Stockholm School of Economics
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Master Thesis

Stakeholder Management and Management Control in an Indian Healthcare Setting

Abstract

An increasing share of healthcare supply in developing countries is provided by non-governmental organizations (NGOs). NGOs are often dependent on various stakeholders, which may result in a high number of different external demands on the organization's management control. This suggests that, in order to consider the interests of external stakeholders, the control practices may become complex. This thesis explores how the external stakeholder demands affect the management control practices in a healthcare NGO. The study is performed as a case study in a small hospital in rural India and data was collected through observation, formal interviews, documents and informal conversations during two months in India. The analysis shows that the external stakeholders that fund the organization require extensive follow-up with a focus on outcome. The internal control though is managed informally through shared belief mechanisms with a strong emphasis on religion. This is made possible as the Hospital Manager handles the relations with the funders and thus absorbs the formal requirements from the external stakeholders.

Key words: Stakeholder Salience, Management Control, Non-governmental Organizations, Healthcare Management

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1. Introduction

1.1. Problem Area

"People are the real wealth of a nation"

(UNDP, 2010, p.1)

One of the major challenges facing developing countries today is the health status of their population. According to the World Health Organization, achieving a well-functioning, high-quality healthcare in today's developing countries will depend heavily on the extent to which healthcare systems can be integrated, funding needs met and underlying health systems strengthened, especially in terms of health personnel, financing and the organization of service delivery (WHO, 2011a). Many developing countries do not have the economy or the capability to provide sufficient public healthcare to its population. The provision of healthcare services is thus increasingly taken care of by private for-profit organizations and by non-governmental organizations[1] (NGOs) (Gray et al. 2006; Unerman & O'Dwyer, 2006).

The operations of an NGO differ from the profit-making business setting through the absence of the *single bottom line* (Jegers & Lapsley, 2001). An NGO is also often dependent on one or many external funders in order to continue its operations (Goddard & Assad, 2006). It is common that funders of NGOs such as governments and development aid organizations have high demands on follow-up and reporting, and differing interests of such various stakeholders may lead to an organization having a high number of different objectives and requirements (Jegers & Lapsley, 2001; Goddard & Assad, 2006). This suggests that the management control might become more complex when the interests of stakeholders are considered (Li & Tang, 2009). However, there are various studies indicating that internal control practices in NGOs often are undeveloped (Ebrahim, 2003; Goddard & Assad, 2006).

[1] Throughout this study we will use the following definition. NGOs are "organizations which are neither governmental (public sector) organizations (such as central or local government services or public hospitals, schools or universities), nor private (for-profit) commercial organizations, such as local and transnational corporations" (Unerman & O'Dwyer, 2006, p. 306).

Turning to the management control research in healthcare organizations, it is interesting to note that these often are internally controlled via informal practices, with shared values as the strongest motivator for the employees (Ouchi, 1980; Nyland & Pettersen, 2004). Formal budget controls are often introduced to satisfy expectations of key stakeholders or to maintain the legitimacy of the organization (Modell, 2009). Thus, there is a similarity to the management controls in NGOs. With an increased usage of NGOs in developing countries to provide healthcare it is interesting to investigate the effect of various stakeholder interests on the management control in a healthcare NGO.

1.2. Scope of Research

The aim of this thesis is to investigate how external stakeholder goals and objectives affect the management control in a healthcare sector NGO. Our investigation is motivated by the apparent conflict between external stakeholders driving formal objectives in the performance evaluation of the NGOs, while the internal systems of control often are ad-hoc and undeveloped (Ebrahim, 2003). The same holds true for healthcare organizations that often perceive formal controls introduced from outside as an unwanted intrusion in their professional activities (Broadbent & Laughlin, 1998). The aim of the thesis is further motivated as previous literature mostly focuses on stakeholder management in the corporate sector while stakeholder impact on other types of organizations such as NGOs is less studied (Collier, 2008).

Our intention is to reach the aim of the thesis by answering the following research question:

> *How do the interests of the various stakeholders affect the management control of a non-governmental healthcare organization?*

This thesis is performed as a case study of MediOrg, a small hospital operating as an NGO in rural India. The choice of the targeted NGO is motivated by its organizational form and by its many different stakeholders. Furthermore, MediOrg's management recognizes stakeholder pressures as one of the major issues in their daily work (Hospital Manager, 2012-02-27).

The study is interesting for funder-organizations such as development aid agencies, national health programs and private funders, since it highlights the challenges that can

occur for an NGO facing conflicting control practices. It can also be interesting for the NGOs themselves and organizations within the healthcare sphere since it explains and highlights issues in the relations with stakeholders and more specifically funder-organizations.

1.3. Outline

The thesis is outlined as follows: in the following section, the framework for stakeholder analysis is presented, followed by a framework of management controls. In addition, specific literature regarding management control in the healthcare sector and NGO-setting is reviewed. The theoretical background is followed by the description of and motivation for the methodology of the study. Thereafter, in section four, the empirical findings are described, starting with a short description on the Indian healthcare climate and the setting for the case organization, followed by our compiled data regarding stakeholder influences and the management control practices at MediOrg. In section five, the empirical material is analyzed using the theoretical framework and the findings from the study are presented. In the sixth and last section the conclusion is presented, together with some practical implications and suggestions for further research.

2. Theoretical Framework

In order to reach the aim of our thesis: to investigate how external stakeholder goals and objectives affect the management control in a healthcare sector NGO, we have to turn to the literature within two different fields of research. The stakeholder theories discussed highlights why stakeholder relations matter in the NGO setting and on what basis organizations can prioritize between different stakeholder interests. Management control theories explain how the question of control is dealt with in organizations and what kind of issues that are likely to be encountered in a healthcare NGO. Finally the theories are summarized and a plan for moving forward is laid out.

2.1. The Stakeholder Approach

As the first part of our research question is based upon the concept of stakeholder theory, the initial section of the theoretical framework aims at pointing out how stakeholder theory can be used as a tool to understand relationships and collaborations in the NGO-setting.

Stakeholder theory is based on the assumption that ethical values are a necessary part of how business is done. Values and ethics are considered to have an ongoing impact on an organization's operations and cannot be separated from the economics of doing business (Freeman, 1994). The organization is an entity through which many diverse participants accomplish multiple and sometimes differing purposes. In order to be successful in the long run, organizations need to satisfy various goals as set by different stakeholders (Donaldson & Preston, 1995; Collier, 2008). Freeman et al. (2004) concludes that a critical part of the success of an organization is the relationship with its stakeholders.

Stakeholder theory contrasts the traditional view of the firm*, agency theory,* where the main concern is the relationship between managers and shareholders (Hill & Jones, 1992). Shareholders are the owners of the company and the purpose of the firm is to maximize shareholder value. Inkpen and Sundaram (2004) argue that the preferred function of the corporation must be to maximize shareholder value since it is the best objective among all available alternatives and thus "the preferred goal for managers formulating and implementing strategy" (p. 350). However, this theory is difficult to translate for NGOs or not-for-profit organizations, which neither have shareholders nor exists with the goal of maximizing profit (Dixon et al. 2006). Shareholder maximization as a single goal is also criticized to result in short-term thinking where a more holistic and long-term view is preferred (Collier, 2008; Christopher, 2010).

Stakeholder Identification and Classification

There are many different suggestions concerning who is a stakeholder in an organization. Hill and Jones (1992) propose a definition where stakeholders are those constituents that have a legitimate claim on the firm. The claim is founded on an exchange relationship where the firm is supplied with critical resources. This definition may however be difficult to operationalize and may not capture the specific circumstances of an NGO. A broader definition, as proposed by Freeman (1984, p. 46), where a stakeholder is "any group or individual who can affect or is affected by the achievement of an organization's objectives", is therefore more suitable for this context. Harrison and John (1996) separate between internal and external stakeholders, where

internal stakeholders are exemplified as employees. External stakeholders are those groups or individuals that are external to the organization. Li and Tang (2009) make an additional distinction, between owners and non-owners, where owners in the NGO setting are both legal owners and funders. Non-owners are other entities such as customers or local communities. They also conclude that owners (and funders) can have a direct impact on the objectives of the organization.

