutions by linking patient flow, resource utilization and organizational responsibilities.

> I wish the same requirements [not to reduce the number of care spaces at a ward if someone from the personnel calls in sick, as at the emergency room] were imposed from above on the hospital wards as well. Just because someone is sick doesn't mean it's not solvable. That should force new thinking!

An initiative to open a short-stay ward for patients who need less than a day of observation, for example after an allergic reaction or a slight concussion, is seen as a solution to improve the crowding of patients at the emergency unit. The operating manager describes the initiative:

> We've applied for "close care" funding for these care spaces, and it's also something patient-centered; many patients receive better care there than in the emergency room. And it's still considered outpatient care [patients that receive care outside hospital admission], so it technically falls within our assignment. The costs of providing inpatient care should burden the ward, and they partly do, but not fully. So that's something I escalate to my boss, who escalates it further. It has to go up to the division level, and it affects another division too, so it needs to reach the division managers and the region's chief financial officer.

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The quote illustrates how the proposed solution is negotiated through accounting practices related to funding, resource allocation and organizational responsibilities. Rather than simply requesting additional resources, managers seek to reorganize existing resources by creating a new form of care provision that falls within the emergency unit's mandate while simultaneously improving patient flow. Funding was applied for and granted by a national initiative aiming to support transitions to close care. Many of the interviewees in this study noted that the short-stay ward would likely never have been established if the number of care spaces had been sufficient to accommodate the number of patients referred from the ER. The short-stay ward can therefore be understood as more than a practical response to crowding. It represents a new organizational arrangement that emerged through ongoing efforts to make resource scarcity, patient flow, and care quality visible and actionable. Through accounting practices, crowding was increasingly framed as a problem requiring organizational intervention, ultimately contributing to the creation of a new care structure. One of the unit managers at the ER explains that the short-stay ward serves a compensatory function and cannot fully meet the needs of patients requiring more advanced and specialized care, such as elderly patients with multiple comorbidities or those in need of surgery.

The short-stay ward solves some of the most urgent problems related to crowding. However, it does not incentivize other units to address the problem. On the contrary, it may reduce the perceived urgency among hospital wards to open additional care spaces. While the initiative improves patient flow and creates a temporary balance between resource constraints and care needs, it does not eliminate the structural conditions that initially produced crowding. This remains an ongoing struggle.

## 5. Discussion

The findings of this study suggest that accounting in healthcare not only supports financial control but also contributes to shaping how resource scarcity is understood and addressed. In this discussion, we argue that accounting operates along three interrelated dimensions: as a means of addressing managerial challenges, as a mechanism for reframing organizational problems and as a material-discursive practice through which organizational realities are constituted and reconfigured. By drawing on these dimensions, we show how accounting actively shapes priorities, decision-making, accountability relations and the organization of care.

### *5.1 Accounting as problem solving*

Our case study of RH, where there's a consistent lack of care spaces at the hospital, illustrates a setting where there is a scarcity of resources across the entire healthcare system. The ER at the hospital is the weak link in the system, where the scarcity is embodied as long waiting times and crowding at the ER. The case shows that the trade-off between delivering cost-efficient and high-quality care is still present in the process of delivering healthcare. Rather than resolving this tension, accounting enables managers to make it visible and navigate the competing demands for cost-efficiency and high-quality care. This suggests that Kurunmäki's (1999) skepticism toward market logic as a mechanism to resolve problems in the management of healthcare remains valid over 25 years later. However, managers and healthcare professionals still find their way around problems stemming from such a view. Despite a rhetoric of various actors (i.e. healthcare managers, controllers and financial managers) that accounting is troublesome in managing healthcare due to its way of separating units and creating suboptimizations, managers engage in accounting as a way to find new and innovative solutions to the crowding at the emergency unit. Instead of (unrealistically) asking for more resources, they muddle through to find alternative ways to handle issues at hand when they collectively engage with accounting practices and representations and relate them to their problems of managing patient flows. For example, their engagement with accounting becomes

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a way to diagnose bottlenecks in patient flow, highlight mismatches between responsibility and capacity, and outline concrete solutions to reduce patient crowding. Even if accounting partakes in creating the problem (e.g. Gebreiter and Ferry, 2016), accounting is also viewed as the potential solution for managing patient flows and resource allocation. Therefore, we argue in line with Revellino and Mouritsen (2015) that accounting is performative insofar as it draws actors into problem-solving processes and encourages new forms of organizational action. In our case, this is illustrated by how accounting practices contribute to the development of a short-stay ward as a response to crowding and resource scarcity.

