



The interplay between ideological control and formal management control systems – A case study of a non-governmental organisation



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ABSTRACT

In this study we explore organisational ideology as an important dimension of management control systems (MCS). Through a case study of a health centre operating as an NGO we found that the ability of 'ideological talk' to emphasise the organisation's uniqueness and importance gave the manager a powerful instrument of control. Ideological control was also key to explaining the limited resistance to the implementation of financially oriented formal MCS. We contribute by detailing an important, yet still insufficiently explored, part of this implementation process, namely that the formal MCS, through the interplay with the predominant ideological control in place, became vested with symbolic significance. Thus, our findings show that the production of 'concurrent visibility' can be sought both through the design of formal MCS (as suggested by Chenhall, Hall, & Smith, 2013) and through the use of ideological control (as in our case). Our results also suggest the need to distinguish between professional and organisational identity when analysing MCS in health care organisations and NGOs.

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1. Introduction

In this study we explore organisational ideology as an important, yet still insufficiently explored, dimension of management control systems (MCS). Organisational ideology is defined as an over-arching idea-system that provides the fundamental justification and legitimation for what it would have employees believe is an established order (Czarniawska-Joerges, 1988; Thompson, 1980). The MCS literature has long recognised the importance of culture, clan controls and belief systems (Ahrens & Mollona, 2007; Dent, 1991; Efferin & Hopper, 2007; Ouchi, 1979; Simons, 1995), but has paid little attention to how managers use ideological control to indirectly govern employee behaviour by controlling their underlying experience, thoughts and feelings. Ideological control concerns managers' use of

rituals and symbols, and their verbal communication of the organisational ideology, through which they target employees' beliefs, emotions and values (Alvesson & Kärreman, 2004; Czarniawska-Joerges, 1988; Etzioni, 1975; Kunda, 1992).

Ideological control should be brought to the fore because it is often found that religious organisations, hospitals and non-governmental organisations (NGOs) have a significant proportion of employees whose commitment is primarily moral (Etzioni, 1964). Etzioni (1961, 1964, 1975) denotes such organisations 'normative organisations' and argues that ideological control is especially significant here. However, as stressed by Etzioni (1975, p. 6, 40–54), even in organisations where ideological control is predominant, certain elements of formal MCS have been established. The overall purpose of this study is to give a grounded account of ideological control and its interplay with formal MCS in normative organisations. We investigate MediOrg, a small religiously affiliated health centre operating as an NGO in rural India.

We also take up the related key issue of how a high level of compliance to formal MCS initiatives is achieved, including

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employees accepting increased use of MCS associated with an intrusion of economic rationality on work practices. The more micro-oriented¹ accounting literature on health care organisations and NGOs has, in the main, focused on resistance to formal MCS (Broadbent, Jacobs, & Laughlin, 2001; Dixon, Ritchie, & Siwale, 2006; Goddard & Assad, 2006; Jones & Dewing, 1997; Kurunmäki, 1999), without paying much attention to compliance. Specifically, we address how managers in normative organisations can use ideological control to achieve a high level of compliance among employees when implementing formal MCS. We examine the implementation and reception of behavioural controls at MediOrg that heralded and promoted a more financially oriented agenda.

Our study contributes to the MCS literature in a number of ways. First, a focus on ideological control is consistent with the emerging accounting research on the “expressive dimensions” of organisational life (e.g., Ahrens & Mollona, 2007; Boedker & Chua, 2013; Chenhall et al., *in press*). However, while this literature has analysed, for instance, the influence of subcultures on formal MCS and how formal MCS play an active role in values expression, less interest has been shown in how managers use organisational ideology to enact a particular form of experience for their employees and to create a highly valued sense of purpose. We found that it is mainly through ‘ideological talk’ in face-to-face contact between the manager and the employees that ideological control assumes specific significance in organisations. The ability of ‘ideological talk’ to emphasise MediOrg’s unique worth gave the manager a powerful instrument of control as it created characteristics of MediOrg that the employees perceived to be central, distinctive and enduring. Second, the use of ideological control and its creation of a strong and articulated organisational identity was of value to explain the absence of any resistance to the implementation of financially oriented formal MCS. Accounting scholarship has provided valuable knowledge of how the design characteristics and the implementation process of formal MCS can help to explain compliance (e.g., Ahrens & Chapman, 2004; Jordan & Messner, 2012; Wouters & Wilderom, 2008). We contribute by detailing a novel part of this implementation process, namely that a strong predominantly ideological control system was significant for how employees perceived the implementation of the formal MCS. Through the interplay with the predominant ideological control in place, the formal MCS became vested with symbolic significance. Third, Chenhall, Hall and Smith (2013) found that compliance increased when formal MCS were designed to produce ‘concurrent visibilities’ such that different evaluative principles of organisational actors were made visible. Our findings suggest that compromise between multiple values can be sought both through

the design of formal MCS (as in Chenhall et al., 2013) and through the use of ideological control, vesting the formal MCS with symbolic significance (as in our case). We also conclude that too much concurrent visibility might be problematic. In situations of apparent resource insufficiency, a limit is introduced on what can be accounted for by means of rational argumentation (c.f., Cho, Laine, Roberts, & Rodrigue, 2015; Messner, 2009). Open discussions may result in too much concurrent visibility, imposing an ethical burden on employees, who need to decide on something that they find difficult, or even impossible, to rationalise.

We also contribute to two related, yet distinct, empirical domains: management control in NGOs (e.g., Chenhall, Hall, & Smith, 2010; Chenhall et al., 2013, *in press*; O’Dwyer and Unerman, 2008), and management control in health care organisations (e.g., Kurunmäki, 1999, 2004; Jones & Dewing, 1997). Less developed countries such as India, where our case organisation MediOrg operates, often have neither the economy nor the capability to provide adequate public healthcare to their population (Banerjee, Glennerster & Duflo, 2008). As a result, the provision of healthcare services in such countries is often taken care of by NGOs. The existing literature has demonstrated that tensions exist in NGOs between financial ideals, namely the pressure to balance budgets and meet the reporting requirements from the various funders, and the employees’ ethos to the social mission (e.g., Chenhall et al., 2010, 2013; Dixon et al., 2006; O’Dwyer and Unerman, 2008). However, accounting research on NGOs has mainly focused on ‘upward’ accountability to funders (Goddard & Assad, 2006; Hopper, Tsamenyi, Uddin, & Wickramasinghe, 2009; Hopwood, 2005; Unerman & O’Dwyer, 2006), paying relatively little attention to the use of ideological control and formal MCS in these NGOs. Our findings suggest that in spite of heavy intrusion of economic rationality on work practices, MediOrg did not appear to have lost its organisational identity. Thus, while recognising the role of formal MCS to manage the tensions between financial and social ideals in NGOs that has been documented in previous research, our findings reveal a more complex picture involving ideological control, formal MCS, moral considerations and spiritual leadership. These dimensions need to be taken into account when analysing how management control can help NGOs attract funding, while maintaining their identity.

Management control in health care organisations has primarily analysed the interplay between financial pressures and professional ideals in health centres and hospitals (e.g., Kurunmäki, 1999, 2004). Medical staff who had worked in direct contact with patients and had acquired many of the tools of management accounting acknowledged that economic reasoning could influence their decisions and the actions they took (e.g., Jacobs, 1998; Kurunmäki, Lapsley, & Melia, 2003; Kurunmäki, 1999, 2004). However, the majority of the studies highlight the importance of professional autonomy, where decisions concerning which patients to admit, how to examine and treat them, and how long to keep them in hospital were taken by the front-line healthcare professionals based on patient well-being, independent of financial concerns (Jones & Dewing, 1997; Nyland & Pettersen, 2004). Attempts to limit the professional autonomy of the doctors and nurses and increase the emphasis on economic reasoning have encountered strong opposition (Jones & Dewing, 1997; Lapsley, 2008), but these studies are mainly based on findings from ‘Western’ hospitals and health centres. Thus, studying the operation of a health centre in rural India, one of the world’s poorest countries, therefore offers the potential for new insights into the role of management control in health care organisations. More specifically, our findings suggest a need to distinguish between professional and organisational identity (see, Empson, 2004). Previous studies of health care organisations have focused on

¹ We acknowledge that there are studies within the domains of accounting and health care (e.g., Lewellyn & Northcott, 2005; Preston, Chua, & Neu, 1997) and accounting and NGOs (e.g., Neu, Everett, & Rahaman, 2009; Rahaman, Everett, & Neu, 2007, 2010) which have demonstrated how accounting calculations and techniques come to constitute or transform these organisations. These studies, inspired by Miller and Rose (1990, 1993, 1994; Rose & Miller, 1992) scholarship, mainly draw on the Foucauldian notion of governmentality and theorise accounting as a technology of government that is linked to wider socio-political objectives (c.f., Preston et al., 1997). As stressed by Miller and Rose (1990), governmentality studies have a programmatic character with an important focus of analysis being on political power, i.e., the way in which the state and other social actors, such as the World Bank, increasingly appear to act on and intervene in the lives of organisations and individuals. In these studies, less attention was paid to detailed accounts of the internal workings of specific health care organisations and NGOs, in particular where formal MCS initiatives from the managers were concerned, and the eventual compliance or resistance of the employees to initiatives. This is where the emphasis of the present study is laid, so our research adopts a more micro-oriented approach than those of Lewellyn and Northcott (2005), Preston et al. (1997), Neu et al. (2009), and Rahaman et al. (2007, 2010).

professional identity, which has meant that organisational identity has tended to be treated as being subsidiary to, or conflated with, professional identity. In contrast, our study shows that professional and organisational identity coexist in a complex relationship. MediOrg doctors and nurses seemed to share a basic understanding of what it meant to be a professional, but the way in which they translated this understanding into practice was influenced by the organisational identity.

In the next section we discuss Etzioni's compliance theory and related accounting research to specify analytically its implications for the understanding of the interplay between ideological control and formal MCS. This leads to a section on research methods. Section four then presents the case analysis, starting with a description of the Indian healthcare climate and the setting for the case organisation. This is followed by an analysis of ideological control and formal MCS in MediOrg during a period in which the reporting requirements were tightened in connection with changes in the way in which funding was obtained. Finally, the discussion and conclusions are presented, along with some suggestions for further research.

2. Theoretical development

2.1. Etzioni's compliance theory

Our theoretical understanding of the interplay between ideological control and formal MCS has its roots in Etzioni's compliance theory (Etzioni, 1961, 1964, 1975). Etzioni classifies organisations on the basis of the nature of their compliance. For him (Etzioni, 1975, p. xv): "Compliance is a relationship consisting of the power employed by superiors to control subordinates and the orientation of the subordinates to this power." In this way, Etzioni combines a structural and a motivational aspect of management control: structural because he is concerned with the kinds and distribution of control in organisations; motivational, because he is concerned with the various commitments of employees to organisations.²

Etzioni proposes three analytical categories: The first is the type of control used by managers to make employees comply. One target of control can be behaviour (through formal MCS) or world-view (through ideological control) (Etzioni, 1961, 1975).³ The category formal MCS refers to attempts to directly control employee behaviour through output control, such as key performance indicators and reward systems, and behavioural control, such as rules

and written guidelines (Etzioni, 1975). Ideological control, in contrast, refers to attempts to govern employee behaviour indirectly by controlling the underlying experience, thoughts and feelings guiding employees' behaviour (Etzioni, 1964, 1975). Ideological control rests on the encouragement of esteem, verbal communication of the organisational ideology, and the use of ceremonies and ritualistic symbols (Alvesson & Kärreman, 2004; Etzioni, 1975). Etzioni (1975, pp. 40–54) argues that most organisations use both ideological control and formal MCS, but the degree to which they rely on each differs from organisation to organisation.

The second analytical category relates to the place and role of leadership in organisations. The power to control other members of an organisation is associated with specific positions (top manager) and personality (being persuasive). Actors whose power is derived mainly from their position in the organisation are called officers (Etzioni, 1964). Actors who have personal, but not official, power over subordinates are referred to as informal leaders. Actors with formal and personal power over their subordinates are called formal leaders (Etzioni, 1964).

The third analytical category concerns involvement, i.e. the attitude of the employees towards the organisation. The intensity of involvement ranges from high to low and can be either positive or negative. Etzioni (1975) refers to positive involvement as commitment and negative involvement as alienation. Accordingly, employees can be placed on an involvement continuum that ranges from a highly intense negative zone through mild negative and mild positive ones to a highly positive zone.

Applying these three analytical categories, Etzioni labels organisations such as MediOrg, i.e., a religiously affiliated NGO, *normative organisations*.⁴ Normative organisations are those in which ideological control is the major source of influence over the employees. The employees exhibit moral commitment and there tend to be few officials or informal leaders (Etzioni, 1961). Formal leaders effectively control the employees. Table 1 summarises the main characteristics of normative organisations.