Mitchell et al. (1997) suggests that stakeholders can be classified with regards to three attributes. This classification of stakeholders is described as *stakeholder salience*. Stakeholder salience is a central notion as it gives guidance to how managers should prioritize between multiple stakeholder interests. In the NGO setting this is important, as these types of organizations often have a wide and multifaceted range of stakeholders (Goddard & Assad, 2006). The first attribute is the stakeholder's *power* to influence the firm, that is, the extent a party has or can gain access means to impose its will in a relationship. The power can be utilitarian and based on monetary means or incentives, which is used to gain control in the relationship. The power can also be based on normative means, where social symbols such as acceptance can be used to influence the organization (Mitchell et al. 1997).

The second attribute is the *legitimacy* of the stakeholder's relationship with the firm. Friedman and Miles (2002, p. 16) propose that only stakeholders in "necessary relations" with an organization are regarded as legitimate by the organization. Mitchell et al. (1997) brings forward this attribute as tool to help identify which stakeholders merit managerial attention and to determine whether a stakeholder's claim on the organization should be adhered. Whether a stakeholder has a legitimate claim on the organization is determined by the organization itself, where management decides whether an external stakeholder should be considered as a necessary relation.

The third identification attribute is the *urgency* of the stakeholder's claim on the firm, the degree to which a stakeholder claim calls for immediate attention. Urgency aims at reflecting how important it is to pay attention to a stakeholder in a timely fashion. How quickly do the parties in an exchange relationship have to adhere to each other's requests? Urgency is based on *time-sensitivity*, the degree to which managerial delay in

attending to the relationship is unacceptable to the stakeholder, and *criticality*, how important the stakeholder considers the relationship with the organization. Urgency by itself will not warrant high salience, but combined with either power or legitimacy, urgency will affect the relationship and increase its salience to the organization (Mitchell et al. 1997).

This first theoretical section is aimed to clarify how the concept of stakeholders is defined and what definition is feasible in the context of an NGO. The stakeholder view is also contrasted against agency-theory, where shareholder wealth is considered as the single goal of an organization. The concept of stakeholder salience (Mitchell et al. 1997) is introduced in order to be able to analyze how stakeholder relations can be prioritized in the operations of an NGO.

2.2. Framework of Management Control

This thesis aims at answering the question on how management control is affected by external stakeholder relations. This section thus aims at describing and understanding the concept of management control and how it works in a healthcare NGO. The concept of absorption is presented since as may appear in traditional public sector areas that meet an increased demand of follow-up from external stakeholders.

Management control is described in Otley (1994) as an activity that ensures that all the operations of an organization are working coherently for the survival of the organization. The activities of management control can be divided into two groups: *formal controls* and *informal controls* (Dekker, 2004). Formal control can in turn be divided into *behavior* and *outcome control* (Ouchi, 1979).

A formal control setting refers to formalized organizational mechanisms for collaboration within the organization. Planning, programs, rules and standard operating procedures determine behavior control. Outcome control consists of ex-ante mechanisms such as goal setting and predefined reward structures. These are followed by performance measurement and follow-up (Dekker, 2004). Otley (1999) describes the definition of goals and key objectives as one of the main mechanism in an organization's

control system. He further recognizes that this activity is dependent on who are defined as stakeholders and how they are prioritized.

Siding with the formal framework of management control is the informal control. Informal control relates to those informal cultures and systems influencing the members of the organization and is self-regulatory (Ouchi, 1979; Dekker, 2004). Ouchi (1980) suggests a form of organizational control described as the clan. In a clan organization, control is exercised through shared beliefs. Traditions are described as the informational requirement for exercising clan control and performance evaluation takes place through "subtle reading of signals", which cannot be translated into "explicit verifiable measures" (Ouchi, 1980, p. 137). Thus, in clan organizations, informal control is the dominating management feature. The organization does not follow or implement performance evaluation measures such as formal behavior monitoring and rewarding (Dekker, 2004).

Management Control in a Healthcare NGO

Management control in an NGO often differs from the profit-making business since they do not have profit as a motivation force for their operations (Jegers & Lapsley, 2001). Goddard and Assad (2006) recognize the complexity of NGOs since they have ideologies and missions that might be hard to combine with the often more business-like control practices of their stakeholders. In Ebrahim (2003) it is also observed that the controls of NGOs are often more focused on control demands from funders while internal control mechanisms remains undeveloped. These external demands are often used as a strategy to establish legitimacy (Goddard & Assad, 2006).[2] Ebrahim (2003) also highlights that it is not uncommon with conflicting views of management controls between NGOs and their funders, where funders tend to focus on tangible results such as "the numbers of schools built, tree planted, and land area irrigated" whereas the NGOs prefer to highlight processes such as "participation" and "empowerment of people", (p. 817).

[2] This legitimacy is not to be confused with the legitimacy attribute used in order to determine stakeholder salience. The legitimacy attribute refers to how management sees the organization's stakeholders (Mitchell et al. 1997). The external legitimacy in the management control setting refers to how external actors see the organization (Goddard & Assad, 2006).

There are specific issues that need to be considered when studying management control in a healthcare organization. Three dominating characteristics of hospitals' tasks and service production are described in Pettersen (1995); healthcare is an intangible product, healthcare production occurs in the interaction between healthcare personnel and patient and production and consumption of healthcare occur simultaneously. Formal outcome control is thus difficult, given the nature of the service. It is thus argued that outcome controls such as performance metrics are only applied in the hospital settings due to institutional pressures (Pettersen, 1995; Modell, 2009). Nyland and Pettersen (2004) also state that informal meetings based on dialogue are the most fruitful way of dealing with strategic uncertainties in healthcare organizations. According to Ouchi (1980), organizations such as hospitals are mainly coordinated through norms and values. However, the literature also shows support for the existence of economical and efficiency rationales for implementing formal budgeting (Järvinen, 2006). Chang (2006) brings forward that goals from external stakeholders, such as the government, sometimes can outweigh clinical decisions. This is mainly explained by the dependency on financial resources distributed by external stakeholders.

The Concept of Absorption

Given that the hospital environment is mainly coordinated through informal control, we should address how management may handle formal control practices imposed by external stakeholders. Laughlin et al. (1994a) found that in handling new government imposed public management systems in British public schools, management had a tendency to create a small group absorbing the formal tasks involved. *Absorption* is described as an organizational change mechanism created in order to cope with an environmental disturbance which intrusive power needs to be minimized. The same type of observation was made in a number of general medical practitioners (GPs) where practice managers and nurses took on a role as absorbers of change when government enforced implementation of new public management system in the public sector. By using absorption groups the GPs could separate intrusions that might have an effect on the doctor-patient relationship and on the way GPs traditionally operate (Laughlin et al. 1994b). The absorption groups are thus formed informally or formally as a resistance function towards outside imposers and shields the organization so that its employees can continue working without financial or accounting concerns (Broadbent and

Laughlin, 1998). It can be noted that the studied organizations appeared to have seen outside actors as intruders to the organization and the absorption function was created to counteract something perceived as negative to the organization.

This second part of the theoretical framework defines management control as an activity that managers pursue in order to direct organizations towards its goals and mission. This activity can be done both formally and informally. Given the existence of multiple stakeholders, goals can be complex and diverse. This is often the case in an NGO-setting. However, literature (Ebrahim, 2003; Goddard & Assad, 2006) suggests that internal controls often are undeveloped while the follow-up required by external funders often is more sophisticated. Management control in a healthcare setting is also often informal and formal control initiatives are often met with skepticism. Formal control imperatives might therefore be absorbed at different levels of the healthcare organization.

2.3. Theoretical Framework in Conclusion and Moving Forward

In the above sections we identified the relevant theoretical framework needed in order to reach the aim of our thesis, to investigate how external stakeholder goals and objectives affect the management control on a healthcare sector NGO.

In the first section we clarified that we will use Freeman (1984, p. 46)'s definition of a stakeholder: "any group or individual who can affect or is affected by the achievement of an organization's objectives". This is a broad definition that is applicable to the NGO context of our investigation. Furthermore, the distinction between external and internal stakeholders (Harrison & John, 1996) was clarified and will be applied throughout the thesis, as we are interested in how outside interests affect the internal dynamics of the NGO. The notion of stakeholder salience (Mitchell et al. 1997) was introduced and will be used in determining whether the studied organization's stakeholders have different influence on the management control system.