Nyland and Pettersen (2004) reported that clinicians in a Norwegian hospital largely disregarded budget information, resulting in a loose connection between accounting representations and clinical action. If accounting is understood as a functional technology for cost control that creates organizational boundaries with the implication of suboptimization and deficient lateral organizing (Nyland *et al.*, 2017), then management of daily activities becomes blurred, and solutions might become counterproductive. Martinussen and Magnussen's (2011) study also demonstrates how healthcare professionals refrained from adopting accounting techniques in the operational parts of the healthcare organization. However, this paper shows that managers who engage in accounting may benefit when they build their reasoning on accounting to raise awareness of their problems in delivering high-quality healthcare.

It may be too simplified to assume that people are all too constrained by accounting, and that it causes them to be perplexed when facing problems. As Llewellyn (2001) argues, people (managers) can handle simultaneously residing in dual positions. The problem is not the separation of a process into units *per se*, but the logic of units happens to stand in the way of the sought solution to managing the flow of patients. Managers come across as having a conscious relationship with the budget (cf. Hopwood, 1972), yet not solemnly so as they reveal stress for "red" accounting numbers, that is, when expenses are exceeded. The logic of separating a process into units, like silos disrupting flow, hinders managers' solutions in this case. The reliance on accounting information does not always lead to systemic change. Instead, it can reinforce siloed thinking and short-term redistribution of resources (Kastberg and Siverbo, 2016), while the problems with crowding remain unsolved. The controller who sees the hospital as a "whole," brings another perspective, one that acknowledges the "construct" of accounting numbers (Chua, 1995). Even from this perspective, problems are, however, not solved, but rather reframed, opening up new organizational responses while leaving the underlying conditions of scarcity largely intact.

### *5.2 Reframing accounting's role in managing patient flow*

Accounting is powerful in its framing (Hoque *et al.*, 2022), as it provides representations that can be persuasive because of their illustrative effects. The interaction of inflow, throughput and outflow reflects a process perspective and a clinical logic of patient flows that generally is framed as conflicting with the hospital's vertical organizational and accounting (budgetary) structures. The case of the emergency unit illustrates how accounting information is mobilized not only to track performance but also to negotiate responsibilities and resources across organizational boundaries. While numbers, budgets and patient safety reports provide legitimacy to managers' concerns, they do not resolve the structural tensions inherent in the healthcare system. Instead, they risk reinforcing fragmented accountability, where units protect their own budgets while patients remain stuck in the ER. This can even lead to unintended consequences such as masking systemic shortages and reducing pressure for broader reforms. This raises important questions about how management accounting systems can be aligned with patient flows, rather than organizational silos, to support both financial decision-making and patient safety.

Le Theule *et al.* (2023) critically claim that it is no longer a practice of finding the necessary resources for care, but to find a way to allocate scarce resources. Healthcare thus becomes

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characterized as a setting where scarcity is naturalized, causing systemic problems of cost and care trade-offs. This is something neither the managers nor the controllers can solve in the short run (and they are aware of it) due to the political dimension and its institutionalized norm. However, they can acknowledge it and seek reframing, as "death" disrupts accounting (Le Theule *et al.*, 2023). Such reframing highlights the performative role of accounting by showing how organizational actors reconstruct organizational realities through accounting. Through budgets, patient flow measures, waiting-time statistics and patient safety reports, crowding becomes framed as a system-wide organizational problem rather than a localized operational challenge. In this way, accounting contributes not only to making scarcity visible but also to shaping how responsibilities are allocated and which organizational responses become possible.

Accounting in established NPM settings is contradictory. On one hand, accounting is disrupting the process of delivering healthcare, and on the other hand, accounting enables management of flow by providing directions for action. By reframing accounting, it gives managers agency to make problems visible, negotiate responsibilities and craft temporary solutions. Despite a generally critical stance with both managers and controllers concerning accounting "silos," all relied on accounting in their framing of problems, but also for the solutions that they deemed viable. Thus, accounting has performative consequences for allocating scarce resources.