In the following, we provide a theoretical discussion of ideological control and its interplay with formal MCS in normative organisations based on Etzioni's three analytical categories and related accounting research. We also discuss how ideological control can create compliance when implementing formal MCS.

2.2. Compliance theory and its implications for studying the interplay between ideological control and formal MCS in normative organisations

A focus on ideological control is consistent with emerging accounting research on the "expressive dimensions" of organisational life (e.g., Ahrens & Mollona, 2007; Boedker & Chua, 2013; Chenhall et al., in press; Efferin & Hopper, 2007; Ezzamel, 2009; Jacobs & Walker, 2004; Quattrone, 2004). This literature has focused on the influence of subcultures on formal MCS (e.g., Ahrens & Mollona, 2007), on how formal MCS is a means through which employees' levels of engagement and emotions can be moulded and managed (e.g., Boedker & Chua, 2013), and on how formal MCS can be used to express the values and beliefs of organisational members (Chenhall et al., in press). However less interest has been shown in how managers use ideological control to enact a particular form of organisational experience for their employees and to create a

² Etzioni (1964, ch. 3–5) posits his compliance theory as a way to study organisations that synthesise the formal (ideal-typical) approach of Weber and the less formal (subjective) approach of Human Relations researchers (e.g., Elton Mayo and Kurt Lewin). Central to Etzioni's ideas is the organisational dilemma that the inevitable strains can be reduced, but not eliminated, between organisational and personal needs, between discipline and autonomy, and between formal and informal relations (see also Sciulli, 2011). Etzioni has been criticised for structural-functionalism (e.g., Prideaux, 2005, ch. 3), but this critique refers, as noted by Etzioni (2005) in his response, mainly to his later (more macro-theory oriented) work on communitarian movement. Etzioni (2005) stresses that his early (more micro-oriented) work on compliance is not at all structural-functionalistic, being rather a middle-range theory designed to facilitate the empirical study of organisations. For the purpose of this study, it is important to note that Etzioni's early work focuses on the major bases of compliance within organisations; that is, on the ways in which leaders establish and maintain order and the effectiveness of the response this elicits from the employees. These are issues of relevance for analysing management control, and as such Etzioni's compliance theory is especially apt when analysing the interplay between ideological control and formal MCS in normative organisations.

³ Etzioni uses the terms 'utilitarian control' and 'normative control' instead of formal MCS and ideological control. However, since formal MCS and ideological control are terms commonly referred to in the accounting literature, we use the latter throughout the paper.

⁴ Etzioni also discusses two other types of organisations: utilitarian and coercive. Utilitarian organisations are ones in which formal MCS are dominant. In coercive organisations, such as a prison or a custodian mental hospital, control is applied through physical means, for instance through the use of a lock.

Table 1

The characteristics of normative organisations.

	Normative organisations
Predominant type of control used	Ideological control – managers target behaviour indirectly (e.g., verbal communication of ideology, rituals and use of various symbols)
Type of leadership	Formal leaders effectively control the employees
Involvement	Moral commitment (i.e., commitment at a high level)

highly valued sense of purpose for the organisation (c.f., Etzioni, 1975).

2.2.1. Leadership and ‘ideological talk’

Etzioni (1975) emphasises the importance of leadership when analysing ideological control. Leadership is defined (Etzioni, 1965, pp. 690–691) as: “the ability, based on the personal qualities of the leader, to elicit the followers’ voluntary compliance in a broad range of matters. Leadership is distinguished from the concept of power in that it entails influence, that is, change of preferences, while power implies only that subjects’ preferences are held in abeyance”. Although the role of leaders has received considerable attention in the management literature, it has, as noted by Abernethy, Bouwens, and van Lent (2010), largely been neglected in research on MCS. But as stressed by Etzioni (1961, p. 59), the use of ideological control largely depends on the ability of the leader to articulate and communicate the ideology for the organisation. Thus, in addition to rituals and symbolic devices, verbal communication is an integral part of ideological control. Accounting scholars have long argued that the relevance of formal MCS in organisations is dependent on how managers use such information in verbal communications (e.g., Ahrens, 1997; Carlsson-Wall et al., in press; Englund & Gerdin, 2015; Hall, 2010; Jönsson, 1998). As stated by Hall (2010, p. 302):

‘It is primarily through talk rather than through written reports that accounting information becomes implicated in managerial work. In particular, verbal forms of communication allow managers to tailor accounting information to specific operational concerns, and provide a context to debate and discuss the meanings and implications of accounting data.’

In studying management control within two British and German breweries, Ahrens (1997) found the particular functioning of formal MCS was crucially linked to the manner of talk as this had the ability to make concepts meaningful to organisational members in their everyday work. The literature on ‘accounting talk’ has established that accounting information is made to work through discussion. However, limited attention has been given to different forms of verbal communication (see, Carlsson-Wall et al., in press). In this study, we argue that it is mainly through ‘ideological talk’ in face-to-face contact between the leader and the employees that ideological control assumes its specific significance in organisations (c.f., Czarniawska-Joerges & Joerges, 1988; Gioia, Thomas, Clark, & Chittipeddi, 1994). ‘Ideological talk’ allows managers to help their employees to envisage how their work fits into the idealised vision of the organisation. The ability of ‘ideological talk’ to categorise the world verbally and to emphasise the organisation’s uniqueness and importance gives managers a powerful instrument of control (Czarniawska-Joerges & Joerges, 1988).

2.2.2. Resistance or compliance – the interplay between ideological control and formal MCS

While ideological control is assumed to be the predominant form of control in normative organisations, Etzioni (1961, 1964, 1975) stresses that these organisations probably also employ

some formal MCS. Thus, the two types of control coexist creating a complex management control structure (see, e.g., Alvesson & Kärreman, 2004; Kunda, 1992, for similar points). As he pointed out (Etzioni, 1964, p. 64), formal leaders in normative organisations therefore often use a combination of formal and ideological control, even though ideological control is often dominant. Later he developed this argument and elaborated on the importance of investigating the predominant control in tandem with the less dominant form of control, which he refers to as (Etzioni, 1975, p. 6, 40–54) “the secondary source of control”. Following Etzioni (1975), we therefore propose that the role and relevance attributed to formal MCS by the employees is likely to be related to the predominant ideological control in place, as the ideological control may vest formal MCS with symbolic meanings. This has important analytical implications for our understanding of compliance and the absence of resistance towards the implementation of formal MCS.

Previous research on this topic has, in the main, analysed how and why employees resist the implementation of formal MCS. Lapsley (2008) noted that, given the robust nature of public sector professions, moves to increase the use of accounting will encounter strong opposition. Field studies have shown strong resistance amongst staff when formal MCS are introduced within the public sector, examples being in health and medical care (e.g., Kurunmäki et al., 2003), schools (e.g., Broadbent & Laughlin, 1998), the police (e.g., Hoque, Arends, & Alexander, 2004), the social services (e.g., Carlsson-Wall, Kraus, & Lind, 2011; Kraus, 2012; Llewellyn, 1998), cultural and historical organisations (e.g., Oakes, Townley, & Cooper, 1998), and NGOs (e.g., Chenhall et al., 2010; Dixon et al., 2006; Goddard & Assad, 2006), where the employees valued their autonomy and prioritised making professional judgements in their client interests over financial concerns. For instance, Kurunmäki (1999, p. 122), studying three Finish hospitals, found a continuous struggle for power and control between those advocating professionally oriented and financially oriented ideals. Other research indicates resistance towards formal MCS with individual or groups of workers, comprised of e.g., senior doctors, absorbing the impact of change by shouldering the burden of formal MCS initiatives so that the core activities can continue unhindered (Broadbent et al., 2001; Broadbent & Laughlin, 1998; Jacobs, 2005).

However, recent research has started to analyse why employees in organisations do not resist MCS initiatives. As Boedker and Chua (2013, p. 264) commented: “... throughout our study, we observed a notable dimension that characterised the case study organisation, namely the compliance of Australian actors to relationships with corporate executives ... our paper indicates that forms of resistance were mostly absent”. Their explanation of the compliance related to formal MCS being able to stimulate enthusiasm, hope, nervousness and anxiety all at the same time. They coined the term “happy slave syndrome” in that managers skillfully used formal MCS to appeal to people’s pride, the prospect of fame in the public press and the threat of loss of market leadership (Boedker & Chua, 2013). Other studies, using the enabling and coercive dichotomy of Adler and Borys (1996), have found that attention to the design characteristics and the design and implementation process of formal MCS can help explain compliance in organisations (e.g., Ahrens & Chapman,

2004; Chenhall et al., 2010; Englund & Gerdin, 2015; Jordan & Messner, 2012; Jørgensen & Messner, 2009; Wouters & Wilderom, 2008). Chenhall et al. (2010), studying an Australian welfare provision NGO, concluded that formal MCS that were transparent, flexible and provided details of interdependencies between specific programmes and other parts of the NGO's operations were met with little resistance, while formal MCS designed with less transparency and flexibility were resisted. On a related note, Chenhall et al. (2013), studying a non-governmental international development organisation, found that compliance increased when formal MCS were designed to produce 'concurrent visibilities' such that different evaluative principles of organisational actors were made visible. Within this context, our study is complementary and contributes to the literature by proposing that compliance can also be related to how formal MCS are linked to ideological control. In relation to Etzioni's concept of involvement, employees in normative organisations tend to have an intensive commitment to the organisation's ideology. As emphasised by Etzioni (1975), ideological control can be used to accomplish change, and not just to maintain a status quo (c.f., Czarniawska-Joerges, 1988). A well-defined, clearly differentiated and widely shared organisational ideology can provide a focus for employee identification in a difficult situation and enhance commitment (Etzioni, 1964).

To summarise, this discussion has highlighted the potential in analysing the interplay between ideological control and formal MCS in normative organisations. In the following, a field study of MediOrg, a small health centre operating as an NGO in rural India, is analysed to explore these issues. But first, the research methods are presented.

3. Research methods

This research took the form of an exploratory case study of MediOrg, a health centre located in rural India.⁵ The area in which MediOrg operates is one of India's poorest and least developed in terms of infrastructure, such as roads, electricity and sewage systems. MediOrg is a small health centre with limited resources and few possibilities for specialist care. The relatively small size of the NGO provided the opportunity to observe the daily work at both managerial and operational levels, and the use of ideological control and formal MCS. In their review of the literature on management control in less developed countries, Hopper et al. (2009) concluded that research has concentrated on large organisations and suggested that future studies ought to include cases from small organisations. In addition, it should be stressed that the health centre manager of MediOrg welcomed this type of investigation and facilitated field visits to many of the funders.

The data collection was conducted through a mixture of formal interviews, informal conversations, observations and the study of documentation. Two of the researchers stayed at the health centre compound for five weeks in late February to early April 2012 where they observed the everyday work and the planning and monitoring of the health centre's practices. On a daily basis, the researchers also participated in the morning ceremonies, had lunch with the health centre manager⁶ and his wife and took part in the tea-break with the employees. This was essential for developing an understanding of ideological control at MediOrg since this type of control is difficult to observe through formal interviews alone (Alvesson & Kärreman, 2004).

Two sets of formal interviews were conducted with MediOrg's management and employees, and with various funders (see Appendix). First, 19 interviews took place on site February–April 2012. Typically, these lasted between 30 and 60 min, with an average length of around 45 min. The interviews were relatively unstructured, but revolved around a few main themes: the work, MediOrg's vision, religion, in addition to which the informants' opinions on the various funders and their requirements were discussed. Many of the interviewees were new to the interview setting, so to make them more comfortable, a tape recorder was not used. Instead, one of the researchers took notes while the other conducted the interview. The open-ended interviews allowed the interview to be adapted to the interviewee and made it possible to create a conversational setting where the interviewee could feel at ease. The interview notes were transcribed following each interview.

The nature of the research process was similar to what Ahrens and Chapman (2006, p. 836) described when they said that: "Problem, theory and data influence each other throughout the research process. The process is one of iteratively seeking to generate a plausible fit between problem, theory and data." When collecting the empirical material, a broad interest in management control in NGOs guided the research. An initial analysis was made of management control in MediOrg. This first analysis indicated that we needed additional analytical concepts to interpret our data. Here Etzioni's work and the focus on ideological control came in; our analysis of field material in relation to Etzioni's compliance theory took place entirely after the data was collected (see, e.g., Ahrens & Chapman, 2004, pp. 285–286, for a similar discussion). During this analysis, we found that a second round of interviews was needed to provide more empirical depth to some of the conceptual claims made in the paper. As Ahrens and Chapman (2006, p. 836) put it: "Theory helps the author structure the masses of data and communicate its significance at the same time as it helps construct that significance." In June 2015, we therefore performed an additional nine telephone interviews with the manager, MediOrg doctors and nurses, and also with a European doctor and two European nurses who had performed five-week internships at MediOrg and a city hospital (see Appendix). The European interns could, for instance, reflect on whether they perceived any differences between MediOrg doctors and nurses and those working in the city hospital. These interviews lasted between 35 and 50 min (average around 40 min).