In the second part, management control was defined as an activity that managers pursue when directing the organization in order to reach its goals and missions. The manager can use both formal and informal control systems (Dekker, 2004). Informal control relates to informal cultures and systems influencing the members of the organization

and is self-regulatory (Ouchi, 1980). When an organization, such as an NGO, has multiple stakeholders, the goals can be complex and diverse, but it is concluded that many NGOs have informal control systems for the internal use (Ebrahim, 2003). Management control in healthcare organizations is often also informal and in order to handle stakeholders imposing formal control imperatives, absorption functions can be created.

Moving forward, we first need to investigate and clarify stakeholder relations within the case-organization. Furthermore, it is important to translate the stakeholder salience attributes into concepts that can be explained with the management control framework. This will be done through identifying and mapping the different stakeholders and thereafter clarifying how the stakeholders ensure that their interests are considered. This will give us an indication of the power, legitimacy and urgency of the different stakeholders and thus the stakeholder salience. MediOrg's management control system will after this be explored, identifying the formal and informal control mechanisms at MediOrg, being an NGO within the healthcare sphere. We will then be able to analyze how stakeholder interest affect MediOrg's management control practices and reach the aim of the thesis.

3. Methodology

3.1. Selecting the Case – Stakeholder Management and Management Control in an Indian Healthcare NGO

This thesis explores the missionary hospital MediOrg, located in rural parts of India. The healthcare situation in the area is to a large extent performed by private actors, often in the form of an NGO. The area is one of India's poorest and least developed when it comes to infrastructure such as roads, electricity and sewage systems. MediOrg is a small hospital with limited resources and little possibilities for specialist care. In order to work towards its mission of helping the community in a holistic manner, MediOrg collaborates with many other organizations in the area as well as with national health promotion programs.

Being dependent upon various funders for the various programs, the hospital is expected by its funders to keep costs at a low level while still providing adequate

healthcare. The organization is closely interrelated with and dependent upon several other organizations. This motivates the rationales for taking up a stakeholder approach in analyzing the organization and the way that it is managed (Freeman, 1984). MediOrg have to manage the relations with funders, collaborators, employees and patients in order to survive and fulfill its mission. MediOrg thus offer a good possibility to study how a small healthcare organization manages its stakeholders. The Hospital Manager of MediOrg was also welcoming to this type of investigation, ensuring contact with both interviewees and field visits to many of the collaborating organizations and funders. Possibilities to study the organization itself in depth with access to interviewees at all levels of the organization were also ensured by the Hospital Manager. Thus, there was both a theoretical motivation and an access factor motivation for choosing MediOrg as case organization.

The choice of a single case approach over a multiple case study is to a large extent based on the time limits given by a master thesis. But there are also advantages with a single case. Dyer and Wilkins (1991) argue that the single case study is powerful since the studied phenomena can be described so well that others will not encounter any difficulties in finding the same phenomena in its own organization. Despite the fact that single case approach can affect the generalizability of the findings (Eisenhardt, 1989), the purpose of the study justifies the methodology, as we are interested in finding an example of how one organization's management control practices is affected by multiple stakeholder interests and not to develop prescriptions of how all NGOs should act in a multi-stakeholder environment.

3.2. Data Collection - Performing a Field Study in Rural India

A combination of information sources was the basis for the data collection. We had the opportunity to stay at the hospital compound for five weeks where we participated in the daily work and the planning and monitoring of the hospital practices. We participated in the daily morning prayer, every day we had lunch with the Hospital Manager and the Senior Counselor and we took part in the daily tea with the hospital employees. Thus, a large share of the information was gathered through interaction and participation. This was imperative in order to comprehend the management controls at MediOrg. Management control practices, especially informal ones can initially be difficult to identify for an outside viewer. They are also difficult to observe via formal

interviews, since they are often implicit and performed in relations between coworkers (Ouchi, 1980). The only way to fully grasp the culture and gain the trust of the organization it was necessary to spend a longer period of time there. This gave us an irreplaceable opportunity to understand the control mechanisms better than if we had stayed a shorter period of time. In addition to the observational data, formal interviews at MediOrg were conducted with the Hospital Manager, the Middle Manager, the Senior Counselor, the Accountant, one Nurse and one Maintenance Lady (see appendix, section 8.1).

The data collection was conducted through a mixture of formal and informal interviews, observations, document studies and physical artifacts (Yin, 1994). Given language and cultural barriers, multiple sources of information were in many cases necessary to fully grasp the material. Triangulating the results with various sources is also argued to give stronger support for the creation of hypotheses (Eisenhardt, 1989) and discover new perspectives on the research problem (Dubois & Gadde, 2002). This was in many cases true for this study as we identified possible elaborations on the topic the further the research process progressed.

Throughout the data collection, at least one of us was taking notes while the other managed the interview. Many of the interviewees were new to the interview setting and to make them more comfortable, we chose not to use a recorder. The interview notes were transcribed and discussed following each interview in order to ensure that information and quotations were correct. During the formal interviews the interviewees were given information about the authors and the overall aim of the study. A template of interview questions based on management control was used. This allowed us to adapt to the interviewee and to create a conversational setting where the interviewee could feel at ease. In total, 19 formal interviews were conducted. On average, the formal interviews lasted between 30 to 60 minutes with an average length of around 45 minutes.

3.3. Data Analysis – Making Sense of the Material

As described in Eisenhardt (1989), the collection and the analysis of data often occur simultaneously. The approach for analyzing data from interviews and observations is similar to the concept of systematic combining as described in Dubois and Gadde (2002). According to the authors, “theory cannot be understood without empirical

observation and vice versa" (p. 555). This method may make it necessary to change or extend the theoretical framework as the data collection proceeds. Given the circumstances of our studied organization, being located in a remote and for us culturally distant area we had little possibility to gather thorough data prior to our arrival in India. Hence, the final theoretical framework evolved simultaneously with the collection of the data, although the theoretical direction was set before departure.

The sorting of the data was based on type of stakeholder relation and management control. Interviews with the Hospital Manager and the Middle Manager served as both as sources of specific as well as explanatory information regarding different observed circumstances, at MediOrg and in the geographical area. The answers have been analyzed using our theoretical framework and language barriers and cultural context have been taken into account when interpreting the findings.

3.4. Validity and Reliability – Some Additional Comments on Performing a Field Study in a Developing Country

In this section we address the validity and reliability of the study in order to layer our findings and highlight some of the challenges when performing a case study in a developing country.

Regarding *validity*, the degree to which the results of the research illustrate reality, a distinction between *inner* and *outer* validity can be made. Inner validity refers to the extent to which the authors have interpreted the data in a correct way (Merriam, 1994). As in all research relying on qualitative information, there may be issues of subjectivity based on the authors' assumptions and interpretations. It is important to note that language and culture barriers may have affected the interpretations of the interviews although efforts were made to counteract this. Also, many of the interviewees were unused to the interview situation, which may have had an effect on their answers.

Outer validity refers to the degree to which the results are generalizable for other contexts (Merriam, 1994). In considering whether the conclusions from this study can be applied to other contexts or situations it should be noted that the setting of MediOrg is in many ways unique. It has a Christian value base in a Hindu country and it operates in one of India's most backward and poor areas. It would thus be hard to argue that

what holds true for MediOrg would be valid for all other NGOs in developing countries. However, this study should not be regarded as an attempt to create normative theory, rather to present an example of how stakeholder interests can affect the management control system in one healthcare NGO.

To ensure *reliability*, the degree to which a study can be replicated in order to reach the same conclusion, it is important not to let the empirical collection be affected by random events or chance (Lundahl & Skärvad, 1999). We stayed five weeks at MediOrg in order to ensure this and to uninterrupted be able to fully comprehend the environment at the hospital. However, the study may still be difficult to replicate, as the setting is quite specific with regards to health level and poverty. The formal interviews followed an overall interview template based on the formal management control framework as proposed by Otley (1999). As we tried to adapt to the interviewees to create a comfortable environment for them it may be difficult to replicate the exact structure of the interviews.

4. Empirical Results

In this section we will start with an introduction to the healthcare situation in India and an overview of MediOrg's organization in order to create an understanding for the environment in which the hospital operates. We will continue by mapping MediOrg's external stakeholders and clarify how they ensure that their interests are considered. After this, MediOrg's management control practices will be explored and we will identify formal and informal management control mechanisms.