### *5.3 Accounting as a material-discursive practice*

By adopting the theoretical lens of accounting as a material-discursive practice (Vosselman, 2022), we argue that rather than merely making inefficiencies visible, accounting participates in constituting crowding as a system-wide problem and enables new reconfigurations of care provision. In this case, a situation of scarcity is expressed as a limited capacity of less than 180 care spaces, which is subsequently translated into the problem of crowding. Through accounting such as throughput measures, waiting-time statistics, cost allocations and patient safety reports, crowding becomes rendered visible and actionable across organizational boundaries. Because healthcare professionals cannot directly control patient inflow, accounting increasingly directs attention toward organizational arrangements capable of improving throughput and patient outflow. The situation is critical both for the patients and the healthcare professionals, and through accounting, managers can visualize the problem of crowding and reframe the problem into an alternative solution of a new ward within the emergency unit. The introduction of the new ward can thus be understood as a material effect of accounting (Yu and Huber, 2023), where accounting not only represents reality but actively reconfigures accountability relations and reshapes the mandate of the emergency unit facing systemic crowding. Rather than merely describing scarcity, accounting participates in materializing a new organizational arrangement through which scarcity is managed, and patient flow is reorganized. Through the interplay of problematization and the reframing of accounting as part of the solution, new organizational arrangements materialize, which in turn generate performative effects. These effects constitute a material-discursive practice in which discourses such as scarcity, crowding and patient safety become entangled with material arrangements such as care spaces, patient flow measures, budgets and the short-stay ward, jointly reconfiguring the organization. Taken together, our case is an example of the multiplying effect of performativity, adding to the few studies illustrating how multiplicity is coordinated by the use of accounting (Firtin and Karlsson, 2020; Yu and Huber, 2023; Firtin, 2024).

## 6. Conclusions, limitations and suggestions for future research

This paper draws on a qualitative case study to examine the performative role of accounting in addressing resource scarcity and coordinating financial control and patient flow in healthcare

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organizations. We show how accounting, rather than merely reinforcing budgetary silos or constraining professional work, becomes performative as managers construct problems, elevate concerns and negotiate redistributions of scarce resources. In doing so, the study demonstrates how accounting shapes organizational action and enables temporary, flow-oriented responses to systemic challenges associated with delivering cost-efficient and high-quality care. Rather than resolving resource scarcity, accounting contributes to making it actionable and to materializing new organizational arrangements through which scarcity is managed.

The paper contributes to current literature by empirically illustrating how accounting not only creates tensions between financial control and patient flow but also becomes mobilized by managers to make problems visible and negotiate the redistribution of scarce resources in healthcare organizations. It further demonstrates how managers engage with accounting to address systemic problems of resource scarcity, showing how accounting has become embodied in healthcare operations and professional work in established NPM settings, rather than refraining from it (Martinussen and Magnussen, 2011; Malmmose and Liboriussen, 2025). In doing so, this paper extends recent research within public sector accounting (e.g. Sjögren and Fernler, 2019; Firtin and Karlsson, 2020; Almqvist and Wällstedt, 2025). Conceptually, the study advances the literature on performativity by specifying the performative role of accounting through three interrelated dimensions: problem constitution, the redistribution of accountability and organizational materialization. By showing how these dimensions jointly shape what constitutes the problem, who is held accountable and which organizational responses materialize, the study provides greater conceptual clarity regarding how accounting becomes performative in practice and what, specifically, it brings into being (Yu and Huber, 2023).

Despite these contributions, this study is subject to some limitations. First, as a qualitative single-case study, the findings are analytically rather than statistically generalizable, and the insights should therefore be interpreted in light of the specific organizational and institutional context in which the study is situated. Second, the empirical material primarily captures managerial perspectives, which may underrepresent how accounting practices are experienced and mobilized by other professional groups from the operational core. Third, the study focuses on a particular set of practices related to resource scarcity and patient flow, which means that other uses and effects of accounting in healthcare organizations may fall outside the scope of this analysis. Finally, while the study addresses the performative role of accounting, it captures these dynamics at a particular point in time and does not fully account for how such practices evolve longitudinally.

We end this paper by suggesting two directions for future research. As accounting plays a central role in managing resources, we start with one direction that takes departure in a recent political and policy debate proposing increased state governance, implying a stronger focus on managerial control, accountability and efficient use of resources. This raises concerns about how political decisions at the state level are implicated in the daily operations of providing high-quality care at the organizational level.

The second direction for future research is to encourage research examining the everyday micro-practices through which managers and healthcare professionals integrate accounting into their clinical and operational decision-making. Such studies could further unpack and explain how accounting influences healthcare professionals' work and the formation of new roles at the intersection of managerial and clinical logics.

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