No formal coding programme was used for the data analysis. First, each interview transcript, the research notes from the direct observations and informal conversations and the documents were read by the researchers. Once the theoretical framing was set, the empirical material was organised and analysed using several categories. The categories initially used were: general information about MediOrg and the context in which it operates, MediOrg's funders, and Etzioni's (1975) analytical categories – ideological control and formal MCS, type of leadership and involvement. Thereafter, selective coding was used, where findings not considered to be of sufficient relevance to the study were stripped out (c.f., Efferin & Hopper, 2007). Empirical material was related to the theoretical concepts of the study to draw unique insights. Finally, the case analysis was written up where the emerging findings were compared to and contrasted with previous research to determine the insights unique to our investigation.

4. Case analysis

4.1. NGOs and healthcare in India

India is the world's second largest country by population. About

⁵ The identities of individuals, and of the organisation itself, have been disguised to preserve anonymity in accordance with our agreement with the organisation.

⁶ Henceforth simply referred to as the 'manager'.

70 percent of people were estimated to be living in rural areas (WHO, 2011). A profusion of local organisations called panchayats, structured mainly around individual caste groups, exist in these rural villages (Pur, 2007). Such caste-based local governance institutions vary from village to village, but they do have a common core agenda of upholding social norms and customs and preserving local law and order (Pur, 2007). Reflecting this, India's rural areas are defined by a relatively strict social hierarchy as the Indian caste system enforces social stratification. A great deal of social stigma and a considerable economic challenge is borne by people belonging to India's poor castes (Borooah, Dubey, & Iyer, 2007). Parallel to this, religion is important in India (Borooah, 2012). Four world religions – Hinduism, Buddhism, Jainism and Sikhism – originated here and Christianity and Islam arrived in the first millennium.

Over the last five decades India has made systematic efforts to alleviate poverty by: increasing economic growth, making direct attacks on poverty by means of targeted programmes, through land and tenancy reforms, and provision of basic services (Mehta & Shah, 2003). In spite of these efforts, according to World Bank estimates, 32 percent of the Indian population lives below the poverty line (\$1.25 per day) (World Bank, 2011). Given the size of the population, its diversity and the economic conditions, India faces a great challenge in providing healthcare to its population. India has a highly pluralistic healthcare system. The private sector accounts for more than 80 percent of total healthcare spending in India (PwC, 2007). However, private healthcare is expensive and therefore almost exclusively targets India's urban middle and upper classes. The severely poor in rural areas have very few natural, physical or financial assets and no money to pay for healthcare.

The healthcare system at the district level consists of three tiers. First, there are aid posts or subcentres. These are primary-care facilities that refer more complicated cases to the health centres, which may in turn refer patients to the third tier, the district hospitals (Banerjee et al., 2008). However, as noted by Banerjee et al. (2008), even if improvements have been seen, India's public health services often fail to deliver care to poor people in need. Government facilities are often closed and the number of skilled personnel is low. In addition, although fees in government hospitals are low, severely poor households still report sizable out-of-pocket expenditures for a visit and for the medication required. Thus, in rural India there is a great need for NGOs that can provide free healthcare for the severely poor (Berman, 1998).

NGOs have mushroomed in India since the 1980s (Waghmore, 2012), however, voluntarism has always been an integral part of Indian society and dates back to ancient times when it operated in fields such as education and medicine.⁷ Modern forms of voluntary organisations began to appear in the colonial period, primarily in the form of socio-religious organisations. Secularist development-oriented voluntary movements received their strongest impetus from Gandhi, who believed that voluntary action was the only path to India's development (Sen, 1999). During the struggle for freedom, dedicated workers from the Indian National Congress undertook rural development programmes. It is within this social and historical context that we must place the comparatively new term 'NGO' in India. Many Indians still believe in a notion of voluntarism that is essentially romantic, inspired by self-initiative and social commitment (Sen, 1999). As a result, small local NGOs such as MediOrg are often highly appreciated, especially in rural areas, whereas large NGOs are perceived locally to be less committed to social change, often employing people motivated by job prospects rather than a social mission.

4.2. MediOrg

MediOrg is part of a healthcare initiative started by a European Christian missionary church.⁸ The last missionaries from the Church left India in the mid-1990s, since then the Church has had a passive role providing financial support for MediOrg in the form of a grant. The grant is not attached to specific activities at MediOrg, instead it is intended as a general contribution to cover general medicine activities in the open clinic and the ward. As the Church's Director of the International Mission explained:

“For NGOs in India there is an increasing problem with funding since most funders like to see clear and physical results, such as a number of children vaccinated or a new operating theatre, things that can easily be translated into results. No other donors want to fund administration, even though the organisation itself has to exist.”

The Church has no specific comments on the follow-up of how the grant is used and there are no formal requirements for MediOrg to report on how the money has been spent. MediOrg has a board of trustees comprised of the Director of the International Mission and a few others from the Church, but it is a passive board. Everything that concerns MediOrg, including financial and operational responsibility, is delegated to the manager, the sole annual decision is whether the Church should continue to support MediOrg and whether the annual report should be approved.

MediOrg is situated in a small village in rural India. One of the European nurses doing a five-week internship described her first impressions as follows: “It really felt like [MediOrg] is located in the middle of nowhere. Having a health centre in such rural areas seems to be really important to help the poor.” The inhabitants are farmers and extremely poor. The health centre is located on the side of the road going through the village, which is shared by mopeds, old tractors, cows and people. A little wall surrounds the health centre compound with a gate that is locked during the night. The compound consists of one main stone building, the health centre, with rooms for open clinic general treatment and in-ward treatment of patients, an isolation room for highly contagious patients, an operations room and a lab. Behind the main building are small stone houses for guests and some of the staff and a chapel.

The manager explained that for many NGOs, especially recent ones, the most difficult task is to gain acceptance and to establish a reputation among the villagers. The informal local governance institutions, the panchayats, are powerful in the area where MediOrg operates, and they are generally suspicious of outside initiatives. However, MediOrg has been operating in the area for a long time and is well accepted by the panchayat leaders and the locals. MediOrg is not perceived to be a threat to the social norms and customs upheld by the panchayats, mostly owing to the fact that MediOrg is a Christian healthcare NGO. The local village politics are based on the caste system, related to Hinduism. For a Christian, individuals have equal worth, so at MediOrg everyone is treated the same and given access to free healthcare in the open clinic. In addition, because of its long presence in the village, MediOrg is considered trustworthy in carrying out its mission to help the severely poor gain access to healthcare. As the manager notes: “MediOrg has been well accepted for a long time and is rooted in the village, so we can wholeheartedly focus on the mission to provide good healthcare”.

All MediOrg employees, including the manager, are Indian. The

⁷ For a more thorough description of the history of NGOs in India, see Sen (1999).

⁸ Henceforth called the Church.

manager is a Christian medical doctor with long experience of healthcare provision in India. MediOrg employs three doctors and five nurses, all educated in India and Christian. In addition, there are two other types of employee: those who directly support the doctors and the nurses in their clinical work, such as a lab technician and assistant nurses, and those who provide more general support, such as counsellors, maintenance personnel, drivers and caretakers. It is not a prerequisite to be Christian to work for MediOrg and some of the staff are Hindu.

MediOrg offers daily primary healthcare to outpatients from the surrounding area, and the NGO also provides ward treatment. On average, 30 to 40 patients are treated in the open clinic and around 25 in the ward each day.⁹ One of the doctors and two nurses work in the open clinic and the two other doctors and three nurses work in the ward. From our observations of the open-clinic work, the medical staff seemed hard working, and at times overworked. Up to 40 patients for one doctor and two nurses per day is a heavy workload; during the period over which we made our observations the open clinic did not close until all patients had seen the nurse or the doctor. The doctors and nurses rotated on a weekly basis between the open clinic and the ward.

The importance of patients is stressed in MediOrg's overall goal: the prevention of diseases and promotion of health among the people in the area. The area where MediOrg is situated is one of the poorest areas in India, and consequently the majority of the patients are illiterate and have no way to pay for healthcare; MediOrg offers the only option available to them.

4.3. The previous context of MediOrg

In the past, MediOrg was fully funded by general grants from the Church and the Indian government. MediOrg had no specialisation, and the doctor working in the open clinic made all the decisions regarding treatment, including who should be admitted to the ward. Both the manager and the doctors described in-patients admitted to the ward as being the most severely ill. Priorities needed to be set, but this was done on the basis of the front-line doctor's professional judgement of patients' health. Screening patients for admission to the ward had been an important part of a doctor's work in the open clinic.

In line with previous research (e.g., Abernethy & Stoelwinder, 1995; Chenhall et al., 2010), formal MCS did not play a dominant role at MediOrg. The doctors and nurses were not involved in budgeting and the discussions between the manager and the medical personnel never addressed the financial situation: this was taken care of solely by the manager. Instead of formal MCS, ideological control was important in MediOrg, which we elaborate on next.

4.3.1. Ideological control at MediOrg

During informal conversations and interviews with the manager it was striking how he made continual reference to MediOrg's ideology of helping the severely poor and doing God's work. For instance, the manager frequently spoke about how the work of MediOrg was appreciated among the severely poor in the area. He also talked about patients who had been cured and how much that meant to them and their families. As he explained: "When we see the fruits of our work we appreciate ourselves and enjoy this as a team. There are many times we can see good fruits of our work in

the field and we enjoy that." The religious and missionary basis of MediOrg has never been mentioned in the health centre's vision, but MediOrg is "proud to present and give our Master's love, concern and care to the needy and for whoever walks into this compound" is a recurring sentence in MediOrg's annual reports. The manager stressed that running MediOrg was about more than simply providing health care:

"You must understand that MediOrg is our cause in life. To help poor people and working for the sake of God is so much more than simply providing health care. It is what gives our lives a sense of meaning."

Ideological control was also apparent in the form of an overall presence of religion, displayed through physical artefacts such as crucifixes on the walls and biblical quotes at every entrance (c.f., Etzioni, 1961). One nurse proudly explained her Christian ideals when she talked of how, through her work at the health centre, she would be safe "standing by the gates of heaven". In addition, she stressed:

"On judgment day, He [God] will see what we all have done to improve this world and help the poor people, my work is my way to show Him that I am doing good."

The most important place for exercising ideological control was the chapel. It was located just behind the main building, with sparsely decorated brick walls, large church windows and a prominent cross above the entrance. Inside the chapel, there was an altar with a cross and two candles in a large room with no benches, everyone stood during the ceremony. Men stood on one side and women on the other, with those of highest rank, i.e., doctors and nurses, in front. All employees at MediOrg seemed to have their own standing place.

The health centre is open Monday to Saturday. Every day commenced at 9.30 with a 10–15 min long ceremony in the chapel. All employees scheduled to work on a particular day participated in the service. Just before 9.30, they entered the chapel, took off their shoes and went to their respective places. At 9.30 the health centre manager entered and greeted everyone by shaking hands. Then the ceremony began, always including a prayer and the singing of a hymn. The health centre manager led the ceremony and the prayer, while the doctors, nurses and other employees, took turns to lead the singing. The health centre manager emphasised that the morning ceremony was a very important part of his idea of running MediOrg, saying: "If you want to understand MediOrg, attend the morning ceremony. We all get together and remind ourselves that we do good for the poor and work for God's sake. And that [MediOrg] is really unique." The morning service followed the same ritual every day, and had done so for "as long as we can remember", as one doctor put it. A nurse explained:

"I am a nurse, yes, but more importantly I am a [MediOrg] nurse. What other health centre or hospital starts the day with a morning ceremony? We have done so every day for more than 20 years and it is really important. [MediOrg] is really unique. We help the poor with health care and work for the sake of God. We are the only option for them [poor patients], we really make a difference."

All European interns at MediOrg and a city hospital stressed the differences between MediOrg doctors and nurses and those working in the city hospital. A recurring expression used by the MediOrg doctors and nurses was: "I am not just a doctor [/nurse], I am a

⁹ We were only allowed to observe the activities in the open clinic directly. The ward was closed for visitors, including us. Our findings are therefore mostly related to the open clinic, where the empirical material is based on both observations and interviews; any references to the ward are based on interview data alone.

[MediOrg] doctor [/nurse].” As the European doctor put it:

“It was so striking during my visit [to India]. Doctors and nurses in the city hospital were very good at their work but it seemed like “simply” work for them. When seeing and interacting with the [MediOrg] doctors and nurses I felt from day one that they were different. The work seemed to give them a much deeper meaning and they were so committed to and proud of [MediOrg]. And the morning ceremony seemed like an extremely important and special ritual for them.”