4.1. Background and Context

Healthcare in India

India is the world's second largest country by the size of the population. In 2009, the WHO was estimated that 1.2 billion people were living in India. About 70 percent of them were estimated to live in rural areas (WHO, 2011b). According to World Bank estimates, 32 percent of the Indian population lives below the poverty line ($1.25 per day) (World Bank, 2011). India ranks number 119 on the Human Development Index (UNDP, 2011), has a life expectancy at birth of 65 years for both sexes and spends 2.4 percent of GDP on public healthcare (WHO, 2011a), which puts the country as low as

185 on a world ranking regarding public healthcare spending (CIA, 2011). The private sector accounts for more than 80 percent of total healthcare spending in India (PwC, 2007). The total number of skilled personnel is low. The WHO (2011a) estimates that the number of physicians is 6 per 10,000 and the number of nursing and midwifery personnel is 13 per 10,000. In addition, the WHO (2011a) states that many of the healthcare institutions are concentrated to urban areas, whilst the demand is highest among the rural population. For them, access to healthcare can be difficult, as rural-urban infrastructure often is poor.

Given the size of the population, its diversity and the economic conditions, India faces a great challenge when it comes to providing qualitative healthcare to its population. There have been continuous improvements in health indicators in recent years, but the progress is slow and has not really proved to match India's economic growth during the past decade. A large proportion of the population still has no access to qualitative healthcare (World Bank, 2011).

MediOrg

MediOrg is a healthcare initiative started by a European Church in the 1970's. MediOrg has a governing board consisting of six members, but the Hospital Manager is responsible for the daily operations at the center. MediOrg is situated in rural India and offers daily primary healthcare to incoming patients from the surrounding area. On average, MediOrg treats 30 to 40 in the open clinic per day and there are between 20 and 30 patients treated in the wards. Next to the primary ward treatments, the center focuses on treatment in four areas, HIV/AIDS, Tuberculosis, Family Planning and Blindness Control, each of them in corporation with the corresponding government programs. The hospital cooperates with other NGOs as well as other healthcare institutions in the surrounding area (Hospital Manager, 2012-02-27). The hospital "is very small, but through our large network, we can provide better service to the poor people" (Middle Manager, 2012-02-27).

MediOrg is described as "semi-private" by the director of the hospital since "most of the programs we undertake here are activities of the national programs and thus we work in close relation and in line with government" (Hospital Manager, 2012-02-27). The

center employs three doctors and five nurses. There are also other employees such as a lab technician, counselors, maintenance personnel, drivers and caretakers. In total, 34 people are employed by the hospital (Middle Manager, 2012-02-27). Some of the employees live at the hospital together with their families.

The Church funded the first infrastructure and equipment of the hospital and still provides MediOrg with a general grant. MediOrg functions as a training center in community health for local medical and nursing schools and for this MediOrg receive some payment. Furthermore, MediOrg receive specific grants from the government for running the four programs conducted parallel to the primary healthcare. The government provides the grants through departments, monitoring the activities (Hospital Manager, 2012-02-27).

4.2. External Stakeholders at MediOrg

The first external stakeholders are the patients. People in the area are seldom able to pay for healthcare and a serious illness is often devastating for the whole family given both costs of healthcare and loss of income. The local community is therefore often dependent on free or heavily subsidized healthcare and social services when an illness occurs in the family (Hospital Manager, 2012-02-27). Moreover, there is a problem of social stigma regarding many of the healthcare problems occurring in the area, such as HIV/AIDS. Even though the patients are aware of the services that they may obtain at MediOrg, they have little ability to determine what type of treatment they need and whether it is executed correctly.

HIV/AIDS Control Program

MediOrg undertake HIV testing and treatment. If the patient is found positive, he or she is admitted to MediOrg. The Hospital Manager says that due to financial constraints, they cannot admit all patients that are positively tested, only those that are severely weak (2012-03-19). The treatment of HIV is free of charge for the patients.

The aim of the HIV government program is to supply HIV/AIDS patients with support and access to quality care. It hopes to improve access and accountability of the services. The funding of the HIV program stands for about 35 percent of MediOrg's total budget. The objectives for the program are set by the government agencies which release the

funds to MediOrg and monitor and evaluate the hospital's work and ensure that the guidelines are implemented. The HIV program has a program manager that regularly visits the hospital and review documentation related to the program. Every month, MediOrg supply the government agency with documents following a predetermined structure. The agency also provides the hospital with training in financial management and reporting (Program Manager, HIV, 2012-04-02). This is done both through brochures and through the structure of a computer program through which the reporting is done. The Program Manager (2012-04-02) stresses that this is an area where hospitals such as MediOrg need help, adding that organizations of this kind has a lot to gain if they can provide more evidence-based operations. The program manager adds that it is only recently that organizations such as MediOrg are working together and in line with governmental programs. NGOs in healthcare India are generally skeptic towards governmental programs since they are known for being corrupt and bureaucratic (Program Manager, HIV, 2012-04-02).

Additional stakeholders in the HIV program are a district hospital and a local network center. The district hospital has an ART[3]-center, where testing for HIV is provided together with counseling and ART-medicine, but they do not admit HIV/AIDS positive patients. These are instead referred to healthcare centers such as MediOrg (Medical Officer, district hospital, 2012-03-16). There are no funding ties between the two organizations, and formal measurement or follow-up systems related to the relationship between the two are not set up. Support group meetings are held for HIV positive people and their families in the area and these meetings are hosted by MediOrg. Once a month, they participate in a "revival day with games, lectures, witness, presentation of problems and their solutions in addition to medical care" (MediOrg, 2010-11, p. 4). Participants are provided with a one-month ration of food products, lunch for the day and travel expenses. The support group meetings are wholly funded by the district hospital which follows the work at MediOrg through recurrent visits where the survey the daily work, however no formal goals have to be attained and there are no formal follow-up procedures. The local network center is another stakeholder related to the HIV program. Following MediOrg's holistic approach to healthcare, they work with the local network center, which gathers HIV positive people in the community (Middle Manager, MediOrg,

[3] ART stands for antiretroviral therapy, and is used to medicate HIV/AIDS (WHO, 2012).

2012-03-16). “The center care and provide support for HIV positive people with housing schemes, support group meetings, nutrition, stigmatism and legal issues” (Center Manager, local network center, 2012-03-16). There is no funding exchange between the organizations and no formal guidelines or follow-ups are performed.

Tuberculosis Control Program

MediOrg run a tuberculosis control program designed to cover a population of 100 000 in the surrounding area for the Government Tuberculosis Program (District Tuberculosis Officer, 2012-03-05). There is a national government initiation for the reduction of Tuberculosis in India. The vision of the government is for a Tuberculosis-free India.[4] The major share of the program is funded through the government agency, including the salary of the lab technician performing the tests (MediOrg, 2010-11; District Tuberculosis Officer, 2012-03-05). The funding for the program stands for about 20 percent of MediOrg’s total budget.

When choosing a center to work with, the government agency considers which areas that are in need of more attention. MediOrg was chosen as they have documented good contact with a large share of the local population and can therefore help them with issues such as detection and information (District Tuberculosis Officer, 2012-03-05). The work within the tuberculosis program is under the supervision of the District Tuberculosis Officer, who once a month comes to the center to assess the progress of the program. He monitors how many patients that are detected, if all detected patients are treated and the reason for why some patients do not go into treatment (Hospital Manager, MediOrg, 2012-03-12). When assessing the success rate of the program, the District Tuberculosis Officer follows national targets. He looks at the case detection rate (the target is 70 percent), the follow-up sputum[5] (90 percent should be converted to

[4] In order to achieve this vision, the program has adopted five targets to by reached by the end of 2015. These targets are: Early detection and treatment of at least 90 percent of the estimated Tuberculosis cases in the community, including HIV-associated Tuberculosis, Initial screening of all re-treatment smear-positive Tuberculosis patients for drug-resistant Tuberculosis and provision of treatment services for MDR-Tuberculosis patients, Offer of HIV Counseling and testing for all Tuberculosis patients and linking HIV-infected Tuberculosis patients to HIV care and support, Successful treatment of at least 90 percent of all new Tuberculosis patients and at least 85 percent of all previously treated Tuberculosis patients.