During the morning ceremonies the manager repeatedly emphasised MediOrg’s ideology and explained how this ideology made MediOrg unique in the area. He continuously positioned MediOrg vis-à-vis the private health centres where health care was very expensive. He compared MediOrg with the public health centres, which did not operate in such remote rural areas, and charged a small fee. As many people in the village had neither money for transport, nor for the fee, MediOrg was the only option for the poor of the area. As the manager explained:

“Without [MediOrg], the people in our village would not get any health care. They have no money to pay for health care elsewhere, and no opportunities to travel for care at other health centres. We are unique compared to public and private hospitals and health centres. We do not simply work with health care. We work for [MediOrg] with health care. And each day during the morning ceremonies it is important to remember and acknowledge what we do and that we are unique.”

A typical morning service took the following form:

Introduction of ceremony:

The manager started by discussing the two parts of MediOrg’s ideology: (1) helping the severely poor people in the area, and (2) working for God’s sake. He also emphasised the important work done by MediOrg and stressed that the organisation was unique and the only option for the severely poor to gain access to free health care. The manager also gave examples of patients who had been severely ill, but were now recovering after being treated by MediOrg. All employees were quiet and listened carefully.

Examples from an introduction:

Manager: “Welcome. We take pride in doing God’s work and providing free health care to India’s poorest”.

Manager: “The people in the village need us, for example, the malnourished man we helped yesterday with well advanced tuberculosis. The woman who got the HIV diagnosis and treatment, would have died without it. We take pride in helping them, and we see that we do good every day.”

Manager: “The people in this village need us. They need free health care close by. Private health centres or public hospitals are not alternatives for them. We are unique and should be very proud of what we do. We make a difference.

Manager: “MediOrg is not like other health centres or hospitals. We are unique. We take pride in helping the poor and working for the sake of God.”

Middle of ceremony:

This part of the ceremony emphasised the religious dimension of MediOrg’s ideology. The health centre manager led the prayer and one of the MediOrg employees led the singing of a hymn. The majority of the employees closed their eyes during this part of the ceremony and they seemed very focused on their prayers.

End of ceremony:

The manager once again quickly emphasised the importance of MediOrg’s work when ending the ceremony.

Examples closing a ceremony:

Manager: “Let us now start work. We help the poor and work for the sake of God.”

Manager: “There are people in need waiting for us. Let us help them.”

Manager: “Keep in mind, we are unique and our work is very important.”

Manager: “Think of the child with tuberculosis that was difficult to treat who we helped yesterday. Our work makes a difference.”

Everyone was very calm and focused during the ritual, listening carefully to what the manager was saying. As one doctor commented: “These ceremonies are really important for us. We all get filled with energy. [MediOrg] is unique and what we do is really important. We help the poor and work for God’s sake.” This was noticeable when the ceremonies ended and the employees headed off to start work. Everyone was smiling and seemed highly committed to doing their daily work. This high moral commitment to the organisational ideology was also apparent in interviews and informal conversations with the MediOrg staff, they all told us about their pride in being able to help the severely poor get access to free basic health care and in working for the sake of God (c.f., [Etzioni, 1964](#)). The manager emphasised that this organisational ideology had been the same since MediOrg started and explained that he nurtured the ideology through his way of running the morning ceremonies. The nurses and doctors had worked for a long time at MediOrg and earned a relatively low salary, but they explained that they did not work for the money, but for the feeling of achieving something meaningful and contributing to society. As one doctor explained:

“[MediOrg] is unique and not like private health centres or hospitals. You [the researchers] have attended our morning ceremonies so you see that we are something special. All of us are committed to helping the poor.”

The doctors and nurses would have obtained a much a higher salary in private hospitals in the cities. They were often approached by recruiters from these hospitals since there is a severe shortage of doctors and nurses throughout India, including in the area where MediOrg operates. But this did not seem to be an alternative for them. As one nurse put it: “We like our work here, this health centre does good work for the people living around here. I know I am working for something good.” Echoing the doctors and nurses, the manager underscored how the commitment to MediOrg’s ideology was shared by all employees, including himself. As he put it: “We all have a common agenda, and we are proud of the work we do for the severely poor”. The manager and his wife had been running MediOrg for a long time and he was seen as a father figure. The employees had a great deal of respect for him. This was evident in the way the employees talked about him. One of the hospital orderlies said: “He is very good. He takes care of us”. Among the doctors and nurses he was highly respected for his long-term commitment to ensuring that MediOrg could continue its important mission. As one doctor explained: “[The manager] makes sure we can help the poor with free health care. We trust him.” During informal conversations with us, the doctors even stressed that they saw the manager as the guarantor for MediOrg’s continuing work.

To summarise, as [Table 2](#) details, MediOrg has the typical characteristics of a normative organisation ([Etzioni, 1961, 1964, 1975](#)). Ideological control dominated, highlighting the importance

Table 2
Predominant type of control, involvement and leadership in MediOrg.

	MediOrg
Predominant type of control used	Ideological control: e.g., during morning ceremonies the manager made continuous reference to MediOrg's ideology of helping the severely poor in rural areas and working for the sake of God. Crucifixes on the walls, biblical quotations at every entrance, prayer and singing in the chapel.
Type of leadership	One formal leader, the manager. Strong spiritual leadership; the manager was seen as a father figure. Among the doctors and nurses he was highly respected for his long-term commitment to ensuring that MediOrg continued with a mission that they believed to be important.
Involvement	High moral commitment. Employees motivated by MediOrg's ideology. Both employees and the manager subscribed to MediOrg's ideology.

of religion and of working for the severely poor in combination with strong spiritual leadership from the manager, who was highly respected and perceived as a father figure by the staff. The employees had a high moral commitment to the organisation and its ideology (Etzioni, 1975). It is in this context that the changes towards a more financially oriented kind of health care delivery should be analysed. We turn to these next.

4.4. Changes towards a more financially oriented agenda

The occurrence of two events at the beginning of the 21st century had a significant effect on MediOrg's finances. First, the general grant from the Church was gradually decreased to the current level of 20%. This is the level that the Church considers to be reasonable and, as pointed out by the Director of International Mission, the Church perceives it to be important for MediOrg to rely primarily on other funding sources. The Church has no plans to alter the grant, and this intention has been communicated clearly to the manager. Second, the pressure to adopt more financially and output-oriented control of NGOs has increased in India, in association with the wider ideas of new public management (NPM) (Broadbent, Dietrich, & Laughlin, 1996; Hood, 1995). These ideas are intended 'to cost' the activities of professionals more closely and evaluate them against performance measures (Abernethy, Chua, Grafton, & Mahama, 2007). More specifically, NPM has driven changes in funding arrangements in India. As a consequence, the Indian government no longer provides general grants to MediOrg, and instead works more intensively with large government programmes targeting specific diseases and purposes.

In recent years MediOrg has therefore actively participated in four such programmes (HIV/AIDS, tuberculosis, family planning and blindness control), and, as shown in Table 3, 75% of MediOrg's funding now comes from these sources. This means that government agencies are amongst MediOrg's most important funders, as the manager explained:

"Most of the programmes we undertake here are activities within the national programmes and thus we work in close collaboration and in line with the government agencies".

MediOrg receives specific payments from the government to run the programmes, but the government does not contribute to the additional general medical activities undertaken in the open clinic and the ward. The government provides these payments through government agencies that then monitor the targeted activities. At times, MediOrg also functions as a training centre for community health for local medical and nursing schools, and for this MediOrg also receives some payment.

The focus on government programmes has been a deliberate choice by the manager. As he put it:

"It is possible for MediOrg to seek out other funders as well, but the government has the advantage of being able to provide a

stable and long-term funding commitment to continue to support operations under MediOrg's mission."

According to the manager, establishing MediOrg as a reliable partner in large government programmes is the best way to secure the long-term survival of the health centre provision. The manager explains that an important advantage of the programmes is that the pre-set payment levels for activities such as HIV tests and operations to prevent blindness are, in his view, generously set. At least, as he argues, for small health centres like MediOrg with less bureaucracy and management layers than larger health centres and hospitals. This means that MediOrg's activities in the government programmes effectively cross-subsidise the general outpatient medicine practiced in the open clinic and the in-patient general medicine.¹⁰ This is perceived to be very important by the manager as he stresses that a vital part of MediOrg's work is to provide basic health care to everyone who comes to the health centre, and funding from government programmes is helping MediOrg to continue with this important work. All employees at MediOrg stressed, with pride in their voices, that no one is denied basic healthcare. As one nurse put it: "As you see, everyone gets help in the open clinic here. We are proud of this. We really make a difference to the people in this village." Our direct observations support this. Every day followed the same pattern: Early in the morning people lined up at the reception to register. After registration, they sat in an austere waiting room until the nurse or doctor called them. The open clinic did not close until all patients had met the nurse or doctor.

However, participation in large government programmes also means that MediOrg must devote an increasing amount of effort to fulfilling formal reporting requirements from the government agencies. There is, as the manager puts it, "very little flexibility" when it comes to reporting to these agencies (c.f., Ebrahim, 2003; O'Dwyer, 2005). In addition, all government funding is delivered after the treatment has been provided and the detailed reports submitted. There is also a pre-set non-negotiable level of care and a fixed number of patients in each programme that cannot be exceeded. The manager emphasised that the only way to secure continuous funding from the government programmes is for him to document all activities related to these programmes. This was supported by our informants from the Indian national agencies, all of whom explained that MediOrg had recently become much better at producing timely and correctly completed reports, which was deemed important by the agencies when they discussed whether to prolong the funding or not. MediOrg is now seen as a reliable partner in these programmes. Observing the manager's daily work, it was noticeable that he spent a considerable amount of his time in

¹⁰ The manager explained that a significant part of the budget goes on general medical activities unrelated to the four government programmes. We were, however, not granted access to detailed reports broken down by activity and cannot therefore assess the extent to which each government programme cross-subsidises general medicine.

Table 3
Funders of MediOrg.

Funder	Programme/aim	Follow-up requirements	Contribution to MediOrg's funding
The Church	Contribution to MediOrg's administration and general medical activities.	None	20%
Government HIV/AIDS Programme	HIV/AIDS control through testing and treatment. Free to patients.	Monthly; number of HIV tests performed and treatment via an on-line reporting system. Regular visits from a programme manager.	35%
Government Tuberculosis Programme	Tuberculosis control. Goal of early detection and treatment. Free to patients.	Monthly; number of tests and treatments. Regular visits from a programme manager.	20%
Government Family Planning Programme	Family planning. Female sterilisations are performed. Free to patients.	Semi-annual reporting on the number of operations performed.	10%
Government Blindness Programme	Blindness control. Cataract operations are performed, with post-operational check-ups. Free to patients.	Monthly; number of tests, diagnoses, operations, and post-op check-ups. Occasional visits by a programme manager.	10%
Local bodies: medical college; nursing college; Education Society	Clinical training for students of nursing and medicine.	Informal. Training reports provided by the students and occasional visits by university personnel.	5%

his office working with MediOrg's finances and various performance statistics for the government funding agencies. The manager explained that he did everything related to budgeting and the actual reporting to the government agencies without the involvement of the doctors, nurses or other staff at MediOrg. He needed documentation from the clinical staff, but he compiled reports for the government agencies personally. The formal reports produced to satisfy the requirements of funders were neither circulated further down in the organisation nor used for internal performance evaluation.

It was noteworthy that when issues relating to funders, performance targets and financial constraints came up during interviews, all employees explained that they did not have any knowledge about these issues since the manager took care of them. Even when they were pushed somewhat by being asked repeatedly about the financial situation, the answer given by both doctors and nurses was always the same: "I do not know". This is illustrated in the following two excerpts.

Researcher: "Tell me about the financial situation at MediOrg"

Nurse: "We do not need to worry about that. You should ask [the manager]"

Researcher: "OK, but where does [MediOrg's] money come from? Can you describe that in your own words?"

Nurse: "I do not know"

Researcher: "Can you give your view on MediOrg's financial situation?"

Doctor: "[The manager] can answer those questions"

Researcher: "But from your point of view, how would you describe it?"

Doctor: "I am not involved. Talk to [the manager]."

Repeatedly referring these types of questions to the manager was even the case on a middle management level, where, when asked about the follow-up procedures for grants, the middle manager immediately referred to the health centre manager, "This question will be relevant to [the health centre manager] since he is the administrator. I do not have much of an idea about this". Our direct observations confirmed this pattern: the discussions between the manager and the medical personnel never addressed MediOrg's financial situation; he undertook sole responsibility for this.

The manager adopted the same philosophy when it came to budgeting. According to him, making sure that the budget was balanced required extensive attention throughout the year. The actual preparation of the annual budget was described as being relatively straightforward: before the year started, the manager knew how much revenue he would receive from the various funders, including the detailed predetermined tasks to be performed to satisfy each of the four government-funded programmes. On this basis, he prepared a budget, where the wages of the staff represented the single biggest expense item. However, the manager emphasised that since the majority of MediOrg's revenues are claimed monthly from the government programmes after providing detailed statistics of the activities performed, he always had to make sure that the doctors and nurses provided the documentation needed to complete the reports. In addition, since each government programme had a non-negotiable ceiling on the amount of care that would be paid for, the manager needed frequent updates on the actual care delivered in each programme. This was especially important for the in-patients as MediOrg only had a 25-patient capacity.

We conclude that the current situation for MediOrg is similar to the findings already reported in the literature, namely, that funders increasingly require those providing welfare services, such as NGOs, hospitals and health centres, to demonstrate efficient use of resources (e.g., [Chenhall et al., 2010](#); [Dixon et al., 2006](#); [Goddard & Assad, 2006](#); [Jacobs, 2005](#); [Kurunmäki, 2004](#) [O'Dwyer & Unerman, 2008](#)). Satisfying the agencies' demands is vital and time-consuming as 75 percent of MediOrg's annual budget is attributable to them.

According to the manager, economic concerns had resulted in difficult decisions on which patients should be admitted for more extensive in-patient treatment. Many patients who come to MediOrg are very ill, and consequently in need of in-patient treatment, but MediOrg's ward capacity is only 25, and there is no funding to expand the number of beds. As a consequence, the patients' need for in-patient treatment is much greater than MediOrg's capacity. Thus, the intrusion of economic rationality inevitably necessitates not being able to admit patients in real need of specialised care. As the manager explained:

"Every day is a day of difficult decisions. As you have seen, almost all people coming to the open clinic are very ill and would be in need of ward treatment. Otherwise they do not come here, they only come when they are very ill. But [MediOrg] is a small health centre, our ward capacity is very limited. So

every day we need to send home very, very sick people after treating them in the open clinic. That is the reality here.”

When asked to exemplify such decisions the manager referred to grave cholera cases and extremely malnourished people, but he also added: “I guess the best way to understand these difficult decisions is simply to look at the people coming to the open clinic. I am sure you agree that they look like people in need of ward treatment. And as you have seen, many of them are not admitted to the ward.” The European doctor who did an internship at MediOrg supported the manager's claims. As he put it:

“Working five weeks at [MediOrg] was really an eye opener for me about differences between health care in less developed countries and developed countries. I mean, we weighed in adults at 25 kilos; heavily undernourished. Many had oedema due to anaemia and protein shortage. In Europe almost all of the patients that visited the open clinic at [MediOrg] would have been directly admitted for ward treatment. But here just a few of them were admitted to [MediOrg's] ward. And it was the same thing day after day. The ward capacity was so limited.”

When making these difficult decisions about who should be admitted to a ward, the manager was clear that patients whose treatment fell under one of the four government-funded programmes needed to be prioritised since these patients gave MediOrg revenue from the government. When asked to be even more specific, the manager said that, in practice, these patients occupy almost all ward capacity: “In this village the need for treatment for HIV, tuberculosis, cataract operations and sterilisations is almost endless. So these patients occupy our ward and this is what we are paid for.” This meant that the earlier policy of admitting the most severely ill patients for ward treatment no longer applied. Relatively healthy patients who would never have been considered for in-patient treatment in the past, such as those in the female sterilisation programme and the blindness programme, who are undergoing surgical procedures continue to occupy beds in the ward for some time during their post-operative treatment. As a consequence, patients who come to MediOrg, but are severely ill with, for instance, cholera will be treated in the open clinic, but rarely admitted to the ward for in-patient treatment. The manager argued that this is the largest drawback associated with being dependent on government programme funding, and that this presents a clear moral dilemma for MediOrg.¹¹

As previously discussed, it was evident that these difficult decisions needed to be made and priorities set continuously because the inflow of patients needing admission to the ward was larger than the health centre's capacity. One way forward for MediOrg, given this situation, would be to try to get employees to embrace economic concerns and to appreciate the need for tough financially informed priorities. However, previous research has shown this to be problematic in welfare provision NGOs (e.g., [Chenhall et al., 2010](#); [Dixon et al., 2006](#); [Goddard & Assad, 2006](#)) and in health care organisations ([Jacobs, 2005](#); [Jones & Dewing, 1997](#); [Kurunmäki](#)

[et al., 2003](#)). [Chenhall et al. \(2010, p. 748\)](#), for instance, concluded that: “This intrusion of economic rationality inevitably involves not undertaking some worthy but expensive causes. If these “causes” to be neglected are part of the targeted welfare group ... the organization [a welfare provision NGO] risks losing its identity”. The majority of the studies on management control in health care organisations show that there is strong opposition from doctors and nurses to attempts to limit their professional autonomy and to efforts to increase the emphasis placed upon economic reasoning ([Jones & Dewing, 1997](#); [Lapsley, 2008](#)). At first glance, the findings from MediOrg seem to support these studies as the manager insulated doctors and nurses from financial matters. However, as previously discussed, economic concerns indisputably impacted upon the treatment provided by MediOrg. When deciding whom to admit to the ward for treatment, the patients covered by the government-funded programmes were prioritised since this would bring MediOrg revenue from the government. The doctors and nurses also provided detailed clinical documentation for external reporting purposes, thereby sacrificing time that could have been spent more usefully treating patients. So, to a great extent, a form of economic logic did govern the healthcare provided by MediOrg. Two formal MCS (discussed below) were used by the manager to implement this economic rationality. In contrast to existing research on NGOs and health care organisations, our observations and interviews with MediOrg employees did not reveal any resistance towards these formal MCS. This is elaborated on next.

4.5. The implementation of formal MCS in MediOrg

The manager, doctors and nurses all stressed the importance of formal MCS in the form of detailed written guidelines on how to complete and continuously update the medical documentation. These guidelines had been introduced by the manager when the changes occurred in MediOrg's financing and stipulated that, in addition to the normal clinical documentation, activities related to the four government programmes should be documented on pre-printed forms specifying the information needed on each patient. As the manager noted, these forms directly mirrored the governmental agencies' reporting requirements. He explained: “The forms for the four government programmes are absolutely necessary in order to comply with the funding requirements.” The other formal MCS took the form of a written instruction from the manager to the doctors and nurses stating that all decisions on admitting patients to the ward were to be taken by him. This formal control was in sharp contrast to past practice, where the doctor in the open clinic made all the decisions regarding treatment, including admissions. In contrast, these written guidelines stipulated that the nurses and doctors in the open clinic were required to consult the manager throughout the day, providing the medical reports of any patients who, after the initial examination, were being considered for in-patient treatment. The manager explained that this formal control needed to be implemented to secure the requisite funding from the government programmes. As he put it:

“We only get paid for ward treatment related to the four government programmes and I need to make sure we have room in the ward for these patients. This means I have to make decisions about ward treatment because I am the only one with the full picture about the four programmes and the funding arrangements.”

However, he also acknowledged that it limited the doctors' professional autonomy to some extent, and said that it introduced an important moral dimension related to not treating the most severely ill patients. The manager explained that the two formal

¹¹ The manager explained that it is primarily during the decision-making for ward admissions that financial and medical/moral rationales conflict. Conflicts between expensive/cheap treatments, for instance, did not exist at MediOrg because, as in similar health centres in the rural areas, in- and outpatient treatment was always carried out with the cheapest medicine and methods available. This had long been the case and all medical staff agreed that it was the best solution because it let them treat more patients without considering trade-offs. Trade-offs between expensive/cheap treatments were considered something of a ‘western’ phenomenon by the doctors and the manager, relevant in India only in the private hospitals that offered a range of medicines and treatments.

MCS were introduced and continuously discussed during the morning ceremonies alongside the already established and strongly articulated ideological control. This was supported by the doctors and nurses' testimonies, as follows:

An example of a morning ceremony discussing the new formal MCS.

Opening of the ceremony:

As already described, the manager opened the ceremony by describing the importance of MediOrg's work and the uniqueness of the organisation as the only option for severely poor people in the area in need of basic health care.

Middle of ceremony:

As already described, the health centre manager led the prayer and one of the MediOrg employees led the singing of a hymn.

End of ceremony:

The manager introduced the new formal MCS by arguing that they needed to be implemented for MediOrg to continue its important work helping the severely poor and serving God. Then immediately he emphasised MediOrg's uniqueness, offering a comparison with the private and public health centres and argued that the new formal MCS helped MediOrg continue to help the severely poor.

One of the doctors explained: "[The manager] emphasised the importance of us using the special forms for HIV/AIDS, tuberculosis, blindness and female sterilisation. Explaining that these forms were necessary for us to continue our important work. MediOrg is unique and the people here rely on us."

As a nurse put it: "[The manager] stressed the importance of us remembering the special forms for HIV/AIDS, tuberculosis, blindness and female sterilisation. They help us continue our important mission to help the poor and work for God's sake."

Another nurse explained: "[The manager] emphasised that he needed to make decisions on ward treatment and for this he needed the clinical journals from us throughout the day. He really stressed that this way of working is the only way for us to continue our important mission to help the people in our village."

The manager emphasised that, since these written guidelines had been introduced, the reporting to the government funding agencies was faster and much more reliable. From our observations in the open clinic, it was obvious that the administrative burden took time away from the actual treatment of patients. After the doctor or the nurse had seen a patient there, they always took time to complete the template form for the detailed clinical documentation of the work. When asked about these controls, the doctors and nurses simply answered that they followed these guidelines and that the manager had made it clear that the guidelines were important for MediOrg's ongoing work. No further reflections were made by the doctors and nurses as illustrated in the following excerpt.

Researcher: "And then we have the special forms for HIV/AIDS, tuberculosis, blindness and female sterilisation."

Doctor: "Yes, we always complete them."

Researcher: "Why are they important?"

Doctor: "[The manager] needs them. He is very clear about the importance of the forms for us to continue our work for the poor."

Researcher: "Can you elaborate?"

Doctor: "[The manager] needs them."

Researcher: "What about the special forms for HIV/AIDS, tuberculosis, blindness and female sterilisation?"

Nurse: "Yes we always carefully complete them for those patients. [The manager] needs the forms to secure our important work with the poor in the future, too."

Researcher: "Can you elaborate?"

Nurse: "The forms are vital for our important work here in the village, [the manager] really stresses it."

The European doctor and nurses who did an internship at MediOrg supported these statements. Working with the MediOrg doctors and nurses, they observed that the staff carefully filled in the special forms for the four government programmes. As one of the European nurses explained: "The nurses documented everything in detail related to HIV/AIDS, tuberculosis, blindness and female sterilisation. It was obvious that these special forms were important."

With regard to the second formal MCS, observations of the daily work at MediOrg showed a flow of patient reports being delivered by the nurses to the manager in his office. On average, ten patients per day (of the 30–40 who visited the open clinic daily) were to be considered for admission. After meeting with the doctor, these patients were placed in a small waiting room set to one side where an assistant nurse looked after them. The nurse took the clinical journal to the manager, who then decided whether the patients should be admitted to the ward. Once the decision was taken, an assistant nurse implemented it. We never observed any complaints from the patients: they simply listened and followed the advice from the assistant nurse.¹² The doctors and nurses were completely compliant, which, in effect, meant that the manager made all the tough admissions-related decisions. As explained by the manager, on average, two or three of the ten patients were admitted. The European doctors and nurses confirmed the manager's claim that very difficult decisions were taken regarding ward treatment. As the European doctor put it:

"I was really impressed by [MediOrg], they do so much with such limited resources. But the reality was that so many more patients would have needed ward treatment than was provided. So even if I was not involved in the decisions about ward treatment it was very obvious that these decisions and prioritisations were extremely difficult."