[5] A patient that has cough for more than 14 days does two sputum tests (Tuberculosis tests) with a certain interval. If both the first and the second test are positive, treatment is initiated.

negative) and finally cured rate (target 85 percent)(District Tuberculosis Officer, 2012-03-05).

Family Planning Program

Another program run at MediOrg is the Family Planning Program, where female sterilizations are performed. Between 200 and 300 operations are performed per year. The operation and treatment is free of charge for the patients (Hospital Manager, MediOrg, 2012-02-27).

The main external stakeholder in this program is the national government, through a specific governmental agency. The funding of the program stands for about 10 percent of MediOrg's total budget. This program aims to improve the health status of the population, focusing on 18 states in India having weak public health indicators and/or a weak infrastructure. There are national targets, however the guidelines communicated to MediOrg refers to overall matters, such as availability and "quality services". Evaluation and monitoring is done through mid-year reviews where MediOrg sends required numbers to the agency. There are also occasional visits by a governmental officer.

Blindness Control Program

Twice a month, MediOrg holds an eye camp, where eye operations for cataract are performed. On average, 25 patients are operated on each camp day, while some 200 to 300 patients come the center for check-ups and eye medicine (MediOrg, 2010-11).

The Blindness Control Program is conducted with the support of a national program for control of blindness. This national program aimed at reducing blindness in India (Hospital Manager; MediOrg, 2012-03-12). The Blindness Control Program stands for about 10 percent of MediOrg's total budget. There is great need for an expansion of the program as there are a large number of people still in need of treatment and there is only one surgeon (Hospital Manager, MediOrg, 2012-02-27). Follow-ups are performed to ensure that the formal guidelines and goals of the program are followed.[6] This is done

[6] Aims: Strengthen service delivery, develop human resources for eye care, promote outreach programs and public awareness and develop institutional capacity.

through demands on formal documentation and occasional visits at MediOrg. The government agency states that random controls need to be carried out in order to assess the validity of reported data, status of follow-ups, provision of glasses and patient satisfaction. Special forms are to be filled with information regarding pre-operative check-up, surgical details, post-operative assessment and follow-up services. Periodic reviews are carried out to assess the progress in each district and by each provider unit. The agency considers outcomes (number of individuals whose eye sight is restored) rather than the number of cataract operations performed.

Other Activities and Stakeholders at MediOrg

There are and have been many smaller activities as part of MediOrg's operations. MediOrg functions as a training center for nursing and medical students who as a part of their education need to have clinical training. The main stakeholders are a medical college, a nursing college, and a university. The training programs are a source of revenue for MediOrg as the colleges and universities pay for the clinical training (MediOrg, 2010-11). The fee stands for about five percent of MediOrg's total budget. The aim is to provide the students with proper training and follow-up is done through training reports provided by the students and occasional visits by university personnel.

Together with a Christian medical college, MediOrg runs an awareness program that aims to empower people so that they can demand the services that they need and to create awareness about what sickness is and what people can do and get in order to treat it (Coordination Officer, Christian medical college, 2012-03-27). No funding is provided by the medical college, there are no formal guidelines that MediOrg has to follow in relation to the awareness program and no formal follow-up is performed. On an area basis, one indicator of success is that the percentage of home deliveries has decreased severely. However, the coordination officer also stresses that there are more informal ways to notice if the program is working or not, such as how the communication with patients is conducted and whether the patients are aware of what they can expect from the healthcare institutions (Coordination Officer, 2012-03-27).

The Church still provides a general grant to MediOrg, which stands for about 20 percent of MediOrg's total budget. The grant is not fixed to a specific operation at MediOrg, instead it is intended as a general contribution so that MediOrg can continue their activities. Formally, the Church has the right to participate in decisions and take part of the governing board. However, they are of the view that it would be better if MediOrg can learn to manage itself and the Church is more to be seen as a moral support and the grant has gradually been reduced throughout the years. They have "no specific comments" on the follow-up of how their grant and there is no specific procedure for this (Director of International Mission, the Church, 2012-05-03).

The stakeholders and funding structure of MediOrg can be summarized in the following table:

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

Table 1: Stakeholders and funding to MediOrg

4.3. Management Control Practices at MediOrg

The overall goal at MediOrg is prevention of diseases and promotion of health. Their mission is to contribute to:

> *"…a community/state/country where all will: have enough to suppress hunger, have clothes to wear, have clean water to drink, have a proper house to stay, have the ability to care for the elderly, have the ability to bring up children, have facilities to limit their family size and the women are empowered and protected irrespective of caste or creed" (MediOrg, 2003, p. 3).*

With the prevailing circumstances in the area, there is also a strong focus on holistic healthcare since many of the patients often have various problems that prevent them from staying healthy. The programs taken up by the hospital falls in line with its mission (Hospital Manager, MediOrg, 2012-03-12). The objectives are set in accordance to the religious and missionary basis of MediOrg. There is no evangelization at MediOrg, and that is not the hospital's aim, but they are still "proud to present and give our Master's love, concern and care to the needy and for whoever walks into this compound" (MediOrg, 2010-11).

Formal Controls

There is periodic submission of reports to the different funding agencies. There are targets for the programs for month, quarter, and year and if these targets are met then it is considered as a successful program (Hospital Manager, MediOrg, 2012-03-19). The funding agencies are mainly interested in the completion of clinical targets. There are different parameters and budget line controls with "very little flexibility" (Hospital Manager, MediOrg, 2012-03-19). Funding is attained (except for the general funding by the Church) by claiming performance afterwards and thus the hospital needs to present both receipts and clinical statistics of the number of operations conducted and the number of patients treated in order to receive payments. There is also a pre-set non-negotiable level of care and number of patients that cannot be overused (Hospital Manager, MediOrg, 2012-03-19).

The performance evaluation conducted by the funding organizations is however mostly the concern of the Hospital Manager. When interviewing other employees at the

hospitals about financial constraints or performance targets, they often stated that they do not need to worry about these issues since it is taken care of by the Hospital Manager. Even the Hospital Accountant was to a large extent unaware of in which way the material she produced would be used. The Middle Manager at the hospital also referred to the Hospital Manager when being asked about target setting and evaluation. The Hospital Manager himself describes that he does not want to worry his employees with too much of the financial measurement and pressures from funding organizations. The visits and reports that are required from funding agencies are not apparent in the daily work, except for the patient journals that need to be updated by the clinical personnel.

There are few formal control practices for the employees. There are some notice boards, both in the hospital building and in the chapel. There are printed notices sometimes distributed among the employees from the Hospital Manager. Moreover, MediOrg have booklets of rules, regulations and practices available for the employees (Hospital Manager, MediOrg, 2012-03-26), however these are seldom used. The daily work at the hospital is planned and performed as routines. There are short, written descriptions of most of the positions in the hospital. However many of the daily routines of the medical employees is already known as consequence of their profession. The nurses follow a job-rotation program where they shift task and position every week. There are procedures such as the daily patient round. When enrolling patients to the hospital, they are first examined and then the hospital manager is asked whether the patient is to be admitted or not. In the pre-set formats for patient journals there is information regarding what type of health and background information that needs to be collected from each patient in order to administrate correctly. The procedures described as well as other processes that are involved in the daily work at the hospital is not formally described but rather rituals into which everyone is integrated into when starting their work at MediOrg.

Informal Controls

Most of the daily work at MediOrg is managed through informal control mechanisms. The culture at MediOrg is very much affected by the fact that the hospital is founded as a missionary institution. There is an overall presence of religion, displayed through physical artifacts such as crucifixes on the walls, biblical quotes at every entrance and a chapel at the hospital compound. It is also displayed through the topics of conversation

among the employees. One nurse proudly told us about her conversion to Christianity and how through her work at the hospital she would be safe "standing by the gates of heaven" (Nurse, MediOrg, 2012-03-09). The chapel plays a large role in the daily work at MediOrg, as every day is commenced by a morning prayer and singing in the chapel. All employees working that day participate in the service. The employees takes turn in saying the prayer, which usually relates to the wellbeing of the patients, the employees and the people living in the area.