The manager explained how he made these decisions. The clinical journals were not overly detailed, but had information about type of disease and the health status of the patients, including boxes for 'ward treatment needed' and 'ward treatment

¹² The manager explained that doctors' decisions were never questioned; the patients and their families accepted the medical treatment suggested, whether it was in-ward treatment or medication to be taken at home. As stressed by the manager, medication and treatment are very abstract to the people in these rural areas and the doctors' authority is considered to be absolute. This was confirmed by our direct observations, and neither the patients nor the relatives questioned anything when the patients were either sent home with medication or admitted to the ward for treatment, they simply accepted the manager's decisions.

absolutely necessary'. According to the manager, and confirmed by the doctors, when the box 'ward treatment absolutely necessary' was ticked, the patient was so severely ill that his/her life was in immediate danger. With MediOrg's limited ward capacity, the manager explained that only two types of patients were admitted to the ward. First those patients covered by one of the government programmes, assuming that the ceiling had not been reached. Second were those patients for whom the box 'ward treatment absolutely necessary' had been ticked even though they did not fit into one of the government programmes. Here the manager emphasised that he could not refuse ward treatment for such patients, and he mentioned that often one or two patients had to lie in the corridor because all 25 of the ward beds were occupied. This was confirmed by the doctors and nurses, who explained that treating patients in the corridor was often part of their work in the ward. In this way, the manager argued, he compromised to some extent with regards to the moral aspect of not treating those most in need of in-patient care, but he never compromised if a patient's life was in real danger through not being admitted to the ward. But as previously mentioned, it also implied that relatively healthy patients who would never have been considered for in-patient treatment in the past, such as patients in the female sterilisation programme and the blindness programme, occupied beds in the ward for some time during their post-operative treatment while patients who were severely ill with, for instance, cholera were not admitted to the ward for in-patient treatment because these diseases were not covered by the four government funded programmes. The manager stressed that he saw this somewhat pragmatic solution as the only viable way to secure continuous funding from the government programmes and thereby secure the future for MediOrg. These relatively straightforward decision-making rules also made it possible for him to make decisions on ward treatment without extensive patient contact: the manager went down to the waiting room and met the patients very quickly, but, as he stressed, he made his decisions primarily on the basis of clinical reports from the doctors.

The doctors and nurses at MediOrg did not resent the imposition of these formal MCS. And, according to the manager, the medical documentation was completed satisfactory, i.e., the doctors and nurses followed the pre-set templates and provided all necessary information on the patients. When asked about the decisions for ward treatment, the doctors and nurses answered that they filled in the clinical reports as required and ticked the appropriate box concerning the need for ward treatment. When asked to be more specific about which patients were actually admitted and why, they referred to the manager as illustrated in the following excerpt:

Researcher: "Can you tell me about the decisions for ward treatment?"

Doctor: "We fill in the clinical reports and then [the manager] makes those decisions."

Researcher: "But who gets admitted?"

Doctor: "[The manager] can answer these questions."

Researcher: "Can you elaborate?"

Doctor: "You should talk to [the manager] about these issues."

The European doctor and nurses also explained that they were struck by the fact that the admission to the ward was not discussed at all among the MediOrg doctors and nurses. As one of the European nurses put it:

"When admission to the ward was brought up by us nothing was ever said about it. The [MediOrg] doctors and nurses always simply referred to the [manager]. They filled in the clinical reports and did their work brilliantly in my view but I remember that I talked to my colleague about the fact that admission to the ward was never brought up during our discussions with the [MediOrg] doctors and nurses in the open clinic and the ward. It seemed like an issue no one discussed."

To summarise, our findings suggest the importance of ideological control in normative organisations such as MediOrg. They also suggest the need to analyse the interplay between ideological control and formal MCS to further develop our understanding of what can explain compliance to formal MCS commensurate with a more financially oriented agenda. In the following we provide a discussion of these issues.

5. Discussion

5.1. Ideological control at MediOrg

Overall our analysis shows that MediOrg has a system of control that is dependent on an ideology, emphasising the importance of helping severely poor people in rural areas and pride in doing God's work, which the employees and the manager appear to subscribe to. As previously mentioned, the MCS literature has long recognised the importance of culture, clan controls and belief systems (e.g., Ahrens & Mollona, 2007; Efferin & Hopper, 2007; Ouchi, 1979; Simons, 1995) and expressive dimensions of organisational life (e.g., Boedker & Chua, 2013; Chenhall et al., in press; Dent, 1991; Ezzamel, 2009; Jacobs & Walker, 2004; Quattrone, 2004), but paid less attention to how managers use ideological control to target employees' beliefs, emotions and values. As Willmott (1993, p. 516) put it, managers need to: "... win the 'hearts and minds' of employees: to define their purposes by managing what they think and feel, and not just how they behave." Our findings show that the manager used ideological control to generate and maintain MediOrg's ideology (c.f., Etzioni, 1975). Ideological control took the form of symbols, such as crucifixes on the walls and biblical quotations at every entrance, and most importantly rituals, in the form of the morning ceremony.

Our study reveals that we cannot disentangle the perceptions of ideological control from MediOrg's leadership (c.f., Etzioni, 1975). The manager can be characterised as a formal leader (Etzioni, 1964) and, based on our informal conversations with the doctors and nurses, their faith in their leader seemed genuine. This is also supported by the fact that the doctors and nurses remained at MediOrg, despite the continuous offers of significantly higher wages that they received from other hospitals. As stressed by Etzioni (1961, p. 59), the use of ideological control largely depends on the ability of the leader to articulate and communicate the ideology for the organisation. We found that the manager exercised ideological control mainly through verbal communication, most notably during the morning ceremonies. As Kunda (1992) noted, gatherings are occasions in which organisational ideology is dramatised and brought to life. We see our findings in this regard as having parallels with the literature on 'accounting talk' (e.g., Ahrens, 1997; Carlsson-Wall et al., in press; Hall, 2010; Jönsson, 1998). Our study reveals how the manager, through 'ideological talk', was capable of having an extraordinary effect on his staff (see, Czarniawska-Joerges & Jorges, 1988). Thus, through this 'talk', ideological control assumed its specific significance in MediOrg (c.f., Czarniawska-Joerges & Jorges, 1988; Etzioni, 1975).

'Ideological talk' in MediOrg concentrated on three aspects: (1)

Repeatedly emphasising the organisation's ideology and clarifying why it is important: During the morning ceremonies, the manager continuously talked about the importance of providing the poor people with free health care and pride in doing God's work. (2) Repeatedly emphasising how the ideology creates organisational uniqueness: The manager continuously positioned MediOrg vis-à-vis the public and private health centres, emphasising that MediOrg was unique and the only option for the severely poor in the area. He repeated that the private health centres charged high fees and were therefore not an option for the severely poor, and that the public health centres were located too far from the rural areas in which MediOrg operated and that they charged a small fee, stressing that as the severely poor had neither money for transportation, nor for the small fee, MediOrg had a unique role to play. (3) Repeatedly displaying exemplary behaviour in line with the ideology. During the morning ceremonies the manager continuously recalled examples of patients who had been cured at MediOrg and stressed the success and importance of the daily work being done.

Through 'ideological talk', the manager enacted a particular form of organisational experience for the employees and created a highly valued sense of purpose for the organisation (c.f., Czarniawska-Joerges & Jorges, 1988; Etzioni, 1961, 1975). Adhering to MediOrg's ideology seemed to create a sense of belonging among the employees. Here our findings have parallels with Empson's (2004) distinction between professional identity and organisational identity. Organisational identity is an expression of how organisational members define themselves as a social group and understand themselves to be distinctive from members of other organisations (Empson, 2004). In our case, organisational identity represented those distinctive attributes that the doctors and nurses associated with their membership of MediOrg. The manager's use of ideological control created unique characteristics of MediOrg that the employees perceived to be central, distinctive and enduring. And as noted by Empson (2004), the perceptions of the distinctive character of an organisation are often formed on the basis of comparison with referent organisations; this was indisputably true for MediOrg. Previous studies of health care organisations have mainly focused on professional identity, which has meant that organisational identity has tended to be treated as being subsidiary to, or conflated with, professional identity. In contrast, our study shows that professional and organisational identity coexist in a complex relationship (c.f., Empson, 2004). An illustration of this was the recurring expression "I am not just a doctor [nurse], I am a [MediOrg] doctor [nurse]". MediOrg doctors and nurses seemed to share a basic understanding of what it meant to be a professional, but the way in which they translated this understanding into practice was influenced by the organisational identity.

In the next section, we will discuss how the manager's use of ideological control and its creation of a strong and articulated organisational identity in MediOrg was important when explaining the doctors' and nurses' compliance to the introduction of the financially oriented formal MCS.

5.2. Explaining compliance to financially oriented formal MCS

Through our analysis of MediOrg, it emerged that the manager implemented formal MCS outlining the behaviour commensurate with a more financially oriented agenda. He largely employed a rational approach to the decisions on whom to admit to the ward based on a cost-benefit analysis driven by patient participation in one of four government programmes. Even though the manager never compromised when a patient's life was in real danger through not being admitted to the ward, the adoption of a

financially rational approach still meant that relatively healthy patients, i.e., patients in the female sterilisation and the blindness programmes, who would have never been considered for in-patient treatment in the past, were admitted to the ward. Thus, the implementation of economic rationality, required to secure the continuous funding of MediOrg, involved the moral dilemma of admitting relatively healthy patients at the expense of severely sick ones e.g., those with cholera, whose illness fell outside the four earmarked government programmes.

However, contrary to the findings in previous research on NGOs and health care organisations (e.g., Chenhall et al., 2010; Dixon et al., 2006; Lapsley, 2008), our observations revealed that the doctors and nurses at MediOrg did not resist the imposition of formal MCS. Chenhall et al. (2010), for instance, drawing on Adler and Borys' (1996) design features of enabling bureaucracies, found that formal MCS lacking flexibility, repair and internal transparency, were resisted and seen as an impediment to spending time on clients. In our study, the written guidelines were premised on centralisation, rather than capitalising on the doctors' and nurses' intelligence (c.f., Adler & Borys, 1996; Jordan & Messner, 2012). In addition, the written guidelines had to be followed, period, and no flexibility was granted to the doctors and nurses in the application of the formal control procedures (c.f., Ahrens & Chapman, 2004; Jørgensen & Messner, 2009). As noted by Ahrens and Chapman (2004, p. 279): "The premise of the enabling logic is that operations are not totally programmable." As such, our case contributes to the literature on enabling control by providing an extreme case of a specific task (i.e., the actual decision of who to admit to the ward) being 'totally' programmable and hence there was no need for doctors' and nurses' input beyond provision of the information specified in the clinical forms.¹³ Resource poverty, an absence of perceived treatment choices, the financial situation of MediOrg and the strategic choice of being involved in government funded programmes created a context in which the manager required no participation from the doctors and nurses when making the actual admission decision, and consequently the doctors and nurses were not enabled at all. However, the formal MCS were nevertheless accepted as necessary and the doctors and nurses spent a considerable amount of time completing forms after providing treatment to patients. The doctors and nurses used the pre-set templates to supply the necessary information for each person treated. Similarly, in relation to previous research on healthcare organisations, the formal MCS did indeed limit the professional autonomy of the doctors and nurses, given that the actual decisions about patient admissions were now taken solely by the manager. On the basis of existing research, such control would almost certainly encounter strong opposition from the line workers (e.g., Jones & Dewing, 1997; Lapsley, 2008). In our case, however, the doctors and nurses filled in the clinical reports as required and ticked the appropriate box concerning the need for ward treatment.

How can these findings be explained? One answer could be that there is a lack of understanding of the conflicts between economic and medical/moral rationale by those involved, i.e., the doctors and nurses are ignorant of the implications of the formal controls being exercised upon them. This is unlikely as MediOrg is a small health centre where the doctors and nurses work both in the open clinic and the ward, and thereby they are fully aware of which patients are treated in the ward. We would rather suggest that these contradictions are overlooked, tolerated and even accepted to sustain MediOrg's ideology of helping the poor people and working for God's sake. Thus, our study reveals that the understanding of formal MCS is not only pre-determined through choices made in

¹³ Thanks are due to a reviewer for pointing this out.

the design of these systems, but also in how the implementation process is carried out (Englund & Gerdin, 2015; Jordan & Messner, 2012; Wouters & Wilderom, 2008). As noted by Jordan and Messner (2012), symbolic practices through which the role and relevance of formal MCS are communicated impact on how the systems are perceived by the employees. We contribute by detailing an important, yet in previous research unexplored, part of this implementation process, namely that a strong predominantly ideological control system had an important impact on how the doctors and nurses perceived the implementation of the formal MCS (c.f. Etzioni, 1961, 1964, 1975). Highlighting the interplay between ideological control and formal MCS, our case showed how the manager through ‘ideological talk’, during the morning ceremonies, linked the formal MCS to MediOrg’s ideology. The two formal MCS, through the interplay with the predominant ideological control in place at MediOrg, became vested with symbolic significance (see, Etzioni, 1975). The MediOrg staff appeared to feel at ease with their formal leader and accepted his arguments about the linkage between the formal MCS and the organisational ideology. This is supported by the fact that the doctors and nurses remained at MediOrg in spite of regularly repeated offers of significantly higher wages from other hospitals. As such, our findings suggest that formal MCS gained relevance for MediOrg’s employees through the manager’s use of ideological control in verbal communication.

Additionally, the implementation of the two formal MCS can be understood as shift in the compromises between two different, and potentially conflicting, means of valuing everyday work. In a recent contribution, Chenhall et al. (2013) found that one important feature when designing formal MCS was that of ‘concurrent visibility’, i.e., that different evaluative principles of organisational actors were made visible. They showed that a performance measurement system designed to produce such concurrent visibility limited the resistance to the imposition of formal MCS. For instance, metrics were accompanied by narrative boxes, which enabled the respondents to compromise between the different evaluative principles. Our findings suggest that compromise between multiple values can be sought both through the design of formal MCS (as in Chenhall et al., 2013) and through the use of ideological control, vesting the formal MCS with symbolic significance (as in our case). Furthermore, an important part of producing concurrent visibility in MediOrg was the manner in which the formal MCS were introduced into the morning ceremonies. The manager always ran these ceremonies in a similar fashion, commencing with a discussion of MediOrg’s ideology. The manager’s choice of the familiar setting of the morning ceremony as a key site for communicating the implementation of the formal MCS arguably reinforced the relevance of the topic for the staff. Yet putting this issue at the end of each ceremony also subordinated these concerns to MediOrg’s ideology, which likely resonated with the doctors’ and nurses’ existing values (c.f., Carlsson-Wall et al., in press). In this way, the manager highlighted the different modes of evaluation. Another example was that a patient whose life was in danger was always admitted to the ward, even if this meant that patients were being treated in the corridor.

However, our analysis also shows that too much concurrent visibility might be problematic. There was an absence of open discussion in MediOrg regarding the financial situation and the rationale for implementing the formal MCS. This was the case both when we observed the communication between the manager and the employees and when we posed questions concerning the rationale to the doctors and nurses. They simply repeatedly referred the researchers back to the manager. Messner (2009) argues that sometimes demands for accountability can become so great as to be ethically problematic for the person or organisation

that is expected to provide an account. In situations of apparent resource insufficiency, a limit is introduced on what can be accounted for by means of rational argumentation (Cho et al., 2015; Messner, 2009). Open discussions may result in too much concurrent visibility, creating an ethical burden for the employees insofar as they need to decide on something that they find difficult, or even impossible, to rationalise (see, Messner, 2009; Roberts, 2009). In this context, Brunsson discusses the danger of open discussions when moral concerns are important. As he put it (Brunsson, 1993, p. 492): “It is easier to implement actions which are regarded as immoral, than to acknowledge them openly; and it is even more difficult to defend them or to propose that they be adopted. In other words, it is difficult to hold an open discussion about actions which are difficult to defend on morally acceptable grounds. This difficulty can lead to things being done without their being openly accounted for.” The manager’s behaviour in our case corresponds to this line of reasoning. Acknowledging the (financially informed) reason for the implementation of the formal MCS openly would reveal moral tensions and could potentially be difficult to defend. MediOrg would risk losing its organisational identity (c.f., Empson, 2004). This difficulty can, as noted by Brunsson (1993), lead to formal MCS being implemented without them being openly accounted for, which can explain the lack of open discussion observed in the MediOrg case.

Finally, we find it important to acknowledge that ideological control has the capacity to be beneficial or damaging, and very often has components of both, at different times and for different groups (see, Czarniawska-Joerges, 1988). The changes in decision-making regarding ward treatment introduced by the manager to accommodate the requirements of the government programmes would have had adverse effects on many of those patients whose illness fell outside the programmes (and probably their families and relatives, too). We did not investigate these adverse effects further in our study.

6. Conclusion

This study explored ideological control and its interplay with formal MCS in MediOrg, a small health centre operating as an NGO in rural India. A focus on ideological control is consistent with emerging accounting research on the “expressive dimensions” of organisational life (e.g., Ahrens & Mollona, 2007; Boedker & Chua, 2013; Chenhall et al., in press; Efferin & Hopper, 2007; Ezzamel, 2009; Jacobs & Walker, 2004; Quattrone, 2004). However, while this literature has analysed, for instance, the influence of subcultures on formal MCS and how formal MCS play an active role in the expression of values, less interest has been exhibited in how managers use organisational ideology to enact a particular form of organisational experience for their employees and to create a highly valued sense of purpose for the organisation. We found that it is mainly through ‘ideological talk’ in face-to-face contact between the manager and the employees that ideological control assumes its specific significance in organisations. This ‘talk’, during morning rituals, was repeatedly directed towards three aspects, emphasising the organisation’s ideology and why it is important; how the ideology makes the organisation unique; and displaying exemplary behaviours that are in line with the ideology. We conclude that these aspects of ‘ideological talk’ enabled the manager to emphasise MediOrg’s uniqueness, giving him a powerful instrument of control (c.f., Czarniawska-Joerges & Joerges, 1988; Etzioni, 1961, 1975).

Ideological control was also important for explaining the limited resistance to the implementation of financially oriented formal MCS. Prior research has provided valuable knowledge on how the design characteristics and the implementation process of formal

MCS can help to explain compliance (e.g., Ahrens & Chapman, 2004; Boedker & Chua, 2013; Jordan & Messner, 2012; Wouters & Wilderom, 2008). We contribute by detailing an important, yet previously unexplored, part of this implementation process, namely that the relevance of formal MCS was emphasised for MediOrg's employees through the manager's use of ideological control when implementing the systems. The formal MCS, through the interplay with the predominant ideological control in place, became vested with symbolic significance (c.f., Etzioni, 1975). On a related note, Chenhall et al. (2013) found that compliance increased when formal MCS were designed to produce 'concurrent visibilities' such that different evaluative principles of organisational actors were made visible. Our findings suggest that compromise between multiple values can be sought both through the design of formal MCS (as in Chenhall et al., 2013) and through the use of ideological control, vesting the formal MCS with symbolic significance (as in our case). We also conclude that too much concurrent visibility might be problematic. Acknowledging the true rationale for implementing the formal MCS would reveal moral tensions and MediOrg would risk losing its organisational identity. Thus, open discussions could result in too much concurrent visibility imposing an ethical burden on the employees as they would become involved in decisions that they would find difficult to rationalise.

Our research also contributes to the empirical domain of management control in NGOs. Our study of MediOrg supports the claims made in the existing literature that NGOs face increased pressure from funders to demonstrate efficient use of resources (e.g., Chenhall et al., 2010; Dixon et al., 2006; Goddard & Assad, 2006). MediOrg responded fully to such pressure and we observed a heavy administrative workload associated with satisfying the government's demands. While the social mission to provide free healthcare for the severely poor was important at MediOrg, economic concerns impacted heavily on how MediOrg was to deliver healthcare services. However, in spite of the heavy intrusion of economic rationality on work practices, MediOrg did not appear to have lost its organisational identity, as had been observed in previous research (e.g., Dixon et al., 2006; O'Dwyer & Unerman, 2008). Thus, while recognising the role of formal MCS to manage the tensions between financial and social ideals in NGOs documented in previous research (e.g., Chenhall et al., 2010, 2013, *in press*), our findings reveal a more complex picture involving ideological control, formal MCS, moral considerations and spiritual leadership. These dimensions need to be taken into account when analysing how management control can help NGOs attract funding, while maintaining their identity.

Finally, our conclusions have implications for the ongoing debate about the role of management control in healthcare organisations (e.g., Jacobs, 1998, 2005; Jones & Dewing, 1997; Kurunmäki, 1999, 2004). This stream of research has highlighted the tensions between economic reasoning and professional ideals experienced by doctors and nurses in hospitals and health centres in developed countries (Kurunmäki et al., 2003; Nyland & Pettersen, 2004). We still know little about how such tensions are handled in different specific social and organisational contexts, however, and in this context, Marcon and Panozzo (1998) and Jacobs (2005) argued that researchers should go beyond the countries habitually considered to analyse these tensions in contextually informed research. Our findings show that the tensions between economic reasoning and professional ideals in MediOrg are more complex than has been suggested by previous research. More specifically, we need to distinguish between professional identity and organisational identity (see, Empson, 2004). Previous studies of health care organisations have mainly focused on professional identity, which has meant that organisational identity has tended to be treated as being subsidiary to, or conflated with,

professional identity. In contrast, our study shows that professional and organisational identity coexist in a complex relationship. In MediOrg, economic concerns strongly impacted on the decisions concerning admission for in-patient treatment, thereby severely compromising the professional autonomy of the front-line doctors and nurses. However, this was not because the doctors and nurses had acquired the tools of management accounting and let economic reasoning influence their decisions, as demonstrated in the existing accounting literature on healthcare organisations (e.g., Kurunmäki, 1999, 2004). Rather, the manager's use of ideological control created a strong organisational identity and the staff appeared to feel at ease using the formal MCS because their formal leader argued that it was important for MediOrg's ongoing work with the severely poor.

Our study shows that there is much scope for future research to specify and contextualise the interplay between ideological control and formal MCS. Our analysis is based on a relatively small religiously affiliated NGO, which, presumably, makes it easier for a manager to be a formal leader and to exercise strong and spiritual forms of ideological control, such as 'ideological talk'. More research is needed on how ideological control, involvement and leadership type (Etzioni, 1961, 1964, 1975) play out in larger organisations and in organisations which are not religiously affiliated. Furthermore, MediOrg had gained acceptance and earned a good reputation among local people and was therefore able to focus wholeheartedly on providing healthcare to the severely poor, avoiding involvement in village politics. In addition, the patients and the relatives simply accepted the doctor's suggestions for medication or ward treatment. Further research could analyse how downward accountability, empowerment and participation (see, O'Dwyer & Unerman, 2010) add additional layers of complexity to the use of management control in NGOs and in health care organisations.

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Appendix. Interview overview

Interviews February–April 2012

1. Coordination officer, local medical college
2. Director of the International Mission, church
3. District tuberculosis officer, government tuberculosis programme
4. Centre manager, government HIV/AIDS programme
5. Dean, local nursing college
6. Department head, local medical college
7. Health centre accountant, MediOrg
8. Health centre manager, MediOrg
9. Health centre manager, MediOrg
10. Health centre manager, MediOrg
11. Health centre manager, MediOrg
12. Health centre orderly, MediOrg
13. Medical officer, nearest district hospital
14. Middle manager, MediOrg
15. Middle manager, MediOrg

16. Nurse A, MediOrg
17. Principal, local education society
18. Programme manager, government HIV/AIDS programme
19. Senior counsellor, MediOrg

Interviews June 2015

20. Health centre manager, MediOrg
21. Doctor A, MediOrg
22. Doctor B, MediOrg
23. Nurse A, MediOrg
24. Nurse B, MediOrg
25. Nurse C, MediOrg
26. European doctor, 5-week internship split between MediOrg and a city hospital
27. European nurse A, 5-week internship split between MediOrg and a city hospital
28. European nurse B, 5-week internship split between MediOrg and a city hospital