The presence of religion was also shown in how the employees communicated with us. We were in an early stage of our stay asked if we were Christians, to which Church we belonged to and how often we attended service. On the Monday mornings we were asked whether we went to the service at the church on the Sunday, and if we agreed that it was a very nice service. There was an unsaid expectation that religion played a large part in our lives as well and we felt an implicit pressure to take part in the religious activities. It should be mentioned that towards the end of the stay, we felt less pressure regarding this. There is a religious freedom at the hospital in the sense that both Christians and Hindus work together without any problem, however there is a norm regarding religion, where it is assumed that everyone has a religion of some sort.

There are different channels of information at MediOrg whereof most of them are informal. Many issues and questions in the daily work are solved and discussed ad-hoc. The main way of communication is informal talks throughout the day. The Hospital Manager claims that there are regular meetings with all the employees twice a month and if needed there are also emergency meetings. However, during the five weeks we collected the data, there were no specific meetings. The main information sharing took place during the daily teatime and in connection with the daily morning service in the chapel.

There are no explicit rewards for employees except oral appreciation, transferred by the management to the employees when they hear of it from the funding agency. "We as a team when we see the fruits of our work we appreciate ourselves and enjoy as a team. There are many times good fruits of our work we can see in the field and we enjoy that (Hospital Manager, MediOrg, 2012-03-26)". Moreover, a motivating force is said to

derive from the religious basis of the organization. The employees receive thanks from patients and visitors saying that they have felt "His presence" at the hospital (MediOrg, 2010-11, p. 1). The employees earn a relatively low salary but the nurses describes that they do not exactly work for the money but for the feeling of achieving something meaningful, contributing to society and to serve God. "We like our work here, this hospital does good work for the people living around here. I know I am working for something good" (Nurse, MediOrg, 2012-03-09).

Adding to the management context of MediOrg is the character of the Hospital Manager. He and his wife, functioning as the Senior Counselor, have been running MediOrg almost since it was started (MediOrg, 2003). The Hospital Manager is seen almost as a father figure and there is a large amount of respect for him among the employees (Senior Counselor, MediOrg, 2012-03-28). This is displayed in the way the employees talk about him. At one point, one of the maintenance ladies said to us, "Sir is very good. He takes care of us" (Maintenance Lady, MediOrg, 2012-03-28). The Hospital Manager has been contemplating retirement for some time, but is afraid of what will happen to the hospital if he does, as there is no apparent candidate who can take over.

There is also a large amount of respect for the Hospital Manager's wife, referred to as "Madam". She works as Senior Counselor at MediOrg and she supervises the cooking and food provision for the in patients. During the initial part of the data collection, Madam was not at MediOrg. When talking about her to us, the employees referred to her in a warm manner, saying that she was a very good and important person. The morning of Madam's return, the employees greeted her very warmly; the nurses turned to her first when saying good morning and the maintenance ladies kissed her toes, as you do to your mother according to tradition. There was a clear distinction between management and employees and management's authority was strong. This was for example displayed in they way that the manager and his wife were addressed, the employees on every level always said "Sir" or "Madam". Moreover, during the day the Hospital Manager would always stay in his office and the employees would come to his office with questions or if they had patients that needed to be enrolled. Also, the Hospital Manager and his wife would never eat or drink tea with the employees. "If we were to have tea together, the

staff would not be able to relax. Even if I told them to relax, they would not. They are too aware that I, as a Manager, is there too" (Hospital Manager, MediOrg, 2012-03-26).

When setting up new programs or collaborations, it is most often the Hospital Manager or the Senior Counselor that has an idea, deriving from a problem that they have seen. This was the case for the blindness control program. The Hospital Manager plays an important role in the relationship with the different stakeholders, in setting up the relationship and maintaining it. He knows the managers at the different organizations and he is a well-known figure in the local community. Religion also plays a role in how the Hospital Manager is able to bring about new practices or collaborations. Through the church, there is a large network of people working in different organizations and the church provides a foundation were these people can meet informally and develop relations with each other.

The management control practices at MediOrg can be summarized as follows. The governmental agencies that contribute with most of the funding to MediOrg requires timely and extensive formal reporting and follow-up of funds while the Church that provides the general grants demands an annual report and some descriptions on how the work is progressing. The daily work at MediOrg is controlled through routines and regulations. However, the motivation force for employees and the overall direction of the organization is very much guided by common belief systems. The religion is deemed very important along with the strong spiritual leadership that the Hospital Manager exerts.

5. Analysis – Stakeholder Management and Management Control in MediOrg

In order to reach the aim of our thesis; to investigate how external stakeholder goals and objectives affect the management control in a healthcare sector NGO, we will answer the following research question:

> *How do the interests of the various stakeholders affect the management control of a non-governmental healthcare organization?*

The question will be answered in three parts, the first to identify which of the stakeholders that actually affect the organization while the second part investigates what happens with the stakeholder demands and interests within the organization and if the management control is affected by these external interests. Finally, the contrast between the external stakeholder requirements and the internal systems of control are discussed and theorized with the concept of absorption.

5.1. Stakeholder Identification and Impact

Given that MediOrg is a non-profit organization the notion of shareholders gets insignificant. Following the reasoning of Jegers and Lapsley (2001) the organization has no single bottom line, but plentiful; the objectives of funders, non-funders, employees and patients, that is, its stakeholders. MediOrg functions under the umbrella of a wide mission, where focus is on using the available resources as wisely as possible in order to ensure a holistic care for patients. As previous literature points out (see for example Goddard & Assad, 2006 and Unerman & O'Dwyer, 2006), it is thus clear that agency theory is too narrow to explain the operations of a healthcare NGO and the tools brought forward by stakeholder theory should be utilized in order to fully grasp MediOrg's operating environment.

MediOrg has a range of stakeholders that are relevant for the analysis. It is evident that the different type of stakeholders exerts different type of impact on the organization. They are however all considered as stakeholders in accordance with Freeman (1984) since they can affect or be affected by the organizations objectives. The majority of the stakeholders are external, generating a large scope for the analysis. External stakeholders, as presented by Harrison and John (1996) are those entities that are outside the boundaries of the organization. In the case of MediOrg, the external stakeholders are the funders, that is, the Church and the government of India. External stakeholders are also the patients and the local network center. The internal stakeholders are the employees at MediOrg and are due to the scope of research not analyzed further in the stakeholder theory framework. The external stakeholders are discussed following the structure of Mitchell et al. (1997), where the three attributes power, legitimacy and urgency will generate an indication of the stakeholder salience.

Salience of Stakeholders

In the empirics, the stakeholders were described in terms of which of MediOrg's activities they belong to, which type resources they contribute with, how these resources are measured and followed-up. This was done in order to be able to analyze the different stakeholders with regards to power, legitimacy and urgency.

Power

Power, as brought forward by Mitchell et al. (1997) is the extent a stakeholder has or can gain access means to impose its will in the exchange relationship. The power attribute can be related to as utilitarian, where it is based on financial means. A stakeholder can use financial means in order to influence the organization. An apparent application to the case of MediOrg is the funders' importance for the organization's ability to carry out its work. The funders have a large degree of power, as they are the economic foundation of MediOrg. As there are no business activities that can generate profits, it follows that MediOrg should keep a functioning relation with their funders. None of the other stakeholders have the same incentive structure to use in order to influence MediOrg. This can be illustrated by contrasting the funders with the patients. The patients are very important to MediOrg as can be seen in MediOrg's mission statement:

> *"…a community/state/country where all will: have enough to suppress hunger, have clothes to wear, have clean water to drink, have a proper house to stay, have the ability to care for the elderly, have the ability to bring up children, have facilities to limit their family size and the women are empowered and protected irrespective of caste or creed" (*MediOrg*, 2003, p. 3).*

However, the relation with the patients is somewhat complex. As described, the area in which MediOrg is operating is one of the poorest in India, patients who come have no or very limited possibilities to pay for healthcare and they are often illiterate. The patients thus have neither knowledge nor power to enforce any impact on MediOrg. They thus fall behind the funders in the power attribute.

Power can also have a normative basis, where it is based on symbolic resources (Mitchell et al. 1997). We can in the case of MediOrg see an example of this in the

collaboration with other organizations, that like MediOrg have a religious basis. Through shared beliefs it is possible that these organizations can influence MediOrg in order operate more according to their interests. However, their collaboration with MediOrg only constitute a small part of MediOrg's total operations; through the HIV/AIDS support group meetings and through the awareness program. Their power to influence MediOrg through symbolic means is thus not as large as the government's financial power. It follows that it is the government that is strongest in the power attribute, as it in total stands for approximately 75 percent of MediOrg's yearly budget.

Legitimacy

For the second attribute described by Mitchell (1997), legitimacy, the analysis becomes less straightforward. At the core of MediOrg's operations are the patients. In the mission of MediOrg, the patients are considered to be the most important stakeholder and as a contrast to agency-theory (Inkpen & Sundaram, 2004) where the increase of the owners' wealth often is considered to be the overall goal of an organization. In this case it is rather the increase of the patient's health that is considered to be the overall goal of MediOrg. MediOrg's reason for being is the patients. The patients in this area of India are poor and are dependent on MediOrg to gain access to healthcare. It can thus be argued that they are the most legitimate stakeholders as they are in the most "necessary relation" (Friedman & Miles, 2002, p. 16) in the sense that their relationship with MediOrg is strongly interdependent.

In determining which stakeholders is the most legitimate, the funders should again be considered. Since they are funding the hospital, they ought to have a legitimate claim on MediOrg thus merit managerial attention. Without funding MediOrg would not be able to continue its operations and it would be impossible for the hospital to carry out its mission. Implicitly, the funders then become legitimate, as they are necessary in order for MediOrg to serve their most legitimate stakeholder, the patients. Within this line of reasoning, the two different funders, the national government and the Church have a slightly different degree of legitimacy. The Church has gradually been reducing their grant, while the government has increased their share in MediOrg's budget (for example through the HIV/AIDS program). The government becomes gradually more important compared to the Church. It is possible for MediOrg to seek out other funders as well, but

government has the advantage of being able to "offer" a stable and long term funding commitment and in doing so continue to support operations under MediOrg's mission.

Other revenue such as student fees (through the clinical training) provide such a small share of MediOrg's budget (five percent) that their impact on the long-term financial survival of MediOrg is very small. They are thus not considered to be as legitimate as the other funders as their financial contribution is not equally necessary. Collaborating organizations cannot be said to be legitimate in this sense either, as there is no financial exchange between them and MediOrg and they cannot be said to be as necessary in terms of MediOrg's survival.

Urgency

Urgency, the last attribute Mitchell et al. (1997) uses to determine stakeholder salience implies that the stakeholders that are most sensitive to a time aspect should be given priority by MediOrg. From a healthcare perspective, the patients' claim is most the time pressing. Not attending to the patients' needs may have fatal consequences and would mean severe mission failure by MediOrg. On the other hand, not following the funders' result measurement in a timely manner and not living up to the funder's requirements would lead to ceased financing, which would have fatal consequences for the organization. This in turn would have a negative effect on the patients. This may well affect MediOrg in that sense that those funders in need of specific results will receive increased prioritization from MediOrg.

A further distinction should then be made between government and the Church, where the former is specific in what their funds should go to and the latter donate a general grant. The Church have less formalized follow-up procedures and following the above reasoning their interests would gradually be less and less prioritized. Support for this can be found in the empirics; the Church do not take an active part in the governing board. They are not pressing in their demands and so focus shifts from them to those other stakeholders who do have demands, such as the government. It seems as though when the funder itself has a claim on urgency, it becomes stronger in the urgency attribute. We can also consider the relationship with the other organisations. There are

no follow-up procedures on financial exchanges that need to be met in a timely manner and so there is not a strong degree of urgency to consider for these organizations.

Which stakeholders are prioritized?

The attributes power and urgency implies that salience should be given to the funders, more specifically the government as it stands for the largest share of MediOrg's budget. Their importance is also reflected by the Hospital Manager in saying "there is a constant struggle to make ends meet" (Hospital Manager, MediOrg, 2012-03-19). However, also considering legitimacy the prioritization may change. What we found during our stay at MediOrg was that the government was an important stakeholder, but it was something that had to be adhered, not what the organization wanted to prioritize. This gives an indication of the importance of the legitimacy attribute, but it does not change the fact that an unwanted prioritization has to be done. Collaborating organizations with a shared religious basis was found to have power and thus influence, but as they are not as strong as patients or funders in the attributes legitimacy and urgency, they are not given the same prioritization.

An example of the importance of funds over patients can be found in the HIV/AIDS program. MediOrg are forced to only admit the most ill patients, as they do not have the funds to expand the number of beds. In line with Chang (2006), we find that stakeholder salience is given to the funders, although there is a will to prioritize the patients. Demands from external stakeholders can outweigh clinical decisions, as MediOrg are dependent on those stakeholders' financial resources.

In this section, we have discussed the different stakeholders in terms of stakeholder salience (Mitchell et al. 1997). Determining which stakeholder is and should be given priority is not completely straightforward as the same stakeholders are not strong in all three attributes; power, legitimacy and urgency. We found that the funders with demands on result measurements are prioritized as they have a combined strength in all three attributes. MediOrg are dependent on financial stakeholders and need to adhere their demands. Given that the government via the four different activity programs is the largest funder, they are then also the most salient stakeholder. The stakeholders' actual

impact on MediOrg's management control practices will be further discussed in section 5.2 and 5.3.

5.2. Management Control in a Healthcare NGO

External Stakeholder Controls at MediOrg

As described in the empirics, the governmental organizations funding MediOrg demand the follow-up of their funds to be extensive and explicit. It is also clear from the stakeholder analysis that the most salient stakeholder is the national government that via its national programs funds approximately 75 percent of MediOrg's yearly budget. The funding stakeholder organizations, in this case the national government have formal objectives based upon clinical outcomes (which is also anticipated by literature, see for example Nyland & Pettersen, 2004). This could for example be objectives such as detection rate and cured rate in the case of the Tuberculosis program and pre-operative check-ups, and surgical details in the Blindness Control program. MediOrg is obliged to present this information in monthly, quarterly and yearly reports to the governmental agencies. Even though the objectives set by the funders are not in direct conflict with the MediOrg's own mission, they are much more explicit and with a stronger focus on outcome measurement (Ouchi, 1979). This work as MediOrg's mission is very wide and functions as an umbrella where the objectives of the funders all can be obliged.

It should be added that many of the funding organizations are not unnecessarily strict in their evaluation procedures and that MediOrg has a continuous dialogue with them. The government agencies explain that MediOrg has become better at producing formal performance evaluation and thus showing more evidence-based operations, which is also deemed important by this particular stakeholder. MediOrg can thus receive higher external legitimacy from surrounding organizations, which implies, following the reasoning by Ebrahim (2003) that they are likely to get continuous funding from national programs. These findings are in line with Modell (2009), proposing that performance measurement are mainly use to satisfy the demands from funders rather than as a vital part of the organization itself.

We see the result of this in how the direction for MediOrg has changed with the intensified collaboration with the government. At present, much of the organizational focus is upon the treatment and counseling of HIV/AIDS-patients. This also coincides

with the fact that large part of the hospital budget (35 percent) is provided by this government program. Li and Tang (2009) predict that funder organization will have a direct impact on the objectives of the organization. However what is interesting in the case of MediOrg is that the objectives remain the same, the funder organizations' interest does not change the MediOrg's mission. We do see that there is an increased focus on the government programs, indicating that their interests have had an impact on the direction of MediOrg's organization. As MediOrg's mission is so wide, this has not implied a change in goals and it has not implied a change in the formal management control practices at the hospital. The few formal control practices at MediOrg is to a large extent based on routines and practices that are already known as a consequence of the profession of the employees. The formal control practices as imposed by the government have for example not changed how the daily patient round is performed or how information is shared. The change in direction rather relates to the types of patients that MediOrg can specialize in treating; patients that they welcome in accordance with their mission as well as the demands by the government.

As a contrast to the funding stakeholders it is interesting to consider what type of control the non-funding stakeholder requires from their collaboration with MediOrg. When it comes to other NGOs that MediOrg collaborates with such as the local network center, they clearly have a more similar point of view when it comes to objectives. They share the same holistic approach and are in greater extent able to understand each other. There seem to be less need to manage the relations, and these organizations are also steered by similar belief systems. As these organizations do not have any financial exchange, there are no demands on formal result measurement or follow-up procedures.