References

- Abernethy, M. A., Bouwens, J., & van Lent, L. (2010). Leadership and control system design. *Management Accounting Research*, 21, 2–16.
- Abernethy, M. A., Chua, W. F., Grafton, J., & Mahama, H. (2007). Accounting and control in health care: behavioural, organisational, sociological and critical perspectives. In C. S. Chapman, A. G. Hopwood, & M. D. Shields (Eds.), *Handbook of management accounting research* (pp. 805–829). Elsevier Ltd.
- Abernethy, M. A., & Stoelwinder, J. U. (1995). The role of professional control in the management of complex organizations. *Accounting, Organizations and Society*, 20, 1–17.
- Adler, P. S., & Borys, B. (1996). Two types of bureaucracy: enabling and coercive. *Administrative Science Quarterly*, 41, 61–89.
- Ahrens, T. (1997). Talking accounting: an ethnography of management knowledge in British and German brewers. *Accounting, Organizations and Society*, 22, 617–637.
- Ahrens, T., & Chapman, C. S. (2004). Accounting for flexibility and efficiency: a field study of management control systems in a restaurant chain. *Contemporary Accounting Research*, 21, 1–28.
- Ahrens, T., & Chapman, C. S. (2006). Doing qualitative field research in management accounting. *Accounting, Organizations and Society*, 31, 819–841.
- Ahrens, T., & Mollona, M. (2007). Organisational control as cultural practice – a shop floor ethnography of a Sheffield steel mill. *Accounting, Organizations and Society*, 32, 305–331.
- Alvesson, M., & Kärreman, D. (2004). Interfaces of control. Technocratic and socio-ideological control in a global management consulting firms. *Accounting, Organizations and Society*, 29, 423–444.
- Banerjee, A. V., Glennerster, R., & Duflo, E. (2008). Putting a band-aid on a corpse: incentives for nurses in the Indian public health care system. *Journal of European Economic Association*, 6, 487–500.
- Berman, P. A. (1998). Rethinking health care systems: private health care provision in India. *World Development*, 26, 1463–1479.
- Boedeker, C., & Chua, W. F. (2013). Accounting as an affective technology: a study of circulation, agency and entrancement. *Accounting, Organizations and Society*, 38, 245–267.
- Boroah, V. K. (2012). Social identity and educational attainment: the role of caste and religion in explaining differences between children in India. *Journal of Development Studies*, 48, 887–903.
- Boroah, V. K., Dubey, A., & Iyer, S. (2007). The effectiveness of jobs reservation: caste, religion and economic status in India. *Development and Change*, 38, 423–445.
- Broadbent, J., Dietrich, M., & Laughlin, R. (1996). The development of principal-agent, contracting and accountability relationships in the public sector: conceptual and cultural problems. *Critical Perspectives on Accounting*, 7, 259–284.
- Broadbent, J., Jacobs, K., & Laughlin, R. (2001). Organisational resistance strategies to unwanted accounting and finance changes. The case of general medical practice in the UK. *Accounting, Auditing & Accountability Journal*, 14, 565–586.
- Broadbent, J., & Laughlin, R. (1998). Resisting the 'new public management'. Absorption and absorbing groups in schools and GP practices in the UK. *Accounting, Auditing & Accountability Journal*, 11, 403–435.
- Brunsson, N. (1993). Ideas and actions: justification and hypocrisy as alternatives to control. *Accounting, Organizations and Society*, 18, 489–506.
- Carlsson-Wall, M., Kraus, K., & Lind, J. (2011). The interdependencies of intra-and inter-organisational controls and work practices—The case of domestic care of the elderly. *Management Accounting Research*, 22, 313–329.
- Carlsson-Wall, M., Kraus, K., Lund, M., & Sjögren, E. (2016). Accounting talk through metaphorical representations – change agents and organisational change in home-based elderly care. *European Accounting Review* (in press).
- Chenhall, R. H., Hall, M., & Smith, D. (2010). Social capital and management control systems: a study of a non-government organization. *Accounting, Organizations and Society*, 35, 737–756.
- Chenhall, R. H., Hall, M., & Smith, D. (2013). Performance measurement, modes of evaluation and the development of compromising accounts. *Accounting, Organizations and Society*, 38, 268–287.
- Chenhall, R. H., Hall, M., & Smith, D. (2016). The expressive role of performance measurement systems: a field study of a mental health development project. *Accounting, Organizations and Society* (in press).
- Cho, C. H., Laine, M., Roberts, R. W., & Rodrigue, M. (2015). Organized hypocrisy, organizational facades, and sustainability reporting. *Accounting, Organizations and Society*, 40, 78–94.
- Czarniawska-Joerges, B. (1988). *Ideological control in nonideological organizations*. New York: Praeger.
- Czarniawska-Joerges, B., & Jorges, B. (1988). How to control things with words. Organizational talk and control. *Management Communication Quarterly*, 2, 170–193.
- Dent, J. F. (1991). Accounting and organizational cultures: a field study of the emergence of a new organizational reality. *Accounting, Organizations and Society*, 16, 705–732.
- Dixon, R., Ritchie, J., & Siwale, J. (2006). Microfinance: accountability from the grassroots. *Accounting, Auditing & Accountability Journal*, 19, 405–427.
- Ebrahim, A. (2003). Accountability in practice: mechanisms for NGOs. *World Development*, 31, 813–829.
- Efferin, S., & Hopper, T. (2007). Management control, culture and ethnicity in a Chinese Indonesian company. *Accounting, Organizations and Society*, 32, 223–262.
- Empson, L. (2004). Organizational identity change: managerial regulation and member identification in an accounting firm acquisition. *Accounting, Organizations and Society*, 29, 759–781.
- Englund, H., & Gerdin, J. (2015). Developing enabling performance measurement systems: on the interplay between numbers and operational knowledge. *European Accounting Review*, 24, 277–303.
- Etzioni, A. (1961). *A comparative analysis of complex organizations*. New York: The free press of Glencoe.
- Etzioni, A. (1964). *Modern organizations*. Englewood Cliffs, New Jersey: Prentice-Hall.
- Etzioni, A. (1965). Dual leadership in complex organizations. *American Sociological Review*, 30, 688–698.
- Etzioni, A. (1975). *A comparative analysis of complex organizations, revised and enlarged edition*. London: The Free Press, Collier Macmillan Publishers.
- Etzioni, A. (2005). Response to Simon Prideaux's "From organisational theory to the new communitarianism of Amitai Etzioni". *Canadian Journal of Sociology*, 30, 215–217.
- Ezzamel, M. (2009). Order and accounting as a performative ritual: evidence from ancient Egypt. *Accounting, Organizations and Society*, 34, 348–380.
- Gioia, D. A., Thomas, J. B., Clark, S. W., & Chittipeddi, K. (1994). Symbolism and strategic change in academia: the dynamics of sensemaking and influence. *Organization Science*, 5, 363–383.
- Goddard, A., & Assad, M. J. (2006). Accounting and navigating legitimacy in Tanzanian NGOs. *Accounting, Auditing & Accountability Journal*, 19, 377–404.
- Hall, M. (2010). Accounting information and managerial work. *Accounting, Organizations and Society*, 35, 301–315.
- Hood, C. C. (1995). The new public management in the 1980s: variations on a theme. *Accounting, Organizations and Society*, 20, 93–119.
- Hopper, T., Tsamenyi, M., Uddin, S., & Wickramasinghe, D. (2009). Management accounting in less developed countries: what is known and needs knowing. *Accounting, Auditing & Accountability Journal*, 22, 469–514.
- Hopwood, A. G. (2005). Editorial: after 30 years. *Accounting, Organizations and Society*, 30, 585–586.
- Hoque, Z., Arends, S., & Alexander, R. (2004). Policing the police service. A case study of the rise of "new public management" within an Australian police service. *Accounting, Auditing & Accountability Journal*, 17, 59–84.
- Jacobs, K. (1998). Costing health care: a study of the introduction of cost and budget reports into a GP association. *Management Accounting Research*, 9, 55–70.
- Jacobs, K. (2005). Hybridization or polarization: doctors and accounting in the UK, Germany and Italy. *Financial Accountability & Management*, 21, 135–161.
- Jacobs, K., & Walker, S. P. (2004). Accounting and accountability practices in Iona community. *Accounting, Auditing & Accountability Journal*, 17, 361–381.
- Jones, C. S., & Dewing, I. P. (1997). The attitudes of NHS clinicians and medical managers towards changes in accounting controls. *Financial Accountability & Management*, 13, 261–280.
- Jönsson, S. (1998). Relate management accounting research to managerial work! *Accounting, Organizations and Society*, 23, 411–434.
- Jordan, S., & Messner, M. (2012). Enabling control and the problem of incomplete performance indicators. *Accounting, Organizations and Society*, 37, 544–564.
- Jørgensen, B., & Messner, M. (2009). Management control in new product development: the dynamics of managing flexibility and efficiency. *Journal of Management Accounting Research*, 21, 99–124.
- Kraus, K. (2012). Heterogeneous accountingisation: accounting and inter-organisational cooperation in home care services. *Accounting, Auditing & Accountability Journal*, 25, 1080–1112.
- Kunda, G. (1992). *Engineering culture. Control and commitment in a high-tech corporation*. Philadelphia: Temple University Press.

- Kurunmäki, L. (1999). Professional vs financial capital in the field of health care – struggles for the redistribution of power and control. *Accounting, Organizations and Society*, 24, 95–124.
- Kurunmäki, L. (2004). A hybrid profession – the acquisition of management accounting expertise by medical professionals. *Accounting, Organizations and Society*, 29, 327–347.
- Kurunmäki, L., Lapsley, I., & Melia, K. (2003). Accountingization v. legitimation: a comparative study of the use of accounting information in intensive care. *Management Accounting Research*, 14, 112–139.
- Lapsley, I. (2008). The NPM agenda: back to the future. *Financial Accountability & Management*, 24, 77–96.
- Llewellyn, S. (1998). Boundary work: costing and caring in the social services. *Accounting, Organizations and Society*, 23, 23–47.
- Llewellyn, S., & Northcott, D. (2005). The average hospital. *Accounting, Organizations and Society*, 30, 555–583.
- Marcon, G., & Panozzo, F. (1998). Reforming the reform: changing roles for accounting and management in the Italian health care sector. *European Accounting Review*, 7, 185–208.
- Mehta, A. K., & Shah, A. (2003). Chronic poverty in India: Incidence, causes and policies. *World Development*, 31, 491–511.
- Messner, M. (2009). The limits of accountability. *Accounting, Organizations and Society*, 34, 918–938.
- Miller, P., & Rose, N. (1990). Governing economic life. *Economy and Society*, 19, 1–31.
- Miller, P., & Rose, N. (1993). Accounting expertise and the politics of the product: economic citizenship and modes of corporate governance. *Accounting, Organizations and Society*, 18, 187–206.
- Miller, P., & Rose, N. (1994). Accounting, 'economic citizenship', and the spatial reordering of manufacture. *Accounting, Organizations and Society*, 19, 15–43.
- Neu, D., Everett, J., & Rahaman, A. S. (2009). Accounting assemblages, desire, and the body without organs. A case study of international development lending in Latin America. *Accounting, Auditing & Accountability Journal*, 22, 319–350.
- Nyland, K., & Pettersen, I. J. (2004). The control gap: the role of budgets, accounting information and (non-) decisions in hospital settings. *Financial Accountability & Management*, 20, 77–102.
- Oakes, L. S., Townley, B., & Cooper, D. J. (1998). Business planning as pedagogy: language and control in a changing institutional field. *Administrative Science Quarterly*, 43, 257–292.
- Ouchi, W. (1979). A conceptual framework for the design of organizational control mechanisms. *Management Science*, 25, 833–848.
- O'Dwyer, B. (2005). The construction of a social account: a case study in an overseas aid agency. *Accounting, Organizations and Society*, 30, 279–296.
- O'Dwyer, B., & Unerman, J. (2008). The paradox of greater NGO accountability: a case study of Amnesty Ireland. *Accounting, Organizations and Society*, 33, 801–824.
- O'Dwyer, B., & Unerman, J. (2010). Enhancing the role of accountability in promoting rights of beneficiaries of development NGOs. *Accounting and Business Research*, 40, 451–471.
- Preston, A. M., Chua, W.-F., & Neu, D. (1997). The diagnosis-related group-prospective payment system and the problem of the government of rationing health care to the elderly. *Accounting, Organizations and Society*, 22, 147–164.
- Prideaux, S. (2005). *Not so new labour. A sociological critique of new labour's policy and practice*. The policy press, University of Bristol.
- Pur, K. A. (2007). Rivalry or synergy? Formal and informal local governance in rural India. *Development and Change*, 38, 401–421.
- PwC. (2007). *Emerging market report: Healthcare in India*. Pricewaterhouse Coopers.
- Quattrone, P. (2004). Accounting for God: accounting and accountability practices in the Society of Jesus (Italy, XVI-XVII centuries). *Accounting, Organizations and Society*, 29, 647–683.
- Rahaman, A. S., Everett, J., & Neu, D. (2007). Accounting and the move to privatize water services in Africa. *Accounting, Auditing & Accountability Journal*, 20, 637–670.
- Rahaman, A., Neu, D., & Everett, J. (2010). Accounting for social-purpose alliances: confronting the HIV/AIDS pandemic in Africa. *Contemporary Accounting Research*, 27, 1093–1129.
- Roberts, J. (2009). No one is perfect: the limits of transparency and an ethic for 'intelligent' accountability. *Accounting, Organizations and Society*, 34, 957–970.
- Rose, N., & Miller, P. (1992). Political power beyond the state: problematics of government. *British Journal of Sociology*, 43, 173–205.
- Sciulli, D. (2011). *Etzioni's critical functionalism. Communitarian origins and principles*. Leiden, Boston: Brill.
- Sen, S. (1999). Some aspects of state-NGO relationships in India in the post-independence era. *Development and Change*, 30, 327–355.
- Simons, R. (1995). *Levers of control: How managers use innovative control systems to drive strategic renewal*. Boston, MA: Harvard Business School Press.
- Thompson, K. (1980). Organizations as constructors of social reality. In G. Salaman, & K. Thompson (Eds.), *Control and ideology in organizations*. Milton Keynes, England: The Open University Press.
- Unerman, J., & O'Dwyer, B. (2006). James Bond and the importance of NGO accountability. *Accounting, Auditing & Accountability Journal*, 19, 305–318.
- Waghmore, S. (2012). Beyond depoliticization? Caste, NGOs and Dalit land rights in Maharashtra, India. *Development and Change*, 43, 1313–1336.
- WHO. (2011). *Global Health Observatory (GHO), India, country data and statistics*. Available online <http://apps.who.int/ghodata/?vid=10400&theme=country>.
- Willmott, H. (1993). Strength is ignorance; slavery is freedom: managing culture in modern organizations. *Journal of Management Studies*, 30, 515–552.
- World Bank. (2011). *World bank country overview September 2011*. Available online <http://www.worldbank.org.in/>.
- Wouters, M., & Wilderom, C. (2008). Developing performance-measurement systems as enabling formalization: a longitudinal field study of a logistics department. *Accounting, Organizations and Society*, 33, 488–516.