For God's Stake –Internal Control Practices at MediOrg

The daily work at MediOrg is to a large extent guided by behavior control as described by Dekker (2004). There are rules and procedures that direct the work of the employees such as daily routines and written descriptions of the different positions and activities. However it seems as this type of behavior controls are mainly a way to direct the performance in the right directions while the true motivation force for the employees is found in other areas of MediOrg's control mechanisms.

Given the mechanics for control as proposed by Ouchi (1980), it is clear that MediOrg internally is very much operating in a mode similar to the "clan control" described. The employees of MediOrg are to a large extent driven by their faith and even though not all of the employees are Christians, faith plays an important part in the work of the hospital. As one of the nurses described it: "On judgment day, he 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" (Nurse, MediOrg, 2012-03-09). Evidently, the chapel at the hospital compound plays a significant role in their work. Information is mainly distributed during and after the morning service. This can be translated into the traditions described by Ouchi (1980). It is in the chapel that we found the subtle signals related to performance evaluation. During the prayer and in the following information announcement, the Hospital Manager would often mention the role of God in the daily operations. When MediOrg had hosted a successful activity day or had successful treatments, the Hospital Manager would thank God for his influence and guiding hand.

It is not only the religious belief that plays a role at MediOrg. It is also the belief that one should contribute to the society. Many of the employees also have spouses/family members also working to help the poor people in the society. The Middle Manager (2012-03-16) describes that the community development is the most important part of his work and what motivates him in his daily work. For the healthcare educated personnel it thus comes down to serving your profession, as described in Ouchi (1979).

The Hospital Manager, as a strong leader and father figure for many of the employees, also has a significant impact on the organization. He and his wife, the Senior Counselor, both exert an informal kind of control through the usage of religion. The very informal and belief-based control systems at MediOrg that they implement internally are a stark contrast to the formal and often numerical targets that are set by the funding organizations and governmental programs.

In conclusion, in this section we analyzed how the formal performance measurement procedures influences MediOrg's management control practices. We started by discussing the formal controls performed at MediOrg and concluded that outcome control is mainly a requirement from external stakeholders and is not used within the organization. Behavior controls are used in order to direct the work of the employees in

the right direction. The motivation force for employees are found in the informal controls as religion and community development is considered as the motivation forces for the employees.

5.3. Contrast Between the External Stakeholder Demands and Internal Control Practices – The Absorber

From the stakeholder analysis we have seen that MediOrg is facing a diverse set of stakeholders that possibly can affect their control practices. From the empirics, we see that many of the external stakeholders have goals and targets that could imply that the control activities in MediOrg should be formal, complex and extensive. However, the analysis of the management control practices at MediOrg shows us that the external control functions are sophisticated, tangible and outcome-based while internal control practices are intangible and subtle. This contrast will in this section be highlighted and explained with the concept of absorption.

The formal reports produced to satisfy funder evaluation are not displayed further down in the organization and is not used for performance evaluation internally in the organization. This is for instance exemplified when talking to the nurses. As one nurse said when asked about the financial situation at MediOrg "we do not need to worry about that. You should ask Sir" (Nurse, MediOrg, 2012-03-09). Another example is the Hospital Accountant who to a large extent did not know in what way the material she produced would be used. It is even exemplified on a Middle Management level, where when asked about the follow-up procedures of grants, the Middle Manager immediately referred to the Hospital Manager, "this question will be relevant to Sir since he is the administrator. I do not have much idea about this" (Middle Manager, MediOrg, 2012-02-27). Thus, what we find is that the Hospital Manager absorbs the demands of formalized controls from external stakeholders. As stated in Laughlin et al. (1994a), this is what can be predicted when changes in the environment implies new directions and mechanisms for the organization.

This implies that the formal requirements as imposed by the national programs are not really introduced into MediOrg's daily operations. Broadbent and Laughlin (1998) describes that this is a way for the management to resist the introduction of outcome-based measures into the organization, so that the medical practitioners can focus on

their daily routines of treating patients. This is also supported from Nyland and Pettersen (2004) and Modell (2009), saying that formal control in healthcare organizations are mainly a way of ensuring legitimacy and to continue to get funding. The formal controls do not imply any changes except for the Hospital Manager/absorber that has to meet the demand from stakeholders on evidences and outcomes from the operations. As described in the empirics, the Hospital Manager at MediOrg does manage the major part of both formal and informal controls at MediOrg. Much of the relations with the stakeholders are taken care of by one person, not transferring the stakeholder demands and requirements onto the other members of the organization, in accordance with the theory of absorption.

It can be discussed whether the formal requirements from the funders have a negative effect on a healthcare organization. It is argued (Broadbent & Laughlin, 1998) that formal measures enforced from external parties often are perceived as intrusive for the healthcare organization and that the role of the absorber is justified since he/she relieves the other employees from intruding goals from outside. It is not necessarily the case that formal control mechanisms as imposed by external stakeholders would have a negative effect on MediOrg. For instance, Järvinen (2006) find both economical and efficiency rationales for implementing formal control mechanisms.

This final section of the analysis highlights the contrast in the findings from section 5.2 where external stakeholder in the form of the national programs often require formal outcome-based follow-up in order to continue to cooperate with MediOrg. However, in the analysis it is also concluded that MediOrg internally are mainly controlled through informal mechanisms such as religious belief. These two types of control-mechanisms can co-exist since the Hospital Manager absorbs the formal outcome-requirements from the external stakeholders and “saves” the employees of MediOrg from the “burden” of formal, extensive and explicit outcome-measurement.

6. Conclusions

6.1. Conclusions – Absorption of External Stakeholder Demands

The aim of this thesis was to investigate how external stakeholder goals and objectives affect the management control in a healthcare sector NGO. By first analyzing the external stakeholders at MediOrg with respect to stakeholder salience as brought forward by Mitchell et al. (1997) we found that the most salient stakeholder is the one that is the largest contributor to the hospital's budget in combination with being the one with the largest demand on result measurement and follow-up procedures. We highlighted that even though this was the case, the organization was still working with a strong focus on its mission, where the patients are at the focal point.

In the second part of the analysis we investigated how the external demands on result measurement and follow-up procedures are dealt with at MediOrg and we found that outcome control (Dekker, 2004) is mainly a requirement from external stakeholders and is not used in the internal management control. The external stakeholders affect the direction of the organization but the internal control mechanisms seems unaffected. The organization is instead managed through informal control, with emphasis on religion and shared beliefs (Ouchi, 1980).

Finally, we found that the two control mechanisms; formal outcome control requirements from external stakeholders and informal control mechanisms through religion internally can coexist as the Hospital Manager takes on the role as absorber. We found, as brought forward by Broadbent and Laughlin (1998) that the absorber captures the external pressures in order to allow the organization to internally focus on its core operations.

6.2. Practical Implications and Suggestions for Future Research

Following our conclusion, there are some interesting implications for MediOrg. We see that the informal power of one strong leader/father-figure coincides with being the absorber of the formal requirements form external stakeholders. Even the Middle Manager is to a large extent unaware of the external requirements. This may have negative consequences in the long run, when there is a shift in management for instance due to retirement. If there are no structures to manage the current stakeholders, as

these are tied to a person rather than a position, MediOrg risks loosing its current stability. In addition, it may be beneficial to highlight certain measures internally in the organization as it can give the employees evidence that the organization is moving in a good direction. There is already a strong credence to the organization among the employees but it could perhaps be strengthened even more.

Whether the Hospital Manager's absorption is deliberate or not is not discussed in this thesis, however it would be an interesting aspect when further discussing management control practices, as it would address issues such as power structures within the organization. Another suggestion for further research is to address external stakeholders' influence on management control in another setting. This would facilitate a comparison in order to capture cultural effects that may have affected the outcome of this study. A future study could for instance take place in a non-developing country where it perhaps could be expected that external pressures on formal control measurement could be even stronger. A future study could also select a non-religious NGO as the case organization as it would highlight other informal controls than religion characterizing the organization.

7. References

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8. Appendix

8.1. Interview Overview

1. Coordination Officer, Local medical college
2. Director of the International Mission, Church
3. District Tuberculosis Officer, Tuberculosis Control Programme
4. Center Manager, HIV/AIDS Network Center
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, MediOrg
17. Principal, Local Education Society
18. Programme Manager, Health Promotion Trust
19. Senior Counsellor, MediOrg